‘Knitting together all Parts of the Vast Structure of Society’: Care Work, Philanthropy and Urban Welfare in Scotland, c 1720 c 1840[1]

Sir David Wilkie, *Pitlessea Fair*, 1804

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PhD Thesis

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December 2023

[1] William Pulteney Alison, *Observations on the Management of the Poor in Scotland* (Glasgow, 1840), 163.

Abstract

This thesis studies care in the context of urban Scotland between 1720s and 1840s. It treats care as a concept, a resource and an economic phenomenon, as well as a practice and a form of labour. In this thesis, care is contextualised by its socio-economic and political milieus. The backdrop of this research is Scotland's industrialisation and imperial expansion that shaped the nation's socio-economic and demographic structures, which contributed to the transformation of the nation's regimes of care. I therefore situate care at the centre of contemporary debates around welfare and social policy. This thesis speaks to the economic histories of Scottish (and British) industrialisation that have thus far not included care and social reproduction as causative factors. It contributes to the field of new histories of labour; surveying the ways changing socio-economic relations reshaped the labours of care. My focus is primarily on commodified forms of care work as opposed to its unpaid forms, aiming to point out the vastness of the care market. As such, I view care work mediated through the market or performed inside institutions such as voluntary hospitals and orphanages. Through this focus, I highlight the nature of care work as an occupation or a form of entrepreneurship. With the continued association between care and the unpaid work of women within the home, gender plays an important role in this analysis, largely inspired by the work of feminist economics. I show that whilst care work in eighteenth-century Scotland was feminised, men performed a lot of it too. Moreover, much care work was commodified and performed alongside other forms of paid work. Supporting new research on gender and work, I argue that familial caring responsibilities did not shape women's labour force participation, instead being distributed amongst available sources of provision, paid and unpaid. Summarily, accounting for economic histories of care is necessary for the understanding of all economic processes, as well as their gendering.

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Acknowledgements

This research was made possible due to the generous support of the Scottish Graduate School for Arts and Humanities, with special thanks to its director, Claire Squires.

First and foremost, my thanks go to Alexandra Shepard. Alex introduced me to the study of care in my undergraduate and her careful supervision and mentorship guided me throughout my academic journey. I never would have come this far without her encouragements, kindness and caring friendship over the years, and for this I am ever grateful.

Throughout the last four years, I benefited immensely from the support of my secondary supervisors, Stana Nenadic and Catriona MacLeod. Stana and Catriona shared their time, knowledge and constructive criticism, which have been invaluable in the process of completing this thesis.

Many historians shared their insights, advice and time reading draft chapters. Special thanks are to Alannah Tomkins and Chris Langley for sharing their thoughts. Additionally, I would like to thank Maria Ågren, Maria Bjorkman and Lauren Kassell for hosting me during my visiting fellowships in Uppsala, Linkoping and Florence. Their support was essential and made my stays ever more rewarding.

Special thanks go to my 'support system'. Anna, Beth and Juliette, you have all been the friends that I could always rely on throughout this process and beyond. Sharing an office with Anna had made every day more joyful and she remains one of my most treasured friends. Additionally, the last months of my PhD were shared with Silvia, who has become a dear friend.

Last but not least, my thanks go to my family who always encouraged my interest in history, supported me in my ever-changing plans and gave me the confidence to write the pages that follow.

Author's declaration

I hereby certify that this thesis has been composed by me and is based on my own work, unless stated otherwise. No other person's work has been used without due acknowledgement in this thesis. All references and verbatim extracts have been quoted, and all sources of information, including graphs and data sets, have been specifically acknowledged.

Date: 12th December 2023
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1 Introduction: Writing histories of care

> In a civilised society [a man] stands at all times in need of the co-operation and assistance of great multitudes [… and] has almost constant occasion for the help of his brethren.[1]

> Whenever any individual of our species is not provided for, either by his own labour, or by the labour of his ancestors, or of his immediate relations, he is in a political sense dependent.[2]

In 1776, Adam Smith wrote of the fragility of human nature compared to other species. His polemic on human interdependence in the *Wealth of Nations* has however been overshadowed by his emphasis on human self-interest and human betterment. Across his writing, his argument for a social contract that turns individuals into brethren is nonetheless clear. For Smith, individual self-interest and human interdependence were never mutually exclusive, and it was through the recognition of both that the human lot progressed.[3] Some sixty years later in his study of the conditions of the poor, William Pulteney Alison, the founder of and physician to the New Town Dispensary and Chair of Medical Jurisprudence at Edinburgh, again highlighted that dependency characterised human nature. This dependency was material, biological and now also political. It linked the individual to their family, community and increasingly a state that was beginning to assume responsibility for the life and welfare of its flock in ways that differed from the parochial familialism of a century prior.[4] Alison was heavily influenced by Smith, especially in matters pertaining to Smith's justice ethics and his early formulation of a 'capabilities approach' to human rights.[5] Both thinkers wrote in a period of social

[1] Adam Smith, *An Inquiry into the Nature and Causes of the Wealth of Nations* (London, 1776), 15.
[2] William Pulteney Alison, 'Illustrations of the Practical Operation of the Scottish System of the Management of the Poor'*, Q.J. of the Statistical Society of London* (1840), 246.
[3] Smith, *Wealth of Nations*; Adam Smith, *The Theory of Moral Sentiments*, Sixth Edition (1790); Cornelia Lambert 'Barefoot Children in a 'Fine Room', Robert Owen, Adam Smith, and social regeneration in Scotland' in David Hitchcock and Julia McClure, *The Routledge History of Poverty, C. 1450-1800* (London, 2020); for scholarship critiquing liberal reading Smith see: Emma Rothschild, *Economic Sentiments: Adam Smith, Condorcet, and the Enlightenment* (Cambridge, 2002); Emma Rothschild, 'Social Security and Laissez Faire in Eighteenth-Century Political Economy', *Population and Development Review*, 21:4 (1995); Frederick Rosen, *Classical Utilitarianism from Hume to Mill* (London, 2003); Christopher J. Berry, *The Idea of Commercial Society in the Scottish Enlightenment* (Edinburgh, 2014).
[4] William Pulteney Alison, *Observations on the Management of the Poor in Scotland* (Glasgow, 1840), 14.
[5] See Amartya Sen, 'Adam Smith and the Contemporary World'; *Erasmus Journal for Philosophy and Economics*, 3:1 (2010); Amartya Sen, *Development as Freedom* (New York, 1999); Stanley Engerman, 'Slavery, Freedom, and Sen', *Feminist Economics*, 9:2/3, (2003); Martha Nussbaum, 'Capabilities as Fundamental Entitlements: Sen and Social Justice', *Feminist Economics*, 9:2/3, (2003).

dislocation that brought the subject of human need to the forefront. With increased mobility, urbanisation and the breakdown of traditional communities, human dependency became palpable, and the political pressure to supplement the eroded social fabric ever more pressing. Consequently, this raised political discussions around provision; maintenance, and more broadly care across the fields of poor relief, labour management and public health. Alison's emphasis on abstracted questions of political dependency (as opposed to more directly experienced ones) shows an important move toward legalism that Smith only hinted at, as Smith wrote in a climate where networks of provision were more directly linked to one's lived environment rather than to an abstract body politic.[6] Contrary to their present-day removal to the margins of economic thinking, human dependency, and by extension questions around care provision, remained at the forefront of political economy and social policy throughout the long eighteenth century.

Using areas of urban Scotland as case studies, this thesis examines care, on one hand as a concept, a resource and an economic phenomenon, and on the other as a practice, a form of labour. In both dimensions care is contextualised by its socio-economic and political milieus. I argue that the lack of understanding of care relations and distribution in this period is the single most glaring omission from the histories of the household, family and community formation, and gendered work as well as the processes of economic change. First, I situate this work within broader debates about Scotland's industrialisation and imperial expansion. Second, I speak to the field of new histories of labour, surveying the ways in which changing socio-economic relations reshaped the labours of care. I focus primarily on commodified forms of care work as opposed to its unpaid forms, aiming to point out the vastness of the care market. As such, I look at care as an economic activity as well as the underpinning of all other economic activities, discrediting its continued association with the economic margins.

In Scotland, the period between 1720s and 1840s was one of radical transformation of the economic and demographic makeup of the nation fuelled by industrialisation and the growing prominence of industrial extractive capitalism. Following from this change, the nation's mechanisms of social reproduction altered. As this thesis argues, early modern care relations in Scotland were organised in a mixed economy of welfare that was highly commodified. It was not until the eighteenth century, however, that the idea of the market began to wield power as the organising principle of social relations, including those of

[6] Mary Poovey, *Making a Social Body: A British Cultural Formation, 1830-1864* (Chicago, 1994).

social reproduction.[7] The emphasis on progress and commerce made by Scottish 'improvers' encompassed varied aspects of human existence and placed the betterment of humankind at the core of its growth-oriented economic thought. Moreover, 'improvement' philosophy linked processes of social reproduction to human capital investment. In the context of the nation's promotion of mercantile and increasingly industrial capitalism as economic systems favoured by the state, the idea of a 'commercial society' became dominant; resulting in social relations becoming embedded in and subject to economic processes.[8]

As proposed by Nancy Fraser, capitalism operates in an inherently contradictory fashion.[9] It relies on the work of social reproduction whilst also continuously undervaluing it and rendering its labours invisible, somehow external to the economy. Capitalism's 'orientation to unlimited accumulation tends to destabilize the very processes of social reproduction' resulting in a crisis of social reproduction. Production and reproduction are positioned as separate, with reproduction viewed as largely secondary to market-oriented production and habitually perceived as 'free', contributed by the housework and care work of women. The conceptual separation of production and reproduction creates a narrow understanding of the economy perceived as a self-regulating mechanism that exists outside of the human dependency and need reflected on by Smith and Alison. But capitalism as well as its 'crisis tendency' have a history.[10] In the long eighteenth century, production and reproduction were viewed as linked economic processes. Political economists debated subjects related to population generation, education and provision to harness them for the purposes of furthering economic growth. For eighteenth-century 'improvers', providing for and educating the population was a way of shaping the nation's economic future. In the early nineteenth century, care and maintenance, especially of the poor, continued to be a public affair, shaping urban planning and institutional developments and public health measures. The externalisation of reproductive processes from political economy and social policy, I argue, was not the product of eighteenth century capitalist transition. Instead, a rising association between work and wages across the nineteenth century and its entrenchment in economic measurements in the twentieth century created this view of

[7] Smith, *Wealth of Nations*; Paul Langford, *A Polite and Commercial People, England 1727-1783* (Oxford, 1989); Craig Muldrew, *The Economy of Obligation: The Culture of Credit and Social Relations in Early Modern England* (London, 1998); Berry, *Idea of Commercial Society*.
[8] Berry, *Idea of Commercial Society*; Ellen Meiksins Wood, *The Origin of Capitalism, A Longer View* (London, 2002), 24; Karl Polanyi, *The Great Transformation* (New York, 1944); E. P. Thompson, *The Making of the English Working Class* (London, 1963), 68.
[9] Nancy Fraser, 'Contradictions of Capital and Care', *New Left Review* 100 (2016).
[10] Fraser, 'Contradictions of Capital'; Nancy Fraser, *Cannibal Capitalism: How our System is Devouring Democracy, Care, and the Planet-and What We Can Do about it* (London, 2022).

reproductive processes. My research aims to historicise the relationships between processes of production and reproduction. It is a goal that carries relevance for an historical as well as an economic study. Contesting the teleology of mainstream economics today that traces its foundations to Smithian political economy, I demonstrate the lack of separation, both conceptual and practical, between production and reproduction in the long-eighteenth century. Simultaneously, I challenge the depiction of reproductive processes as somehow timeless and naturalised. Instead, I highlight their historicity and dependence on broader socio-economic and demographic factors.

Whilst this thesis focuses on areas of urban Scotland, the economic history of this locality is inextricable from its imperial contexts. Scotland was heavily embedded in the imperial project, particularly after the Treaty of Union of 1707.[11] As indicated by the 1701 petition co-signed by 185 inhabitants of Glasgow, many of whom were members of the Merchants and Trades house, Scottish imperialism also preceded the Union, suggesting 'there is nothing dearer to us than the free exercise of our religion, and next the support of our trade' and to 'assert our company's right to our colony of Caledonia, in which so great a part of our stock is employed'.[12] Whilst the ambition to establish a Scottish colony never came into fruition, Scotland's engagement in the British Empire was significant, and the proceeds made by Scots in colonial pursuits including plantation slavery were pivotal to the reshaping of urban landscapes. Upon the signing of the Union treaty, Scotland became a key player in colonial expansion and politics, reshaping the nation's economic structures both externally and internally. As will be shown in Chapter 6, philanthropic institutions in Scotland benefited from resources gained through colonial commerce, including the production and trade in commodities produced by enslaved workers. Whilst the revenue from colonial ventures likely did not exceed 10 per cent of annual inputs of institutions such as the Edinburgh Royal Infirmary, its effect on Scottish care regimes and care infrastructures was nonetheless significant.

Further to this point, the intricate relationship between the family and empire contributed to the reshaping of caring relations during the long-eighteenth century. Research by historians such as Margo Finn, Emma Rothschild and Deborah Cohen demonstrates the ways in which the empire shaped familial structures, relations and economies, whilst altering performances of femininities and masculinities in the context of

[11] Tom Devine, *Recovering Scotland's Slavery Past: The Caribbean Connection* (Edinburgh, 2015).
[12] George Crawfurd, *A Sketch of the Rise and Progress of the Trades' House of Glasgow* (Glasgow, 1858), 113.

the family.[13] Imperial consciousness played a role in how many Scottish families formed and navigated the expanding world, across social strata, often separating in order to multiply their fortunes in the colonies, join the naval and armed forces or try their luck elsewhere by emigrating. Caring responsibilities were thus often removed from the dispersed nuclear family to the extended household, shared amongst friends or delegated to paid providers. As shown by Helen Berry on the case of the London Foundling Hospital and supported by this thesis, institutional childcare was also envisioned with imperial populationism at heart, with children admitted to institutional care educated to labour for the growing empire. In the context of this thesis where the family features as an analytical lens more than a subject of enquiry, the relationship between the biological family and the Empire is not explored in much depth. The changing nature of the family and, as a consequence, familial care provision at the forefront of the Empire nonetheless needs acknowledging. As Berry suggests, the emerging systems of welfare provisions feature as 'another dimension to the discovery that imperial ambitions shaped society within the British Isles (the 'inner empire') as much as in the 'outer empire' of overseas colonies'.[14]

Scotland's manufacturing sector transformed into a pro-export economy of scale and industrial capital largely replaced mercantile with the growing focus on large-scale production in the nation's industrial hubs. This new regime of production reshaped labour relations.[15] Processes of social reproduction already embedded and shaped by capitalist structures were reconceptualised as tools of human capital formation in line with the emphasis on the labouring potential of the population. The varying degrees of unfreedom that characterised slavery and indentured servitude in the colonies also structured forced employment and labour exploitation measures applied to the local poor, which can be viewed as a periphery within the core. Whilst forced labour in Scotland cannot be conflated with racial slavery, the epistemological linking of these coercive labour practices is nonetheless essential. As recently shown by Christian De Vito et al., histories of labour have traditionally taken a narrow view, focusing primarily on waged workers and excluding 'workers in any other labor relation—such as slaves, serfs, and indentured servants but also those in all other forms of unpaid, nonmarket work, mostly performed by

[13] Deborah Cohen, 'Love and Money in the Informal Empire: The British in Argentina, 1830-1930', *Past and Present*, 245 (2019), 79-115; Emma Rothschild, *The Inner Life of Empires: An Eighteenth Century History* (Princeton, 2011); Margo Finn, *The East India Company at Home* (London, 2018).
[14] Helen Berry, *Orphans of Empire: The Fate of London's Foundlings* (Oxford, 2019).
[15] Devine, *Recovering Scotland's Slavery Past*; T. M. Devine J. Wormald (eds.) *The Oxford Handbook of Modern Scottish History 1500-2000* (Oxford, 2011); Stephen Mullen, *The Glasgow Sugar Aristocracy: Scotland and the Caribbean Slavery, 1775-1838* (London, 2022).

women and children'.[16] Additionally, as Diana Paton demonstrates, histories of slavery have rarely adopted a gendered lens, discounting the variedness of exploitation by gendered persons and their bodies. She shows the ways in which the gendered bodies of enslaved women and their reproductive labour allowed chattel slavery to reproduce itself and remain profitable. Crucially, her work places the work of social reproduction at the heart of extractive capitalism, exemplified by the commodification of the lives and bodies of the enslaved, but equally crucial in narrating labour relations in the imperial core.

I write in line with De Vito's call for an expanded, global view of labour relations that challenges the enduring paid/unpaid, free/unfree, and productive/unproductive binaries.[17] Whilst this thesis does not directly engage with the histories of slavery, it recognises the ways in which, on a global scale, slavery shaped labour relations across the Empire. Furthermore, similarly to Paton, I conceptualise social reproduction as the underpinning of extractive industrial capitalism as well as a key determinant of labour relations in any given society. In a regime where slavery is an acceptable structure of production, all labour relations are altered.

1.1 Defining *Care Words*

How do we define *care words*, that is, terms and concepts pertaining to the subject of care? While they are common-use terms, they are also imbued with complex political meanings that need to be acknowledged. In the context of this research, I define *care* as practices linked to the material, physical, affective and political aspects of providing for the needs of living beings, that are necessary for the sustaining and development of their lives; bodies and/or minds, thereby underpinning all economic processes.[18] Beings rather than persons is used to encompass the breadth of non-human caring and the ways in which animal and human care were perceived and practiced in parallel, stemming from a shared principle of duty to care. That being said, this thesis does not explore human-animal relations, instead outlining the extensiveness of caring relations, practices and cultures. Purposively broad, this definition allows for the study of ideas and regimes of care alongside their manifestations in the realm of social realities, as practices, institutions and infrastructures. As suggested by Green and Lawson, 'studies of care often focus on discrete sets of

[16] Christian De Vito, Juliane Schiel, Matthias van Rossum, 'From Bondage to Precariousness? New Perspectives on Labor and Social History', *Journal of Social History*, 54:2 (2020).
[17] Vito, 'From Bondage to Precariousness'; Caitlin Rosenthal, 'Capitalism when Labor was Capital: Slavery, Power, and Price in Antebellum America', *Capitalism: A Journal of History and Economics*, 1 (2020); Diana Paton, 'Gender History, Global History, and Atlantic Slavery: On Racial Capitalism and Social Reproduction', *American Historical Review*, 127:2 (2022).
[18] See Ch 3.

practices (such as child care, end-of-life care, emotional support and house cleaning) associated with certain sites (home, community, hospice, inter alia). This domestic domain associated with the needy subjects is in contrast to the public domain of economy, which is characterised by calculative market rationalities and populated by autonomous rights-bearing individuals who are free to make their own choices'.[19] This separation results not only in a narrow understanding of care as a practice, but also naturalises it within limited sites. With the overwhelming majority of research focusing on care as a feminised domestic practice, this representation of care is reinforced despite its actual variedness.[20] This simplification occurs in spite of the vastness of the *public* medical and care sector populated by trained professionals many of whom are men. As suggested by Kristeva, 'medical research and the practical art of care are assigned to different ontological domains (nature and culture) and to different time zones: the first to the universal stasis and Platonic non-time of biomedical evidence; the second to the mundane biographical time of care as an intertextual co-creation of meaning in encounters between practitioners and patients'.[21] Positioning professionalised, trained, public forms of care alongside the familial, casualised, domestic forms of care highlights the arbitrariness of this demarcation. It points out the similarity of the actual work of care, in sickness and in health and across varied loci. Additionally, a space for acknowledging the types of care situated between the professional and the familial emerges. In this thesis I examine residential institutions such as orphanages and boarding schools that emerged in early eighteenth-century Edinburgh in order to challenge the professional/familial separation. Other key examples are care homes or residential communities.

Alongside the broader term *care*, I talk about *bodywork* and *care work*. *Bodywork* involves hands-on, often embodied tasks, which include the direct care of the body of another. This may include child or sick nursing, end of life care, physical caring for someone with reduced mobility, convalescent care as well as the work of clinical medicine and surgery or pathology. Traversing the categories of sickness and health, and ranging across different time spans, and applicable to living and dead bodies, the term bodywork is key as a way to bridge the ontological divides between different types of caring and different roles or occupations as part of which these tasks are performed.[22] In the long

[19] Maia Green and Victoria Lawson, 'Recentring Care: Interrogating the Commodification of Care', *Social and Cultural Geography*, 12:6 (2011).
[20] Green, Lawson, 'Recentring Care'.
[21] Julia Kristeva et al. 'Cultural Crossings of Care: An Appeal to the Medical Humanities', *Medical Humanities,* 44 (2018).
[22] Mary Fissell, 'Introduction: Women, Health and Healing in Early Modern Europe', *Bulletin of the History of Medicine*, 82:1 (2008); see also: Montserrat Cabré, 'From a Master to a Laywoman: a Feminine Manual of Self-help', *Dynamis: Acta Hispanica ad Medicinae Scientiarumque*

eighteenth century, the varied tasks of bodywork overlapped significantly and neater categories focused on distinct tasks such as surgery or midwifery do not capture the complexity of tending bodies. As will be demonstrated in Chapter 4, recognising the lack of occupational boundaries is key in understanding the nature of contemporary work in the care sector.

I understand the broader term *care work* to include bodywork as well as caring tasks that do not involve direct physical contact between the carer and the cared for, encompassing affective and intellectual provision such as teaching, minding children and play, providing religious and moral guidance and pastoral support. Preparing food and remedies, laundry and cleaning, often carried out by lodging providers, are also included here. Lastly, material provision such as supplying food and clothing, housing and warmth are integral parts of care work. I adopt this broad understanding of care work in order to capture the range of forms of providing for the needs of others, both from the point of view of the cared for, as well as the care provider.

Two other concepts to which I refer frequently are *welfare* and *social reproduction*. *Welfare* is a highly politicised term, largely used in relation to state provision for its inhabitants, primarily those in a position of disadvantage. In the context of this research, I use the term more loosely, to designate the health, comfort and wellbeing of an individual or a group. I use *welfare provision* to designate philanthropic, charitable and state based initiatives to promote the welfare of an individual or a group, largely taking place within an institutional space and primarily directed at the poor. My application of the term draws on the work of David Green and Alastair Owens, who expand the notion of early modern welfare, habitually linked to the much narrower welfare state and its linear development. Their focus on the 'mixed economy of welfare' captures the many ways throughout the life-cycle of individuals and families in which different care providers were integrated into welfare strategies in response to varying needs. Their expansive notion of welfare beyond provision for the poor demonstrates the centrality of care arrangements to horizontal familial, neighbourhood and kinship relations, but also to vertical links of patronage, social obligation, and state oversight.[23]

As I demonstrate, adopting this expanded notion of welfare beyond the state allows for a modified chronology, suggesting that the concept of welfare precedes the welfare

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Historiam Illustrandam, 20 (2000); Monica Green, 'Bodies, Gender, Health, Disease: Recent Work on Medieval Women's Medicine', *Studies in Medieval and Renaissance History,* 3:2 (2005); Sandra Cavallo, *Artisans of the Body in Early Modern Italy: Identities, Families and Masculinities* (Manchester, 2007).

[23] David Green, Alastair Owens, 'Introduction: Family Welfare and the Welfare Family', in Green and Owens (eds.), *Family Welfare: Gender, Property, and Inheritance Since the Seventeenth Century* (Santa Barbara, 2004).

state. Crucially, the welfare state of the twentieth century is seen as directly emerging from the mixed economy of welfare, through a process of centralisation, formalisation, and externalisation of pre-existing 'organic' and 'pragmatic' institutions, and linked to demographic and socio-economic change. Despite the paradigm shifts that separate our current understanding of care and welfare from their eighteenth-century counterparts, Green and Owens suggest there has always been a mixed economy of welfare, stressing the need to capture continuities as well as change. They pay attention to the complex role of the state and its changing historical nature as both a care provider and an agent shaping the roles of other providers. This insight is key to my study, which touches upon the emerging narratives of centralisation and standardisation of care provision in the lead up to the New Poor Law.[24] Care as a practice is essential to these discussions in spite of often being side-lined. My focus on care within the broader context of welfare strategies and welfare provision is intended to centre care in these debates.

Likewise, *social reproduction* is both a politicised and a highly theorised term rooted primarily in Marxist theory and Marxist Feminism that recognises the spheres of production and reproduction as inherently linked.[25] Within this framework, I understand *social reproduction* as the aggregate of life producing and sustaining mechanisms that underpin human biological and social existence. The work of social reproduction contributes to human capital formation that underpins the processes of capitalist production and accumulation.[26] In understanding the linking of production and reproduction identified by Marx (as opposed to treating them as separate spheres and processes as suggested by structuralism), my work is rooted in the tradition of Marxist Feminism. Inextricable from the arbitrary opposition between production and reproduction accepted by mainstream economics, I view social reproduction as both the underpinning of the so-called 'productive economy' (that is monetised, income generating) as well as its integral component. The work of social reproduction has been cast as women's labour and consequently viewed as low-skill and low-value, naturalised, and lacking in professional recognition.[27] This interpretation holds true for a large segment of the unpaid work of social reproduction, subsumed under mothering, and providing for aged relatives (disproportionately done by women), as well as the unrecognised emotional labour of everyday acts of care, kindness, and support, expected in a greater degree from women compared to men. Similarly, it is applicable to the underpaid and under-recognised forms

[24] *Ibid.*
[25] Susan Ferguson, *Women and Work: Feminism, Labour and Social Reproduction* (London, 2020); Fraser, 'Contradictions'.
[26] Fraser, 'Contradictions'.
[27] Fraser, 'Contradictions'.

of paid care such as nursing, social care or paid childcare, all highly feminised occupations. At the same time, however, other tasks of social reproduction associated with medicine, education, and also private care provision for the propertied classes have historically enjoyed greater professional and monetary recognition. Crucially, through focusing on institutionalised and market-based forms of care work as opposed to its unpaid forms, I aim to point out the vastness of the paid care sector, discrediting the continued association of care work with the economic margins. In doing so, I aim to challenge the essentialising view of care work as underpaid and undervalued.

In more practical terms, I distinguish between *care regimes* and *care infrastructures*. Drawing on feminist economic theory, I define a *care regime* as the sum of policies, formal and informal practices, and socio-cultural narratives of the care of and between persons in a given society.[28] Chapter 2 provides more context on the subject of care regimes and offers an analysis of Scotland's care regime transition between the early eighteenth and mid-nineteenth centuries. I use *care infrastructure* to describe the physical network of actors providing care that is organised within any given society depending on its regime of care. It consists of informal structures such as families, communities and forms of mutual aid as well as formal institutions. In other words, care infrastructure is the practical/physical implementation of a care regime that mirrors the regime's normative framework.

As this thesis demonstrates, varied types of care institutions emerged over the eighteenth century as a result of private philanthropic ventures, municipal efforts to provide for local populations or for-profit enterprises operated by private individuals. The fluidity of institutional provision is one of the key points made here, demonstrating the ways in which market-oriented, philanthropic or municipal forms of care overlapped via those who drew on their services as well as those who were employed to provide care. When discussing care as a form of employment, I situate its practices within the *care sector*, a segment of the paid service sector that comprises various types of care and bodywork, as well as housework and pastoral care, in order to highlight the myriad ways in which people found gainful employment or opportunities for entrepreneurship as care providers.

[28] See: Emiko Ochiai, 'Care Diamonds and Welfare Regimes in South-East Asian Societies: Bridging Family and Welfare Sociology', *International Journal of Japanese Sociology*, 18 (2009), Parvati Raghuram, 'Global Care, Local Configurations- Challenges to Conceptualizations of Care', *Global Networks*, 12:2 (2012), Shahra Razavi, 'The Political and Social Economy of Care in a Development Context: Conceptual Issues, Research Questions and Policy Options', UN Gender and Development Programme Paper No. 3 (2007), Francesca Bettio, Janneke Plantenga, 'Comparing Care Regimes in Europe', *Feminist Economics*, 10:1 (2004).

Care labour is an important thread that runs through the chapters of this thesis, challenging the continued depiction of care work as underpaid and undervalued, highlighting instead its contingency on a variety of factors. The value of care, as will be shown, was determined by who was doing the caring and for whom, and was shaped by relations of gender, status, class, and race but also by affect, responsibility and obligation. Since my primary interest is in comprehending and historicising the value of care, most of this thesis looks at examples of paid care provision. The rationale for this is twofold. First, when a form of exchange is involved, the relation is easier to quantify and compare across different spaces and circumstances. Secondly, following the affective turn in the field of history, we know more about what caring relations looked like within the home and the parish level of community. Relations within households, between parents and children, masters and servants or apprentices have been richly documented, with historians focusing on affect as well as conflict underpinned by domestic hierarchies and power structures.[29] Despite its ubiquity, paid care continues to be sidelined and its centrality in the familial and familiar contexts remains underappreciated. Equally, paid care outwith the bounds of medical and nursing histories remains understudied. It is these histories, therefore, that this thesis aims to bring to light.

1.2 The 'Care Diamond'

A useful model I repeatedly reference is Shahra Razavi's 'care diamond', which I have adapted for the purposes of this research. Drawing on existing models of welfare distribution, Razavi devised the diamond model to capture the sharing of care responsibilities between four principal actors. As she suggests, 'we could think of the 'care diamond' as the architecture through which care is provided, especially for those with intense needs'.[30] The actors are 1) families/households, 2) markets, 3) the state or public sector, and 4) the not-for-profit sector including community care provision. The state poses as both an actor and an arbiter, shaping the other actors' functioning through policy and

[29] For earlier debates see: Philippe Aries, *L'Enfant et la Vie Familiale sous l'Ancien Régime* (Paris, 1960); Edward Shorter, *The Making of the Modern Family* (London, 1976); Lawrence Stone, The Family, Sex and Marriage in England 1500-1800 (New York, 1977); for master/servant relations see: Laura Gowing, *Common Bodies, Women, Touch and Power in Seventeenth-Century England* (New Haven, 2003); Carolyn Steedman, *Labours Lost, Domestic Service and the Making of Modern England* (Cambridge, 2009); Carolyn Steedman, *Master and Servant: Love and Labour in the English Industrial Age* (Cambridge, 2007).

[30] Razavi, 'Political and Social Economy', 21; Shahra Razavi, 'Care and Social Reproduction: Some Reflections on Concepts, Policies and Politics from a Development Perspective' in Rawwida Baksh and Wendy Harcourt (eds.) *The Oxford Handbook of Transnational Feminist Movements* (Oxford, 2015).

regulation. The role of the state varies across societies depending on the size of its apparatus and resource allocation. In different societies the distribution between these varies, reflecting their care regime. For example Japan today is heavily familial whilst Nordic countries rely largely on state welfare. Levels of involvement of the actors are shaped by their mutuality, with one substituting inadequacies in the other in ways that are not permanent but instead adapt to the society's varying needs.[31] As suggested by Razavi, 'the notion that countries often move back and forth across sectors is important because it belies the view, deeply entrenched in the modernization narrative, of a linear path along which all countries move with inevitable shift from '"private" (especially family and voluntary) provision of care to "public" provision (by the state and market)'.[32]

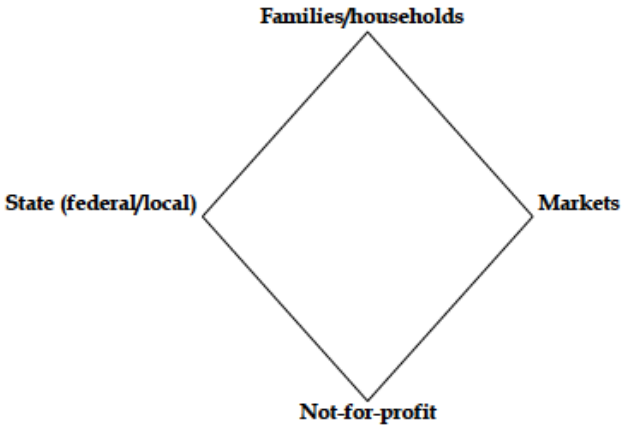

Fig. 1.1 The Care Diamond

Razavi's model is adaptable to the study of past care regimes owing to its flexible conceptualisation of the individual actors. As shown below (fig. 1.2) I have expanded on the model for the purposes of this research. I have also changed the composition of the four actors slightly. Whilst families/households and markets remain the same, I change the 'not-for-profit' to 'community' in order to reflect the strong communitarianism of the long eighteenth century, which is not to be conflated with more organised forms of charity and philanthropy. Whilst Razavi's model combines charitable and community provision, I instead include charitable, philanthropic and voluntary bodies and institutions under the 'state/municipality/parish' category. The reason for this is twofold. First, these organisations were largely top-down structures run by local elites also involved in governance and church leadership as opposed to forms of mutual aid (which are included

[31] Razavi, 'The Political and Social Economy of Care'; Ochiai, 'Care Diamonds and Welfare Regimes'.
[32] *Ibid*., 22.

under community). Secondly, it was this structure that increasingly became subsumed under municipal/state control, forming the foundations of the welfare state. All the while, bottom-up community forms of care and mutual aid remained significant providers that interacted with these more top-down structures and should be viewed in their own right. I have expanded the 'state' actor to include broader formalised structures of the state, municipalities and parishes. This is to encompass the combined secular and religious forms of governance and capture the decentralised nature of formalised provision prior to the emergence of the welfare state. Whilst town councils and parishes operated on a more personalised and socially integrated basis than the state rooted in universalism, they represented top-down formalised structures of provision whilst also fulfilling the role of arbiters of the more localised care regimes. The state is included in this category as responsible for the legal framework shaping the provision of poor relief. The process of centralisation and shifting of the responsibility for welfare from the parish/town to the state is here identified as an early nineteenth-century phenomenon, as will be shown in Chapter 6. Crucially, as this thesis shows, the majority of care did not take place in strictly demarcated loci of the familial, communal or market based. Care sourced through the market was often carried out in domestic spaces and families sometimes cared for their members in institutional spaces. I use this model to point out the continued overlapping of varied forms of care provision across spaces in what constituted the mixed economy of welfare.

As the middle section of my adapted model indicates, the mechanisms that shape care regimes such as laws and policy but also material, physical and affective practices of care play out across the four actors against the backdrop of the mixed economy of welfare. I identify eight factors that determine and shape care regimes (law, policy, culture and ethics, medicine, care institutions, material provision, physical care and affective care). These are distributed and carried out by the actors in their overlap, resulting in the fluctuating and contingent nature of care regimes. By expanding the diamond model, I aim to provide a visual tool showing how the actors may shape the realities of care. The model is by no means exhaustive, but rather indicative of the range of factors at play.

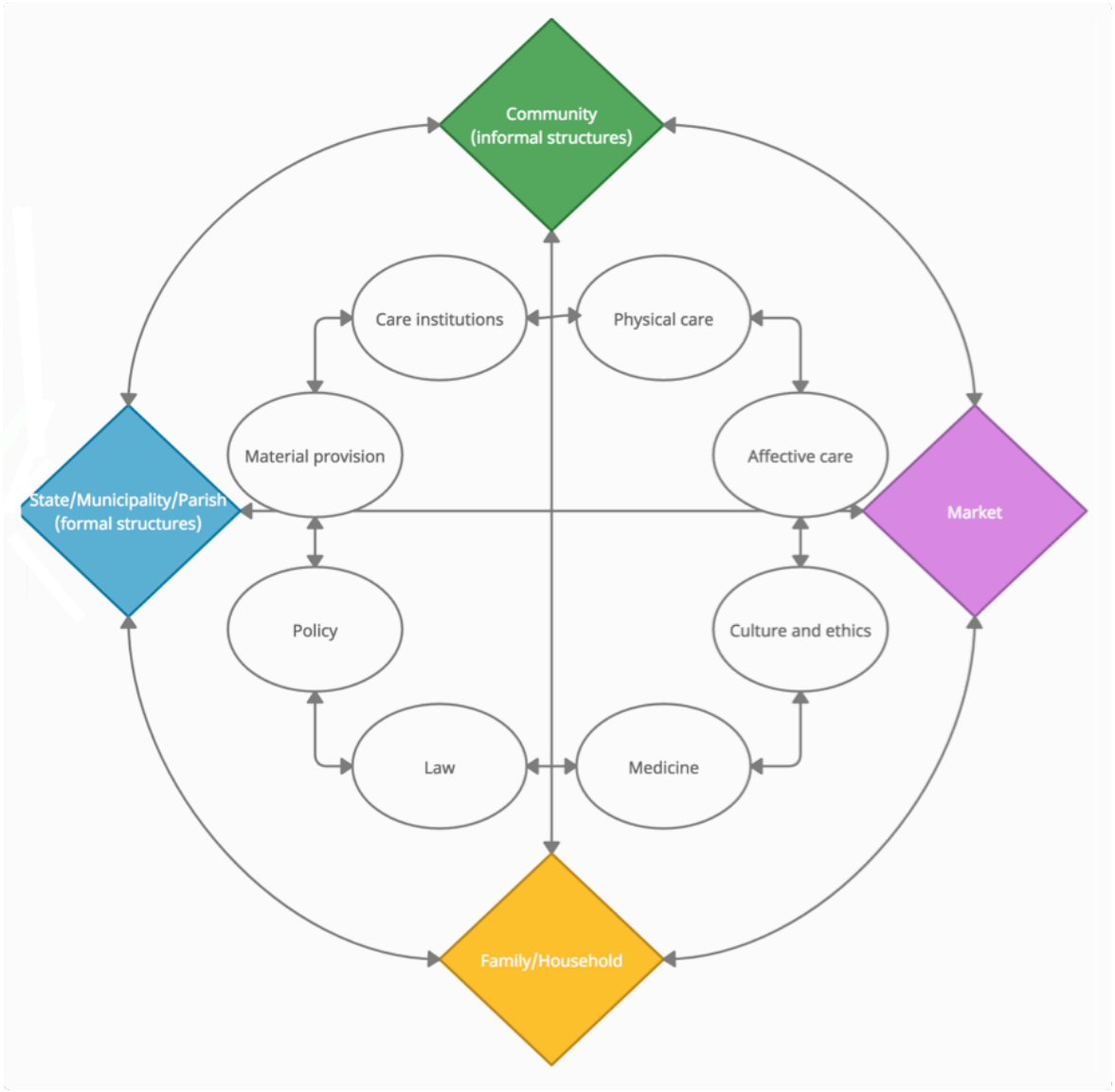

Fig. 1.2 Adapted model of the Care Diamond

1.3 Care and Histories of Labour

Whilst economic historians have paid ample attention to the 'productive' or monetised economy, this has not been the case for the 'other economy' of reproduction, perpetuating its depiction as naturalised and ahistorical.[33] Economic historians have focused on the processes of economic growth and development, in the British context largely framed by debates about industrialisation.[34] Scottish economic history has contributed to recognising the regional variation of economic processes, de-homogenising the linear narrative of

[33] Razavi, 'Political and Social Economy of Care'; Alexandra Shepard, 'Care' in C. Macleod, A. Shepard, & M. Ågren (eds.), *The Whole Economy: Work and Gender in Early Modern Europe* (Cambridge, 2023).

[34] See for example: Stephen Broadberry, Bruce Campbell, Alexander Klein, Mark Overton, Bas van Leeuwen, *British Economic Growth 1270-1870* (Cambridge, 2015); Robert Allen, *The British Industrial Revolution in Global Perspective* (Cambridge, 2009).

British histories solely focused on England and Wales.[35] As recently suggested by Alex Shepard, however, 'economic historians interested in early modernity and modernizing processes have paid scant attention to the structure, value and cost of care in their narratives of change'.[36] Traditionally, the data used for constructing economic histories were limited to documenting the paid work of adult men, omitting the work of women based on the assumption that women, especially married ones, were excluded from market-oriented work, instead engaging in unpaid work within the home.[37] The underreporting of both women's paid and unpaid work is not coincidental; instead stemming from the money-oriented focus of mainstream economics that shaped the field of economic history. Additionally, defining work as waged work remains entrenched in Marxist economic approaches, with only a limited subfield of economics and economic history expanding on this view.

In the recent decades, new histories of labour have emerged, recognising the limitedness of the wage criterion when defining work. First, histories of slavery and coerced labour highlight the need to incorporate unfree forms of work into the field of labour history, departing from the traditional Marxist definition of work as free and waged.[38] Second, growing research on pre-industrial economies emphasise the complexity of labour relations and challenged the enduring stadial theory of a transition from feudalism to capitalism. It demonstrates the concurrence of varied labour relations and their recognition as work, again highlighting the limitedness of the paid/unpaid binary.[39]

Third and most importantly for this research, gender historians have increasingly focused on work, belying the depiction of women as passive bystanders of economic processes. Furthermore, moving beyond census records and traditional occupational denominators, they challenge the narrow understanding of work as determined by fixed occupational categories, instead recognising the fluidity of working lives in the past.

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[35] See for example: Christopher A. Whatley, *The Industrial Revolution in Scotland* (Cambridge, 1997); Devine and Wormald, (eds.) *Oxford Handbook*; Stuart M. Nisbet, 'The Making of Scotland's First Industrial Region: The Early Cotton Industry in Renfrewshire', *Journal of Scottish Historical Studies*, 29:1 (2009).

[36] Shepard, 'Care', 57.

[37] Broadberry et al., *British Economic growth*; Allen, *The British Industrial Revolution*.

[38] See Rosenthal, 'Capitalism'; Joseph C. Miller, *The Problem of Slavery as History: A Global Approach* (New Haven, 2012); Peter Linebaugh and Marcus Rediker, *The Many-Headed Hydra: Sailors, Slaves, Commoners, and the Hidden History of the Revolutionary Atlantic* (London, 2000); Christian G. De Vito and Alex Lichtenstein (eds.), *Global Convict Labour* (Leiden, 2015); Alessandro Stanziani, *Bondage: Labor and Rights in Eurasia from the Sixteenth to the Early Twentieth Centuries* (New York, 2014) and *Labor on the Fringes of Empire: Voice, Exit and the Law* (London, 2018).

[39] See Jane Hathaway, *The Politics of Households in Ottoman Egypt: The Rise of the Qazdaglis* (Cambridge, 2010); Metin Kunt, 'Royal and Other Households', in Christine Woodhead (ed.) *The Ottoman World* (London, 2012).

Recent contribution of the Gender and Work (GaW) project focused on early modern Sweden shows the fluidity of work across time and space, suggesting the need to move beyond the strictures of occupational titles and focus our attention on the work activities, or *repertoires* involved. They conclude that 'most working people lacked occupational titles, much work was unpaid, and the work of women and children was often eclipsed by that of the male head of the household'.[40] Occupational descriptors often denoted status as opposed to the work actually performed, suggesting a distinction between occupational identities and work practices.[41] Similar findings are revealed by recent research of Jane Whittle and Mark Hailwood.[42] As they suggest, work in early modernity was understood as a productive activity, in opposition to leisure, but outwith the mechanisms of monetary exchange. Crucially, the unpaid nature of much care and subsistence work did not disqualify these tasks from contemporaries' definitions of labour.[43] Furthermore, much work took place within the home, and much of it was commodified, deeming the term 'domestic work' unhelpful in the early modern context. Whittle suggest the alternative use of the term subsistence production and subsistence services (inclusive of care and housework) alongside market-oriented production and services.[44] I draw on Whittle's terminology in this thesis, using the term subsistence services as encompassing the largely feminised (though not necessarily unpaid) categories of care and housework.

Drawing on the work of GaW and Whittle, Shepard places care firmly within the discussion of past economies and their gendering, stressing the need to historicise care and recognise its crucial role in historical economic processes. Speaking to the histories of economic change, development of capitalist modes of production and gendered patterns of work she highlights that care has never been constant or external to the economy. Shepard's overview frames the emerging field of the history of care that stems from current historical debates inspired by feminist economics as well as the current 'crisis of care' that brings the subject to the forefront of academic enquiry across fields.[45]

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[40] Maria Ågren, *Making a Living, Making a Difference: Gender and Work in Early Modern European Society* (Oxford, 2017), 2; Raffaella Sarti, Anna Bellavitis, Manuela Martini, (eds.) *What Is Work? Gender at the Crossroads of Home, Family, and Business from the Early Modern Era to the Present* (New York, 2018).

[41] Jane Whittle, 'A Critique of Approaches to "Domestic Work": Women, Work and the Pre-Industrial Economy', *Past & Present*, 243 (2019); Shepard, 'Care'; Shepard, 'Working Mothers'.

[42] Jane Whittle and Mark Hailwood, 'The Gender Division of Labour in Early Modern England', *Economic History Review*, 73 (2020), 20- 22.

[43] Whittle, 'A Critique'.

[44] Whittle, 'A Critique'.

[45] See for example: Marilyn Waring, *If Women Counted: A New Feminist Economics* (San Francisco, 1988); Marianne Ferber and Julie Nelson (eds.), *Feminist Economics Today: Beyond Economic Man* (Chicago, 2003); Caroline Saunders, Paul Dalziel, 'Twenty-Five Years of Counting for Nothing: Waring's Critique of National Accounts', *Feminist Economics*, 23:2 (2017); Xiao-

New quantitative research contributes significantly to these debates, providing evidence of both women's labour force participation and contribution to the household budgets and the broader distribution of care work amongst household members, contrary to its association with women, particularly married ones. As shown by Jane Humphries et al., earnings of married women across the long eighteenth century constituted between 18-22 per cent of families' budgets, alongside subsistence production and services.[46] Furthermore, it was demand for women's labour that shaped women's labour force participation, suggesting that women engaged in paid employment when they had the opportunity, despite or alongside their caring responsibilities.[47] This thesis supports these findings, highlighting the complex relationship between market-oriented work, subsistence production and services for both women and men. As shown by Whittle and Hailwood, married women, habitually assumed as responsible for the majority of housework and care work within the home were in fact underrepresented in carrying out caring tasks, which were instead performed by more junior household members and largely commodified.[48] New research on married women's work shows that despite the assumptions around women's life-cycle, women engaged in paid work after marrying and bearing children, performing casualised work, finding stable employment and running businesses.[49]

In Scotland, quantitative evidence of women's labour force participation is scarce, making it difficult to reconstruct quantitative data similar to the wage series produced by Humphries et al. Nonetheless, looking at gendered patterns of work in the Scottish urban context, Catriona MacLeod shows that 'the urban economy was certainly gendered, but women participated in varied ways and their legal position as wives did not prevent them

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Yuan Dong and Xinli An, 'Gender Patterns and Value of Unpaid Care Work', *Review of Income and Wealth*, 61:5 (2015); N. Folbre, 'Measuring Care: Gender, Empowerment, and the Care Economy', *Journal of Human Development*, 7:2 (2006); N. Folbre, 'Reforming Care', *Politics and Society*, 36:3 (2008); Nancy Folbre, Julie A. Nelson, 'For Love or Money- Or Both', *Journal of Economic Perspectives'*, 14:4 (2000); Julie A. Nelson, 'Of Markets And Martyrs: Is It OK To Pay Well for Care?', *Feminist Economics*, 5:3 (1999).

[46] Sara Horrell, Jane Humphries, 'Women's Labour Force Participation and the Transition to the Male-Breadwinner Family, 1790-1865', *Economic History Review*, 48:1 (1995), 107; Jane Humphries, Carmen Sarasúa, 'Off the Record: Reconstructing Women's Labour Force Participation in the European Past', *Feminist Economics*, 18:4 (2012); J. Humphries, and J. Weisdorf, 'The wages of women in England, 1260-1850', *Journal of Economic History*, 75:2, (2015).

[47] Humphries, Sarasúa, 'Off the Record'.

[48] Whittle, 'A Critique', Whittle and Hailwood, 'Gender division of labour', 20-22.

[49] Amy L. Erickson 'Married Women's Occupations in Eighteenth-Century London', *Continuity and Change*, 23:2 (2008); Amy L., Erickson, 'Eleanor Mosley and Other Milliners in the City of London Companies 1700-1750' *History Workshop Journal*, Vol. 71 (2011); Alexandra Shepard, 'Working Mothers in Eighteenth-Century London', *History Workshop Journal* (2023); Alexandra Shepard, 'Crediting Women in the Early Modern English Economy', *History Workshop Journal* (2015).

from running independent or joint business ventures'.[50] As my recent study shows, married women's familial lives and living arrangements may have been determined by their employment requirements, leading to spouses living separately when employed in service or residential institutions. Whilst requiring further research, this challenges the idea that live-in forms of employment such as domestic service were only performed by unmarried individuals, extending this type of work throughout the life cycle.[51]

These findings have crucial implications that challenge the assumption that women performed most housework and care, instead suggesting that subsistence services (as well as subsistence production) were shared amongst household members according to availability and need, organised around individuals' engagement in paid work.[52] This supports the argument that organisation of both paid and unpaid work was incorporated into broader welfare optimisation strategies practiced by individuals and households, and thus economically conditioned as opposed to primarily culturally embedded. My research draws extensively on both feminist economics and feminist economic history. The theoretical framework of this thesis is informed by its broader understanding of the economy, in the present day and in the past, that allows for the scrutiny of subsistence and market-oriented, paid and unpaid forms of work in their interlink. Drawing on the work of Humphries and Whittle, I view care work as an economic phenomenon largely shaped by the labour market and patterns of labour force participation. My contribution to the field of gendered labour history is twofold. Firstly, through focusing on paid care, I highlight the varied avenues for employment available to both women and men in the care sector that included low-paid and casual forms of work, but also highly skilled, valued and remunerated forms of care work. At the same time, I demonstrate the vastness of the paid care sector, challenging the association of care with the unpaid work of women within the home. Moreover, following on from Shepard's study, it is the aim of this thesis to contribute to the emerging field of economic history of care in its own right.

1.4 Care across Historiographies

In addition to the scholarship on gender and work, this thesis draws mainly on three historiographical strands. First, historians of emotions and the family have studied caring

[50] Catriona MacLeod, 'Women, Work and Enterprise in Glasgow c. 1740-1830', PhD Thesis, School of Humanities, The University of Glasgow (2015), 23.
[51] Eliska Bujokova, 'On the Respectability of this Person Every Thing Depends': Hospital Matrons and Power Relations in the Royal Infirmary of Edinburgh, c. 1817-1820', *Women's History Review*, 32:5 (2023).
[52] Whittle, 'A Critique'.

relations, especially in their affective forms and this strand has been strongly represented in Scottish history in recent years.[53] Similarly, histories of medicine and nursing have examined the physical work of caring, focusing on the aspects of care associated with healing and convalescent care.[54] The political dimension of care is subsumed within histories of the poor laws, charity and philanthropy, institutional developments, and the emerging welfare state.[55] The physicality and materiality of caring is often missing in these histories, however, with the exception of the histories of medicine and nursing. In the Scottish context, histories that touch on the subject of care work have focused on the developments of infirmaries and care institutions, scientific advances, professionalization and the politics of public health.[56] Recent studies by Chris Langley and Katie Barclay look at Scottish care regimes and welfare structures.[57] Economic histories of care as a resource as well as a practice remain understudied, however.

Recent historiographies of the family have departed from the teleology of modernisation theory, instead focusing on notions of kinship and cohabitation or studying the emotional regimes that determined expressions of affect as well as practices of care.[58]

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[53] See Elizabeth Ewan and Janay Nugent (eds.), *Children and Youth in Medieval and Early Modern Scotland* (Woodbridge, 2015); Katie Barclay, 'Love, Care and the Illegitimate Child in Eighteenth-Century Scotland', *Transactions of the Royal Historical Society*, 29 (2019), 113; Katie Barclay, 'Natural Affection, Children and Family Inheritance Practices in the Long Eighteenth Century', in Ewan and Nugent, *Children*; Katie Barclay, *Love, Intimacy and Power: Marriage and Patriarchy in Scotland, 1650-1850* (Manchester, 2011).

[54] See Deborah Harkness, 'A View from the Streets: Women and Medical Work in Elizabethan London', *Bulletin of the History of Medicine*, 82:1 (2008); Anne Summers, ''The Mysterious Demise of Sarah Gamp: The Domiciliary Nurse and Her Detractors, c. 1830-1860', *Victorian Studies*, 32:3 (1989); Sue Hawkins, *Nursing and Women's Labour in the Nineteenth Century: The Quest for Independence* (London, 2010); Barbara Mortimer, *New Directions in Nursing History* (London, 2004); Barbara Mortimer, 'The Nurse in Edinburgh c. 1760-1860: the Impact of Commerce and Professionalization', PhD Thesis, , School of History, Classics and Archaeology, The University of Edinburgh (2001).

[55] Rosalind Mitchison, *The Old Poor Law in Scotland: The Experience of Poverty, 1574–1845*, (Edinburgh, 2000), R. A. Cage, The Scottish Poor Law 1745-1845 (Edinburgh, 1981), Robert Cage, 'The Scottish Poor Law 1745-1845', PhD Thsesis, Faculty of Arts, The University of Glasgow, (1974); John McCallum, *Poor Relief and the Church in Scotland, 1560-1650* (Edinburgh, 2018); Andrew Blaikie, 'Nuclear Hardship or Variant Dependency? Households and the Scottish Poor Law', *Continuity and Change*, 17:2 (2002); Thomas Ahnert, *The Moral Culture of the Scottish Enlightenment, 1690-1805* (New Haven, 2014).

[56] See Guenter Risse, *Hospital Life in Enlightenment Scotland*, (Cambridge, 1986); Guenter Risse, *Mending Bodies, Saving Souls: A History of Hospitals*, (Oxford, 1999); Christopher Hamlin, *Public Health and Social Justice in the age of Chadwick, Britain, 1800-1854* (Cambridge, 1998); 56; Daisy Cunynghame, 'The Roles of the Edinburgh, Kelso, and Newcastle Dispensaries in Charitable Relief, 1776-1810', PhD Thesis, School of History, Classics and Archaeology, The University of Edinburgh, (2020).

[57] Chris R. Langley, *Cultures of Care: Domestic Welfare, Discipline and the Church of Scotland, C. 1600-1689,* (Boston, 2020); Katie Barclay, *Caritas: Neighbourly Love and the Early Modern Self* (Oxford, 2021).

[58]Naomi Tadmor, *Family and friends in eighteenth-century England: Household, kinship, and patronage* (Cambridge, 2001); David Sabean, Simon Teuscher, Jon Mathieu, *Kinship in Europe:*

Increasingly, these histories demonstrate the lack of separation between caring *about* and caring *for*, with material provision being recognised as an expression of 'natural affection'.[59] Works by Linda Pollock, Patricia Crawford and Katie Barclay show that material circumstances mattered in familial relations.[60] Kate Gibson's recent study of illegitimacy highlights the socio-economic and legal underpinnings of family formation as both facilitators and barriers to affect. She sheds light on the reality of the family outwith its biological and nuclear forms, highlighting the complex ways in which kinship was constructed.[61]

Recent work by Linda Oja situates familial care within the context of work and the economy of makeshifts. She demonstrates the variedness of childcare arrangements mostly performed by women (mothers and female relatives, servants, wet-nurses) but not outside of the scope of men's work. She points out the importance of the material circumstances and a stricter reliance on mothers for childcare in poorer families as opposed to more shared arrangements in larger, better-off households that employed servants. She underlines the relationship between household structures (and their frequent fluctuations) and the distribution of care.[62] She shows the dispersed, often commodified practices of childcare as typical at the private as well as parish level, demonstrating the collective nature of the mixed economy of welfare. With parishes frequently employing poor mothers as wet or dry nurses to local foundlings, they doubly supported the children and their carers. Oja's case study sheds light on the complexity of familial caring and its rootedness in the broader contexts of the community, township and the market, echoing the diamond model of care distribution.[63]

With the family continuously imagined as the primary locus of care in eighteenth-century Scotland, these historiographies provide a useful footing for this thesis. Whilst the family in a traditional sense is not my focus, I am interested in its imagined ideal as a tool

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Approaches to Long-Term Development (1300-1900) (New York, 2007); Peter Laslett, 'Family, Kinship and Collectivity as Systems of Support in Pre-Industrial Europe: A Consideration of the "Nuclear-Hardship" Hypothesis', *Continuity and Change*, 3 (1988); Barbara Rosenwein 'Worrying about Emotions in History', *American Historical Review*, CVII:3 (2001); see also for overview of traditional approaches to the family: Michael Anderson, *Approaches to the History of the Western Family 1500-1914* (Basingstoke, 1980); Keith Wrightson, 'The Family in Early Modern England: Continuity and Change' in S. Taylor, R. Connors and C. Jones (eds.), *Hanoverian Britain and Empire: Essays in Memory of Philip Lawson* (Woodbridge, 1998).

[59] Emma Griffin, 'The Emotions of Motherhood: Love, Culture, and Poverty in Victorian Britain', *American Historical Review* (2018); Barclay, 'Love, Care'.

[60] Linda A. Pollock, *Forgotten Children: Parent-Child Relations from 1500 to 1900* (Cambridge, 1983); Patricia Crawford, P*arents of Poor Children in England 1580-1800* (Oxford, 2010); Katie Barclay, *'Love, Care'*.

[61] Kate Gibson*, Illegitimacy, Family & Stigma in England, 1660-1834* (Oxford, 2023).

[62] Linda Oja, 'Childcare and Gender in Sweden c. 1600-1800', *Gender and History*, 27:1 (2015).

[63] Oja, 'Childcare and Gender'.

of institutional formation, reformism and social policy. Throughout the thesis, I bring contemporary ideals of the family, kinship and natural affection to the fore, although often as an analytical tool rather than a subject of enquiry. The family in conjunction with domesticity thus function as important viewpoints from which I examine commodified practices of care.

Histories of medicine and nursing are the second strand I draw on. The work of Mary Fissell has shaped my thinking around bodywork and the fluidity between medical, nursing and everyday forms of care and their gendering. As she suggests, care and cure in the early modern past were not demarcated, but rather intertwined, with the practices of healing less interventionist and more expectant, interwoven with food preparation and watching and mending.[64] This more fluid understanding of caring and healing as overlapping also brings into sharper focus its gendering. It shows that women and men were engaged in varied types of bodywork, but it was the women's limited access to apprenticeships and university training that excluded them from certain care professions. Fissell's work here resonates with Whittle's distinction between more dispersed forms of labour contrasted by limited occupational descriptors, determined by access to professional bodies rather than the work itself.[65]

Margaret Pelling's work also highlights the nominal rather than practical gendering of care work, with many men providing care in the capacity of domestic and 'body servants' despite the enduring conceptualisation of care as women's work. Expanding the debate on occupational denominators into the care sector, she demonstrates women and men's unequal claims on occupational identities and women's concentration in low-paid and poorly defined jobs, including the majority of caring occupations. She partially links this lack of definition to the persisting issues with care being undervalued and invisibilised, a tendency that seems remarkably enduring across time and space.[66] She nonetheless refutes the gendered division into a private sphere of female practitioners and domestic healers and the male sphere of public medicine, focusing instead on the overlap between the practices of caring, highlighting the often interdependent nature of the work of female and male practitioners.[67]

The work of Barbara Mortimer, which examines nursing practices in urban Scotland, highlights the intertwining of the nursing profession with medicine and midwifery, again demonstrating the relatedness of various forms of care provision.

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[64] Fissell, 'Introduction'.
[65] Whittle, 'A Critique'.
[66] Margaret Pelling, *The Common Lot, Sickness, Medical Occupations and the Urban Poor in Early Modern England* (Harlow, 1998).
[67] *Ibid.*

Similarly, she highlights the scale of commodification of care in nineteenth century Edinburgh, and the opportunities for employment and entrepreneurship available to women. She belies the nature of pre-reform nursing as lacking in skill and training, demonstrating instead the vast network of female practitioners working in the care sector and gaining considerable professional recognition and economic benefits. She nonetheless maintains the negative effects of professionalization on female practitioners, confirming the earlier findings of Fissell and Pelling.[68]

Histories of medicine and nursing inform my research to a great extent. It is my aim to expand on these findings by way of incorporating the medical and nursing histories into social and labour histories, recognising the continuity of the care and bodywork carried out across occupational denominators and spaces.

The last strand of scholarship that informs my analysis is the history of welfare and poor relief. The historiography of the period has, until recently, emphasised low growth and low urbanisation, parochialism and inadequate provision for the poor with the work of Rosalind Mitchison serving as the last word on the subject.[69] Recent scholarship such as Chris Langley's *Cultures of Care* proposed new interpretations of the early modern care regime as rooted in traditional familialism, Presbyterian notions of charity and social order that resulted in more stable, albeit complex networks of support than previously assumed by historians. Langley's study informs my research through the depiction of care structures as complex and complementary, highly contingent and interweaving formal and informal, monetised and voluntary forms, offering a more nuanced depiction of caring relations in the Scottish past.[70] Crucially, it begins to outline the distinctiveness of Scottish attitudes towards care and the poor as separate from the English model, contrary to what has been assumed by historians of poor relief.[71] My study continues on from where his ends, focusing on the newly formed milieu of urban Scotland.

Katie Barclay's study of *Caritas*, described as an emotional regime centred on the notion of reciprocal obligation and Presbyterian charity, represents a key study that places the subject of welfare at the centre of social formation. She highlights the importance of voluntarism in Scottish conceptualisations of charity as the organising principle of the mixed economy of welfare. Her understanding of caritas as a mechanism of compassion and love as well as discipline rooted in the notion of a godly community places religion as

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[68] Mortimer, 'The Nurse in Edinburgh'.
[69] Mitchison, *The Old Poor Law*; Cage, *The Scottish Poor Law*.
[70] Langley, *Cultures of Care*.
[71] Mitchison, *The Old Poor Law*; I. Levitt, C. Smout, *The State of the Scottish Working-class in 1843* (Edinburgh, 1979), L. H. Lees, *The Solidarities of Strangers. The English Poor Laws and the People, 1700-1948* (Cambridge, 1998), R. A. Houston, 'Poor Relief and the Dangerous and Criminal Insane in Scotland, c.1740-1840', *Journal of Social History*, 40:2 (2006).

the organising principle of Scotland's social fabric. Similarly, Thomas Ahnert emphasises the importance of good works as opposed to doctrinal rigour in Scottish Presbyterianism. Both authors inform this study in recognising the centrality of Presbyterianism to the formation of Scotland's care regime, which intersected with the creation of a commercial society, both motivated by the betterment of humankind.[72] Whilst my conclusions differ from Barclay's depiction of a benevolent godly community, emphasising instead mechanisms of coercion and control, her centring of eighteenth-century mentalities as shaped by Christian ethics is an important piece of scholarship for the discussion presented here.

Bringing together the strands of scholarship focused on emotions and the family, medical and nursing histories as well as welfare regimes alongside the histories of gender and work provides a complex footing upon which this thesis builds. Employing a broad range of sources that reflect public, institutional and market oriented forms of care, this thesis aims to strike a dialogue between these varied scholarships, highlighting their intertwining through practices of care in spite of their ontological and epistemological demarcations within separate historiographies.

1.5 Sources and Methods

This thesis brings together a varied range of archival and printed historical records. My methodology comprises a combination of historical approaches and historical epistemology, focusing on past practices in conjunction with their linguistic and socio-cultural meanings as embedded in their historical contexts.[73] Individual chapters of the thesis adopt varied focal points, ranging from case studies of individual practitioners, institutions and urban markets to scrutinising discourses, linguistic forms and regimes of care. Read together they aim to capture the importance of care as a practice, a service, a resource and an economic activity on multiple levels of analysis. The focus on care as labour as a category of analysis runs through all chapters, representing a common denominator between their varied subjects. With the inherent gendering of care in practice and imaginary, gender also represents key category of analysis throughout the following pages. In addition to labour theory, it forms the majority of my theoretical and conceptual frameworks. Drawing largely on the works of feminist economics, my interest is primarily in gender as an economic factor, as opposed to a biological or a cultural one. This thesis

[72] Barclay, *Caritas*; Ahnert, *The Moral Culture*.
[73] Poovey, *Making a Social Body*.

thus highlights the embeddedness of gendered relations in economic processes, with the gendered hierarchy between production and reproduction at its core.

The main body of materials this thesis draws on are institutional archives. These consist of minute books, institutional histories, architectural plans and other visual materials, books of rules and regulations, but also correspondence, petitions, characters and applications for posts. Medical institutions' archives also contain medical casebooks, patient registers and statistics as well as clinical lectures. The benefits of the institutional archives are the greater level of systematic and rigorous accounting and a high survival rate of materials. Its downsides are the largely top-down representation of institutions' running, with regulatory frameworks and official documents that silence the mundane and structurally 'insignificant'. The everyday realities of institutional lives are thus only accessible in accidental details reported as part of incidents and cases of conflict that carry structural relevance. From the point of view of labour histories, correspondence with potential employees and the reporting of hiring processes offers rich detail, including wages and prerequisites. Similarly, when compared to rules and regulation they reveal key disparities between institutional frameworks of employment and its realities, shaped by interpersonal relations, labour supply and candidates' professional and familial lives. Social histories of institutional structures nonetheless require a level of reading against the archival grain, cross-referencing and filling the silences of the archiving process. In this thesis, I draw largely on the archives of the Dean Orphanage, the Royal Infirmary of Edinburgh and the Glasgow Royal Infirmary. These are complemented by archives of other institutions in Edinburgh and Glasgow that do not feature as independent case studies but are used as points of comparison.

The second large body of sources the thesis draws on are Scottish Newspapers, especially commercial advertisements. These inform the discussion on the care market and commodification and structure the debate on carers' professional self-fashioning. As further discussed in Chapter 4, medical advertising has been studied by historians, providing a valuable source base for the 'medical marketplace' narrative of the commodification of medicine in the eighteenth century.[74] In the context of this thesis, adverts by carers are used to demonstrate the overlap between the various occupational categories ranging from barber-surgeons and physicians, midwives, body workers, domestics and landlords. Using this broader body of advertisements sheds light on the expansion of the service sector across its varied segments. It also allows for the situating of

[74] Roy Porter, *Health for Sale: Quackery in England 1660-1850* (Manchester, 1989); R. Porter, *Disease, Medicine and Society in England, 1550–1860*, 2nd ed. (Cambridge, 1993); R. Porter and D. Porter, *In Sickness and in Health: The British Experience, 1650-1850* (London, 1988).

caring practices firmly at the centre of this development. As demonstrated by historians, newspapers and newspaper advertising represent a rich historical source, though present the danger of over-representing commercialised processes. Furthermore, adverts provide a picture of heavily commodified market relations, which in the absence of similar recording of informal and oral market practices appear less socially embedded and rooted in broader networks of thick trust. As such they require contextualisation and attention to their historical environments.

The third body of sources used are the Old and New Statistical Accounts of Scotland compiled between 1791-99 and 1834-45 respectively by John Sinclair. Sinclair was a lawyer and an MP as well as an avid proponent of the characterisation of scientific approaches to land and human management. Sinclair proposed that:

> Many inquiries, it is certain, have, at various periods, been made into the political circumstances of nations: Unfortunately, however, they have uniformly been instituted, with a view of ascertaining the state of the country, for the purposes of taxation and of war, and not of national improvement. Their object has been, not to meliorate the condition of the people, but to fill the exchequer, or the armies of the state; and the utmost that could be expected from them was to render taxation, and other public burdens, less unequal.[75]

Instead he designed a survey focused on the human, geographic, economic, religious and moral aspects of the social fabric with the clear goal of classifying Scotland's development on a regional level that would underpin future 'improvement' projects. The result of this inquiry is a detailed parish-level account of Scotland's physical, socio-economic and cultural landscape that has proven a rich source for social historians.[76]

The last body of sources used here are numerous printed pamphlets, treaties and polemic on political economy, 'improvement', poor relief and public health. Informing the theoretical debates on economic issues, social welfare and their increasingly medical dimensions, printed sources are used both as a way of contextualising archival materials and in their own right, as evidence of the changing attitudes to social questions. Primarily, they serve as the source base for my analysis of contemporary perceptions of economic and demographic change and the subsequent change in care regimes.

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[75] Sinclair, 'Address to the Clergy of the Church of England', Appendix F. Communications to the Board of Agriculture on Subjects Relative to the Husbandry, and Internal Improvement of the County, (London, 1797), xxxv.

[76] Rosalind Mitchison, *Agricultural Sir John: the Life of Sir John Sinclair of Ulster 1754–1835* (London, 1962); C. W. J. Withers, *Geography, Science and National Identity: Scotland since 1520* (Cambridge, 2001).

To gather demographic and biographical data, I have drawn on parish records including birth, baptism, marriage and death registers and probationary records. Furthermore, I have used the post office directories to corroborate addresses, household composition and occupational data. I have also drawn on the 1841 census in a few instances. Furthermore, I drew on court records, which offered further biographical evidence for my case studies. Crucially, these sources reveal important disparities due to underreporting and omission. In a number of instances, recording of occupational categories included in the census is only partial, especially in the case of women, confirming historians' reservations about the limits of census occupational data.

1.6 Thesis Structure

The body of the thesis consists of five chapters. Chapter 2 focuses on economic and demographic change over the long eighteenth century. It continues by outlining the changing regime of care as shaped by its socio-economic underpinnings. Drawing on a body of contemporary writing, it opens the discussion around care as a practice and a form of labour. Contextualising the urban histories this research traces in their broader national and imperial contexts, the role of this chapter is situating the research within the development of industrial extractive capitalism and the ways in which it shaped patterns of care and social reproduction.

Chapter 3 traces the etymology of *care words* as used and understood by contemporaries. Drawing on historical linguistics, this chapter maintains that the study of social phenomena across time is complicated by their changing linguistic regimes. Understanding the ways in which care was defined and discussed by contemporaries allows the historian to access its practices in their socio-cultural contexts. This chapter thus commences with an analysis of *care words* and their text-contexts in order to shed light on their meanings. Maintaining that language carries practical as well as affective meanings, its detailed analysis allows for a historically-sensitive understanding of the practices explored as well as their cultural meanings.

Chapter 4 examines the care market accessed through a large body of newspaper advertisements placed by care providers of those seeking care work. It includes a range of care-related services, highlighting the location of care work across occupational categories. Focusing on the gendering of care adverts, it demonstrates that men were not absent from commodified practices of care, as professional medical practitioners as well as body servants and educators. The chapter culminates with two case studies of midwives who worked as medical entrepreneurs. It shows the avenues within the care sector available to

both single and married women practitioners, contributing to the on-going discussion on women's work. Additionally, it takes a look at proto-institutional care provision in the care market, integrating the narratives of market-based and institutional care provision.

Chapter 5 takes a close look at the Edinburgh Orphan Hospital from its inception in the 1720s until the 1840s, focusing on its internal organisational structures and labour relations. It develops a model of household-family formation of residential institutions, focusing on the patterns of residence and identity of institutional staff. Contrary to the common imagining of residential staff and children in opposition, I examine their experiences alongside one another, highlighting their often-shared socio-economic background and lived experiences of precarity. I thus place the institutional space in the context of the mixed economy of welfare for both staff and resident children and their families.

Chapter 6 expands on the institutional focus, situating the developments of Edinburgh and Glasgow infirmaries within the context of the changing care infrastructures. The second part of the chapter looks at the epidemics of infectious 'fever' as a catalyst for change in the care regime. It argues that as a result of public health crises, the medical institutions of the two cities transformed, becoming the central organising bodies of medical relief. As such, it is argued, the developments in public health were made manifest in the hospitals' institutional structures and labour relations.

The case-study approach adopted in the chapters of this thesis sheds light on the varied aspects of care provision as shaped by economic and demographic change and firmly rooted in the social fabric of eighteenth-century Scotland. Focusing predominantly on paid care and care labour, this thesis complements the histories of care focused on the emotions, affects and the family. Historicising care is crucial in order to challenge its on-going depiction as naturalised, universally experienced and ahistorical, placed outside the 'productive' economy and processes of socio-economic change.

2 Contextualising the Landscapes of Care: Economy, Demography and Changing Care Regimes

Fig. 2.1 Sir David Wilkie, Pitlessea Fair, 1804

In his 1804 oeuvre depicting his native Pitlessea, a village in Fife, David Wilkie offers a pastoral scene that echoes the nostalgia of the early-nineteenth century for the imagined parochial harmony of the century prior. The hustle and bustle of the market fair is a portrayal of a pluriactive society that combined collective practices of making a living, providing care for human and animal beings as well as partaking in leisure activities. None of these existed in isolation or in separate spaces, instead overlapping, hardly distinguishable at times. At the forefront of the painting are a number of children, held, caressed, attended to or reprimanded by women as well as men, some of whom were likely their primary carers whilst others were distant relatives or members of a community, demonstrating the dispersal of caring practices amongst the varied actors of the care diamond. In the right corner, a woman is tending an infant, aided or distracted by an older child, perhaps a sibling. On the left, a man is holding an infant, likely buying goods from a market vendor. Although Wilkie's scene of rural harmony is not to be taken at face value, the incidental detail of people interacting, trading and navigating the public space of the fair is telling in a number of respects. It highlights the lack of separation between the productive and reproductive lives of communities. It is this context of the pluriactive mixed economy of welfare that my analysis stems from, situating practices of care in the very public spaces of markets and institutions, often monetised and rarely invisible.

Wilkie's romanticism echoes the efforts to bring to light the local familial and social structures of the changing nation that drove genre art. Amidst industrialisation, urbanisation and territorial expansion, it was the pastoral of rural communities that provided an escape to many authors whilst furnishing reformers such as Thomas Chalmers with a utopia useful as an antipode of social change. The parochial idyll contrasts the socio-economic transformation that Scotland underwent during the long-eighteenth century. Providing the foundation for the case studies that follow, this chapter explores these changes between 1720s and 1840s and how they reshaped the regimes of care in place. Drawing on feminist economic theory, I define a 'care regime' as the sum of policies, formal and informal practices, and socio-cultural narratives of the care of and between persons in a given society.[1] In their work on European care regimes, Bettio and Plantenga situate them as 'social joins' that ensure 'complementarity between economic and demographic institutions and processes'.[2] Relations between such institutions and processes and care regimes are not static, but rather dynamic, with notions around care placed at the core of national and social identities, while also shaping family structures, population growth and labour force participation. Studies of present day care regimes draw on the diamond model, distinguishing between four actors/care providers: the welfare state, the family, the market, and the community. Community provision is habitually absent in studies of developed countries, but essential in those focused on the developing world or societies in the past.[3] Whilst stressing the overlap between these actors, present day studies view them as clearly definable, mirrored in social policies and legalistic frameworks.[4] Building on the care diamond model, I distinguish between four primary care regimes, namely familialism, communitarianism, market-based and state-organised systems, though these habitually exist in a combination of two or more. Using the concept of care regimes as a tool of historical analysis proves useful, I argue, in mapping the ways in which socio-economic and demographic changes shaped the historical developments of socially reproductive processes. This chapter thus provides the historical and theoretical context

[1] See for example: Emiko Ochiai, 'Care Diamonds and Welfare Regimes in South-East Asian Societies: Bridging Family and Welfare Sociology', *International Journal of Japanese Sociology*, 18 (2009); Parvati Raghuram, 'Global Care, Local Configurations- Challenges to Conceptualizations of Care', *Global Networks*, 12:2 (2012); Shahra Razavi, 'The Political and Social Economy of Care in a Development Context: Conceptual Issues, Research Questions and Policy Options', UN Gender and Development Programme Paper No. 3 (2007), Francesca Bettio, Janneke Plantenga, 'Comparing Care Regimes in Europe', *Feminist Economics*, 10:1 (2004); Sigrid Leitner, 'Varieties of Familialism: the Caring Function of the Family in Comparative Perspective', *European Societies*, 5:4 (2003).
[2] Bettio, Plantenga, 'Comparing Care Regimes', 1.
[3] Ibid.; Ochiai, 'Care Diamonds'; Raghuram, 'Global Care, Local Configurations'; Razavi, 'The Political and Social Economy of Care'.
[4] Bettio, Plantenga, 'Comparing Care Regimes'.

that underpins my research, situating the subject of care firmly in the story of Scotland's industrialisation.

The chronological starting point for this research is the aftermath of the Union of 1707. After the loss of a separate parliament and Scotland's incorporation under the British crown, the nation's avenues for shaping its political arena diminished.[5] By contrast, newly gained access to colonial markets as well as a larger domestic one gave Scotland the opportunity to expand economically, contributing to the growth of capital concentration necessary for one of the fastest routes to industrialisation. Additionally, reduced political participation on a national scale led to the burgeoning of more localised 'improvement' projects aimed at strengthening the nation within Britain and the Empire. 'Improvement' as discussed here was not a distinctly Scottish phenomenon, present across the British Isles as well as (particularly protestant) Europe. Whilst this thesis examines the Scottish manifestation of this broader trend, it is crucial to acknowledge the role of exchange, emulation and adaptation that took place across national boundaries.[6] Crucially, as suggested by Bob Harris and Charles McKean, 'the significance and unusual visibility of improvement in Scotland can be fully understood only in terms of a country searching for a new role and identity as part of the new Kingdom of Great Britain created by union in 1707, and an economy and society perceived by influential Scots to be lagging well behind the more prosperous countries of Europe'.[7] As demonstrated by Christopher Whatley, the effects of the Union were not felt for some decades after the treaty was signed, however, and the crisis that ensued across sectors led many to conclude that the contentious agreement had entrapped Scotland under England's rule without delivering any benefits to the struggling nation.[8] High duties on Scottish goods as well as English competition led to the initial dwindling in Scottish staple trades such as linen, brewing or candle making triggering an economic crisis that lingered throughout the 1720s, marking the first decades of the political and economic consolidation of the union with difficulties. By 1723, however, the Honourable Society of Improvers in the Knowledge of Agriculture was established as one of the first 'improving' societies in Europe, followed by the Board of

[5] Eliska Bujokova and Juliette Desportes, 'Poor Relief as 'Improvement': Moral and Spatial Economies of Care in Scotland, c. 1720s-1790s', *Continuity and Change,* 38:2 (2023); Robert J. Morris, 'Philanthropy and Poor Relief in 19th Century Edinburgh. The Example of a Capital City without a National State Government', *Mélanges de l'École française de Rome*, 111:1 (1999).
[6] Eliska Bujokova and Juliette Desportes, 'Poor Relief as 'Improvement': Moral and Spatial Economies of Care in Scotland, c. 1720s-1790s', *Continuity and Change,* 38:2 (2023); Bob Harris and Charles McKean, *The Scottish Town in the Age of the Enlightenment 1740-1820* (Edinburgh, 2014).
[7] Bob Harris and Charles McKean, *The Scottish Town in the Age of the Enlightenment 1740-1820* (Edinburgh, 2014), 5.
[8] Christopher A. Whatley, *Scottish Society 1707-1830: Beyond Jacobitism, towards industrialisation* (Manchester, 2000), Introduction.

Trustees for Fisheries, Manufactures and Improvements in Scotland (1727), which yielded immediate benefits to the underdeveloped industries across the country. The 1730s saw a slow but steady growth followed by an upswing in the 1740s, mainly owing to the growth in linen manufacturing, newly emerging ironworks and the Glasgow based tobacco and sugar trades.[9] Following from Whatley's detailed analysis, this thesis commences in the 1720s, which saw the articles of the Union come into effect, accompanied by the foundation of philanthropic ventures as well as improving societies that underpinned a large part of the care infrastructures here examined.

The idea of 'improvement', as discussed by Chris Berry, involved a transition recognised and named by its instigators from amongst the Scottish mercantile and gentry elites, literati and clergy in the post-Union climate.[10] By the seventeenth century, the notion of 'improvement' in the context of agricultural land management for profit maximisation had been coined, but only by the eighteenth century did it become more broadly applied to spatial and particularly human management.[11] Crucially, whilst the histories of 'improvement' thought have highlighted the emphasis on rationalism, in the Scottish context it was religion as well as reason that shaped attitudes to progress and reform, especially in the context of welfare.[12] As proposed by Andrew Gairdner, the Edinburgh merchant and reformer who will be further discussed in Chapter 5, 'negative Holiness will not bring any Man to Heaven, it will not be enough to be able to say, I did not such and such evil thing, if we do no Good with the Talents we have been intrusted with'.[13] Gairdner linked individual salvation with national prosperity achieved through improvement and virtue. His stance on the importance of good works in the journey towards salvation was not unusual, as proposed by Thomas Ahnert, suggesting 'a growing tendency among eighteenth-century Presbyterians to emphasize practical holiness of life rather than adherence to the precise tenets of the Westminster Confession as the real essence of Christianity'.[14] Practical Christianity remained one of the central tenets of Scottish attitudes to community, natural affection and social obligation throughout the period, contributing to distinctly anti-welfarist attitudes to social policy that persisted well into the nineteenth century. In combination with the spirit of commercialism and the

[9] *Ibid*, ch 2.
[10] Christopher Berry, *The Idea of Commercial Society in the Scottish Enlightenment* (Edinburgh, 2014); see also Neil Davidson, 'The Scottish Path to Capitalist Agriculture: The Enlightenment as the Theory and Practice of Improvement', *Journal of Agrarian Change*, 5:1 (2005); Patricia Dennison, *The Evolution of Scotland's Towns: Creation, Growth and Fragmentation* (Edinburgh, 2018), ch 6&7.
[11] Ellen Meiksins Wood, *The Origin of Capitalism, A Longer View* (London, 2002), 106.
[12] Ahnert, *The Moral Culture of the Scottish Enlightenment.*
[13] Gairdner, *An Historical Account of the Old Peoples Hospital,* 53.
[14] Ahnert, *The Moral Culture of the Scottish Enlightenment,* 26.

politics of mercantilism that helped Scotland's economic boom, religion shaped much of the early 'improvement' discourse, since, according to Gairdner, 'the Hand of the diligent, with the Blessing of the Lord, maketh Rich'.[15] Traditional notions of godly community continued to shape attitudes towards the family, kinship and care provision distinguishing the Scottish care regime from its southern counterpart. Crucially, even within the secular strand represented by David Hume and Adam Smith, human interdependency was emphasised, both as an affective and an economic principle, highlighting the notion of reciprocal obligation that underpinned the family, community and the body politic.

As part of a national project, a range of societies, voluntary organisations and institutions developed, merging 'public' and private interest in economic and social advancement. Bodies such as the Society for Propagating Christian Knowledge in Scotland (SSPCK) (1709), the above mentioned Board of Trustees (1727), the Board of Annexed Estates (1752-1784), and the Select Society of Edinburgh (1754) were formed to promote civic leadership via implementing localised 'improvement' schemes, aimed at cultivating industry, and land and human capital. These primarily Edinburgh-based bodies were heavily involved in the foundation of some of the institutions that form the case studies of this thesis, such as the Royal Infirmary of Edinburgh and the Edinburgh Orphan Hospital. Edinburgh was, however, by no means exceptional in the proliferation of voluntarism, which gained prominence across Scottish towns in the early nineteenth century.[16] The aim of the emerging societies was both the promotion of a 'commercial society' whilst alleviating the social pressures associated with economic change. Crucially, in line with the populationism that was widespread across Western Europe in the eighteenth century, human capital investment was recognised as the principal tool of economic expansion, based on the belief that population, when 'virtuously educated, and industriously employed', was the nation's greatest asset.[17] Investment in population in the varied forms of public and private philanthropy was thus seen as the precondition to economic success, placing the provision of care and welfare at the heart of political economy. With the bourgeoning of Scottish business ventures in the colonies, philanthropic endeavours at home became a way of bringing resources back to Scotland as the imperial core. As shown

[15] Gairdner, *An Historical Account of the Old Peoples Hospital,* 4.
[16] Harris and McKean, *The Scottish,* 462.
[17] Robert Maxwell, *Select Transactions of the Honourable Society of Improvers in the Knowledge of Agriculture in Scotland* (Edinburgh, 1743), 445; Donna T. Andrew, *Philanthropy and Police: London Charity in the Eighteenth-century* (Princeton, 1989); Otto Ulbricht, 'The Debate about Foundling Hospitals in Enlightenment Germany: Infanticide, Illegitimacy, and Infant Mortality Rates', *Central European History*, 18:3 (1985); Louis S. Greenbaum, '"Measure of Civilisation": the hospital thought of Jacques Tenon on the eve of the French Revolution', *Bulletin of the History of Medicine*, 49: 1, (1975).

by Karly Kehoe in the case of the Scottish Highlands, the story of Scotland's developing care infrastructure is inextricable from the nation's engagement in colonial production and trade.[18] Exact quantification of imperial proceeds received in the form investments, donations and bequests by philanthropic institutions across Scotland awaits precise documentation, and quantitative claims regarding the scale of such investments cannot be made with precision until this has been achieved. It is nonetheless clear that the significance of this stream of revenue was vast in both real and symbolic terms, and resulted in hinging local philanthropic ventures to the larger imperial project of population 'improvement', reform and retention. Similarly, it linked the development of approaches to labour management in Scotland and the colonies. Crucially, care provision, broadly understood, was seen as an investment in future prosperity rather than expenditure, highlighting the economic utilitarianism (as opposed to humanitarianism) underpinning the development of public welfare during the long eighteenth century.[19]

Over the course of the eighteenth century, Scotland's economic development, demographic makeup and levels of urbanisation were transformed, resulting in the growing inadequacy of localised systems of support and increased calls for a more centralised system of welfare. Between 1707 and 1851, Scotland's population grew from about 1 to nearly 3 million inhabitants and levels of urbanisation rose exponentially.[20] The social composition of urban Scotland changed drastically, eroding traditional forms of community and kinship as well as reliance on trades and corporations for relief.[21] Social provision was under pressure to become increasingly formalised, moving under the auspices of the expanding state, here discussed in relation to the New Poor Law reforms and the emergence of the public health movement, but not exclusive to these phenomena.[22] This transition, I argue, was a reaction to increasing demographic and economic pressures, and shaped by eighteenth-century discourses of Scottish 'improvement', yet again emphasising the complementarity of discourse and practice. Care as a concept and practice moved from the realm of social bonds and reciprocal relations to the emerging sphere of individual rights and collective social securities, which transition, I argue, lies at the core of the shifting care regimes this chapter tackles.

Inevitably, the story of the transformation of Scotland's regimes of care is inextricable from the nation's transition to extractive industrial capitalism as the dominant

[18] Karly Kehoe, 'From the Caribbean to the Scottish Highlands: Charitable Enterprise in the Age of Improvement, c.1750 to c.1820', *Rural History* 27:1 (2016).
[19] Helen Berry, *Orphans of Empire: The Fate of London's Foundlings* (Oxford, 2019).
[20] RJ Morris, 'Urbanisation' in Anthony Cooke (ed.), *Modern Scottish History, 1707 to the Present* (Burlington, 2007), ch. 19; Dennison, *The Evolution of Scotland's Towns*, ch. 6.
[21] Harris and McKean, *The Scottish Town*, 440.
[22] Mitchison, *The Old Poor Law;* Cage, *The Scottish Poor Law.*

economic form. The intellectual developments that underpinned the 'improvements' and associated forms of human capital investment are traceable to the mercantile capitalism of the century prior (although the transition from mercantile to industrial capitalism was by no means clear-cut and the two forms continued in concurrence for much of the eighteenth century). It was, however, the social dislocation brought on by industrialisation that constituted the driver of the care regime transition. This thesis thus positions itself against this backdrop, subscribing to the understanding of historical processes as determined by material conditions. I view the structures of care in place as shaped primarily by the social and economic realities from whence they emerged, and only secondarily determined by cultural and affective norms. Simply put, material circumstances always matter. In a time when the majority of the population experienced material hardship, precarity of employment and dependency on unstable supply chains, although regulated by magistrates, for basic necessities, they mattered especially. It is with this understanding of historical materialism in mind that I write the following chapters, largely outwith the histories of affect and the biological family, instead placing care at the heart of the histories of labour, social politics and economic thought.

2.1 Economic and Demographic Change

Over the course of the long eighteenth century Scotland transformed from a predominantly rural economy to one led by a largely mechanised industrial sector powered by steam, becoming an entrepôt for colonial trade with Glasgow as its principal port. The speed of structural change was unparalleled south of the border with England's industrialisation following a more gradual path.[23] Economic change led to an even more far-reaching social transformation, resulting in changing its socio-cultural fabric, notions of family and community.[24] As shown by Harris and McKean, however, notions of 'public good' and 'community of the burgh' remained at the forefront of the management of urban space, albeit transformed by the economic and demographic pressures, fuelling thus a range of public ventures that combined elements of relief and control.[25]

The first few decades post-Union were met with economic stagnation due to increased competition, crippling duties on Scottish goods as well as Westminster's initial failure to deliver compensations for the failed Darien scheme amongst other failed

[23] Whatley, *Scottish Society,* ch. 7.
[24] Christopher A. Whatley, *The Industrial Revolution in Scotland* (Cambridge: Cambridge University Press, 1997).
[25] Harris and McKean, *The Scottish Town,* 466, 462.

promises to stimulate Scotland's economy.[26] 'Ironically', as Whatley suggests, 'it was the failure of the Union in the short-term to provide the economic benefits which had been promised that produced the changes in state policy towards Scotland which are generally acknowledged to have been necessary to lift Scotland out of her post-Union malaise'.[27] By the 1720s, the articles of the Union that were to benefit Scotland were finally being adhered to and by the 1740s the integration of Scotland into British and imperial markets as well as new investments made by the British government started to procure benefits.[28] Textile industries counting cotton, linen, jute, woollens and silks as well as fringe sectors such as cotton-thread production on one hand and coarse raw linen fabric were at the core of the first phase of industrialisation with 89 per cent of manufacturing labour concentrated in the sector by 1800, mostly organised through systems of putting out.[29] Production was reliant on low wages, favoured by the majority of political economists suggesting that 'the price of labour resembles water, which always levels itself'.[30] Scotland's consumption levels never grew to match those south of the border and Scotland remained an export economy throughout the industrialising process. By the mid-eighteenth century, Scotland was making large profits from colonial trade namely in tobacco and much of local manufacturing was aided by colonial outputs. As shown by Stephen Mullen, colonial ventures were a key contribution to Scottish industrialisation.[31] With growing mechanisation in various textile manufacturing from the 1790s, most production became concentrated, especially in Glasgow and Paisley (98 out of the total of 192 cotton manufactures by 1839).[32]

Predominantly built on textiles, Scottish economic growth drew on female and child labour and as such provided numerous opportunities for women to engage in paid work. As Whatley suggests, female labour was more readily available in Scotland than

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[26] Whatley, *Scottish Society.*
[27] *Ibid*, 7.
[28] Whatley, *The Industrial Revolution*, ch. 1 & 2*;* Whatley, *Scottish Society*; Stana Nenadic, 'Industrialisation and the Scottish People.' in T. M. Devine and J. Wormald, (eds.) *The Oxford Handbook of Modern Scottish History 1500-2000*. (Oxford, 2011); Stuart M. Nisbet, 'The Making of Scotland's First Industrial Region: the Early Cotton Industry in Renfrewshire', *Journal of Scottish Historical Studies*, 29:1 (2009); Charlotte Bassett, 'Lead-mining and the lead industry in Scotland, 1680–1780', *Journal of Scottish Historical Studies*, 39 (2019); Elizabeth Foyster, Christopher Whatley, *A History of Everyday Life in Scotland, 1600-1800* (Edinburgh, 2010).
[29] Anthony Cook, Ian Donnachie, Ann MacSween, Christorper Whatley, (eds.) *Modern Scottish History 1707 to the Present, Vol. 1.* (Edinburgh, 2001), ch. 7; Stana S. Nenadic, 'Industrialization and the Scottish People', in *The Oxford Handbook.*
[30] Lord Kames, *Sketches of the History of Man*, 537.
[31] S. Mullen, 'A Glasgow-West India Merchant House and the Imperial Dividend', 1779-1867*'* *Journal of Scottish Historical Studies*, 33:2 (2013), Nuala Zahedieh, 'Colonies, Copper, and the Market for Inventive Activity in England and Wales 1680-1730', *The Economic History Review*, 66:3 (2013).
[32] Whatley, *The Industrial Revolution*, ch. 2.

south of the border as a result of low sex ratios, low nuptiality and higher age at first marriage and high rates of celibacy. Most women thus had experience of independence and work before marriage and many remained in paid employment after marrying.[33] Spinning, traditionally a female occupation long remained outsourced through systems of putting out, which enabled women to work alongside household labour and care work, but even upon moving to factories, women still predominated. With the increasing mechanisation of spinning in factories, many women took up handloom weaving, which enabled them to work from home.[34] Glasgow's manufactories were responsible for much employment in adjoining areas through persisting systems of putting out, especially in case of winding for weaving and warping, but also embroidery and whiteworks.[35]

For many women, textile work through putting out industries became a key component of the makeshift economy alongside taking in washing or mending clothes, often alongside agricultural work during harvest.[36] In 1792 Torpichen, according to the Statistical Accounts, 'there are many women who do very well the year round, by spinning flax, with their harvest wages'.[37] In Linlithgow,

> A day-labourer earns between L.14 and L.15 yearly […] Their wives are occasionally employed by the farmers on the fields; at other times, besides earning something by spinning, washing, &c. they frequently nurse children which turns to great emolument.[38]

Many others, especially in urban spaces worked outside of home, often taking their children with them or arranging alternative care arrangements, with the support of older children, extended family and neighbours as well as paid carers.[39] In 1791 Fife, the estimated income of a labourer's family with small children was around £18, with the husband contributing £14 8s for 48 weeks of waged labour and the wife £3 12s earned 'in

[33] Whatley, Foyster, *A History of Everyday Life in Scotland,* Introduction.
[34] Catriona MacLeod, 'Women, Work and Enterprise in Glasgow c. 1740-1830', PhD Thesis, School of Humanities, The University of Glasgow (2015).
[35] *Ibid;* Sally Tuckett, 'Needle Crusaders': The Nineteenth-Century Ayrshire Whitework Industry', *Journal of Scottish Historical Studies* 36:1 (2016).
[36] Peter Earle, 'The Female Labour Market in London in the Late Seventeenth and Early Eighteenth Centuries', *Economic History Review,* 42:3 (1989); Amy L. Erickson, 'Married Women's Occupations in Eighteenth-Century London', *Continuity and Change*, 23:2 (2008); Alex Shepard, 'Working Mothers in Eighteenth-Century London', *History Workshop Journal* (2023), Eliska Bujokova, 'On the Respectability of this Person Every Thing Depends': Hospital Matrons and Power Relations in the Royal Infirmary of Edinburgh, c. 1817-1820', *Women's History Review*, 32:5 (2023).
[37] John Sinclair, Statistical Accounts of Scotland, EDINA, Edinburgh: University of Edinburgh, The Old Statistical Account of Scotland, Torphichen, 1792, 471.
[38] The Old Statistical Account of Scotland, Linlithgow, 1791, 234.
[39] Shepard, 'Working Mothers'.

spinning besides taking care of her house and children'.[40] Following the historical findings regarding gender and work, the composition of Scotland's labour force counted women and children as well as men, highlighting the centrality of including women's labour in accounting for the nation's economic transition. Equally, the nation's reproductive economy was shaped by the dynamics of demand for industrial labour and the ample supply of paid care organised through the market. Whilst the household-family in its many forms remained the primary locus of care, care work was provided by various actors, often outsourced and often commodified. Women's labour force participation (esp. married women) was a key shaper of the care regime in place, highlighting the dispersed nature of market-oriented and subsistence production as well as subsistence services within the household, hinting at the need for outsourcing care work when the demand for women's labour was high.

Alongside textiles, extractive industries grew rapidly throughout the eighteenth century.[41] Heavy industries drove the second phase of Scottish industrialisation, which followed the decay of traditional sectors such as salt making and kelp burning. The textile sector started losing its profitability by 1825 with cheaper suppliers that emerged during Napoleonic wars. With a downturn in demand resulting from growing competition and the cotton famine (following the American Civil war and the blockade of raw cotton production by Southern enslavers and the rising prices of raw cotton in China), many cotton masters instead invested in iron production, which bourgeoned by 1830 and counted for 25 per cent of British output by 1849. By 1851 most foundries were located in and around Glasgow and Greenock drawing on its large pool of labour. Coal extraction continued to expand and other industries such as shipbuilding and heavy engineering profited from cheap supply of the two key commodities.[42] Demand for women's industrial labour declined with the downturn in textile work, but the growing urban service sector including the array of caring tasks continued to rely on female labour.[43]

2.1.1 The Urban Landscape

As suggested by Robert Rodger, 'the construction of the state in nineteenth-century Britain relied heavily on the cities. It was there that intervention in housing, health and public utilities and social policy generally first was tested once it was deemed necessary to

[40] The Old Statistical Account of Scotland, Auchterderran, 1791, 449.
[41] Whatley, *The Industrial Revolution*, ch. 1; Cook, Donnachie, MacSween, Whatley (eds.) *Modern Scottish History*, 146.
[42] Nenadic, 'Industrialization and the Scottish People', Whatley, *The Industrial Revolution*, ch. 2.
[43] MacLeod, 'Women, Work'.

ameliorate the adverse human consequences of laissez-faire capitalism'.[44] Expanding this notion to the eighteenth century when the majority of Scottish industrial cities were shaped, I take a primarily urban approach, focusing on the impact of industrialisation and urbanisation on the regimes of care. As Harris and McKean argue, studies of urban Scotland have tended to focus on Edinburgh and Glasgow as the two different manifestations of the changes underway, overlooking thus the diverse ways in which Scotland urbanised.[45] At the risk of not capturing the complexity of the Scottish urban space, this thesis primarily examines the two largest cities in Scotland, following archival leads and focusing on case studies that best allow for capturing of both, continuity and change. For this reason, this thesis does not claim to map the whole of urban Scotland. Instead, it offers case studies of some of the most prominent/visible forms of public provision that largely informed Scottish welfare developments across the board, though cannot speak for the diversity of the emerging urban space as a whole.

The four major cities that emerged as a result of the economic transition were Glasgow, Edinburgh, Aberdeen and Dundee, where by 1851 20 per cent of the population resided. Apart from Edinburgh, the remaining three cities expanded through industrialisation. Aberdeen was a textile hub as well as a centre of the whaling industry, whilst Dundee was one of the primary locations for linen manufacturing prior to the founding of jute factories in the late 1840s.[46] All four cities were marked by rapid urban development, spatial segregation of the rich from the poor, increased control and management of urban space and the creation of urban slums. Additionally, industrial towns such as Falkirk, Greenock and Paisley grew dramatically, overtaking traditional market towns such as Perth or Inverness. Scotland was the most urbanised nation in the world apart from England and Wales, and the importance of this for the purposes of this study cannot be overstated.[47] Being largely driven by migration, Scottish cities quickly began to resemble the heavily commodified, anonymised economy of London, though with none of the capital's established networks of casual housing and employment. Incomers were slower to incorporate into traditional systems of trust and belonging, which were being eroded, replacing the 'thick' forms of trust comprised of personal networks with 'thin' forms of trust in written references and qualifications as explored in Chapter 4. Needing bed and board, new incomers relied on the expanding casual and overcrowded rental market, but the lack of support network or forms of social or cash insurance made them

[44] Richard Rodger, *The Transformation of Edinburgh: Land, Property and Trust in the 19th century* (Cambridge: Cambridge University Press, 2001), 3.
[45] Harris and McKean, *The Scottish Town,* Introduction.
[46] Richard Rodger 'The Scottish Cities' in *The Oxford Handbook,* 460.
[47] *Ibid.*

volatile to market fluctuations, weather conditions and sickness, contributing to the rising mortality rates in the cities compared to the national downturn. As remarked by Pulteney Alison,

> In the two greatest cities in Scotland, where the science and civilization of the country might be supposed to have attained their highest development, and where medical schools exist…the annual proportions of deaths to the population is not only much beyond the average in Britain, but very considerably greater than that of London.[48]

The social dislocation linked to economic change and urbanisation, primarily experienced by the poor and mobile, forms the backdrop of this study. Whilst the change underway was less pronounced in the numerous towns not shaped by industrialisation, the long eighteenth century nonetheless saw a transformation of traditional communities and changing approaches to the poor.[49] The transition between care regimes was a direct consequence of socio-economic factors at play. These developments were followed by administrative endeavours to limit and 'improve' the urban space, with Glasgow (1800) and Edinburgh (1805) Police Acts giving the municipal administration greater powers to control the built environment as well as trade and commerce, transport and public life. Management of the urban space became an important subject for the Scottish Benthamites. Promoting the effects of physical space on the minds, bodies and souls of those who inhabited it became the key concern behind institutional architecture. The exterior grandeur and imposing presence that marked the importance of institutional patrons was matched with an interior that embedded mechanisms of control and oversight with sanitation and spaciousness precluding the sense of privacy. William Adam, a key figure in the context of Edinburgh's spatial and institutional developments and the man behind the Royal Infirmary and the Bridewell, was an avid proponent of Bentham's panopticon, receiving instructions from the English reformer in the application of his architectural 'principle of invisible inspection'.[50] This thesis does not map the connections between punitive establishments such as the Bridewell or houses of correction and institutions of social and medical care. Nonetheless, their explicit connectedness through patronage and imagining as spaces of reform of the poor needs pointing out. Linked through their architects, overseers and funders, the institutional spaces primarily built for the cities' poor

[48] William Pulteney Alison, *Observations on the Management of the Poor in Scotland* (Glasgow, 1840), iv-v.
[49] Harris and McKean, *The Scottish Town,* Ch 7.
[50] *Correspondence of Jeremy Bentham, Volume 4: October 1788 to December 1793*, Alexander Taylor Milne (ed.), (UCL Press, 2017), 310.

inhabitants were embedded in a network that combined provision with control, increasingly becoming a staple of urban space. With the small circle of 'improvers', patrons such as the Earl of Hopetoun, the sponsor of Edinburgh Orphan Hospital, the Infirmary as well as the Bridewell, shaped the management of the urban landscape and population, increasingly understood as a resource to be managed, contained and reformed. Additionally, as will be shown in Chapter 6, concerns around health were central to these developments, placing institutions of medical care and poor relief at the forefront of the nineteenth century formalisation of urban space.

With the majority of institutional developments of the period located in Edinburgh, a large part of this thesis focuses on the capital. Additionally, Glasgow Town's Hospital and Royal Infirmary will be studied alongside examples of market provision from the industrial hub. Whilst very much connected, the two cities differed in the ways in which their landscapes were transformed, both physically and socially, thus providing a useful point of comparison for the study of care and welfare provision. Aberdeen features in one of the case studies that constitute Chapter 4, reflecting the growing medical market in the city. Dundee is not included in this study.

Post 1707, Edinburgh remained the legal, educational, religious and financial centre of Scotland despite ceding some of its political significance in the aftermath of the Union. It was the intellectual hub where the 'improvement' debates were shaped. Housing the country's courts, financial institutions and Edinburgh University, it was a city inhabited by professionals, crown officials, merchants as well as the landed elites and its infrastructure reflected the high demand for services and finery. Edinburgh's population grew much more dramatically than the national average, from 45,000 by 1700 to 190,000 in 1850 and this growth was largely accommodated by the construction of the New Town encircling the medieval heart of the city from 1760s. Nevertheless, until the end of the eighteenth century Edinburgh resembled a traditional medieval city with clusters of trades organised in close quarters and members of varied social ranks living in close proximity, with poverty of the Old Town wynds a common sight to all inhabitants. By the 1830s, however, the New Town was a largely middle class settlement comprising 40 per cent middle class inhabitants compared to the 5.5 per cent in the old town and 20 per cent in the suburbs (compared to only 5.9 per cent in Glasgow as a whole).[51] Between the eighteenth and mid-nineteenth centuries the level of affluence in the city had grown rapidly and Edinburgh had become the Scottish centre of fine manufacturing and luxury consumption.[52] The occupational structure was skewed towards the service sector with large numbers of people

[51] Dennison, *The Evolution of Scotland's Towns*, ch. 6; Rodger 'The Scottish Cities'.
[52] Nenadic, 'Industrialization and the Scottish People'.

working in professions and commerce and as smaller scale crafts and tradespeople as opposed to large manufacturers.[53] The many small craftsmen and tradesmen represented the 'labour aristocracy' with production focused on finishing trades and luxury goods for direct sale as opposed to the wholesale manufacturing which drove industrialisation. Medical professionals and care providers, domestic servants and landlords were also highly represented with many women working in the sector. Whilst many worked in industries such as textiles, printing and bookbinding, Edinburgh was never the industrial hub that Glasgow was becoming. The gulf between the capital and rural areas was widening as Edinburgh's occupational structure came to resemble London with its strong service sector, a large network of hospitality providers and luxury goods traders.[54] Unlike heavily industrialised centres, Edinburgh's occupational structure was both diverse and stable, and in turn more able to withstand market fluctuations and the irregularity of employment. As a result, those in casual employment and the poor received greater support than in any city in Scotland by way of regular payments as well as institutional provision, as will be shown in subsequent chapters. With the Scottish system relying on a parochial level of administration, the care infrastructure in each parish differed. In Edinburgh, this level of disaggregation meant that the City of Edinburgh, Canongate and St. Cuthbert's were administered by separate bodies. By the mid-eighteenth century, a network of workhouses was established in the three administrative units and funded through the sessions, payments for marriages and burials, poor boxes placed at churches and graveyards, legacies and the annuity of £200 from the city of Edinburgh.[55] The administration of relief was organised by members of the town council, kirk sessions, representatives of guilds and trades, city college and the college of physicians collectively responsible for municipal governance. By the late eighteenth century, the House of Refuge, Strangers Friend Society, Destitute Sick Society and the newly established Police joined the existing institutions in providing for the poor. They remained disjointed, despite the city authorities' efforts to centralise their administration. Additionally, numerous institutions providing for orphaned children or the sick and infirm were established, representing the heterogeneity of the eighteenth-century voluntary movement. Furthermore, a number of punitive institutions such as the city jail, the Bridewell or the Magdalene were intertwined into the network of housing, employing and containing the city's poor, envisioned as a network of transient spaces of social and moral reform.

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[53] T. C. Smout, *A History of the Scottish People* (Glasgow, 1970), ch. XV.
[54] Whatley, Foyster, *A History of Everyday Life in Scotland,* Richard Rodger, 'Employment, Wages and Poverty in the Scottish Cities 1841-1914', in George Gordon (ed.), *Perspectives of the Scottish City* (Aberdeen, 1985).
[55] Cage, *The Scottish Poor Law*, 119.

Glasgow's role as a significant local hub began to develop in the mid-seventeenth century, overtaking both Aberdeen and Dundee in population size by the 1670s. Glasgow developed leading industrial ventures in soap, glass and sugar production alongside its existing textile manufacturing and metalwork.[56] Alongside its growing commercial infrastructure, the city's administration, including the management of a workhouse and prison, was expanding and the first philanthropic ventures such as Hutcheson's Hospital begun to develop. Between the 1750s and 1830s the city transformed into an international commercial and industrial hub, becoming the second city of the Empire with 147,000 inhabitants by 1821 (compared with just over 30,000 in 1755).[57] By 1850, the city's population had more than doubled reaching 345,000 inhabitants, fuelled by migration from the local hinterlands, and the city's industries became largely mechanised and supported by steam-power rather than human and animal labour. Because of its rapidly expanding economy and population starting to overtake Edinburgh by the 1800s, Glasgow is often taken as representative of industrialisation in Scotland, despite the regional variation of the phenomenon and uniqueness of the Glasgow case.[58] Initially, the city's wealth was largely built on the tobacco and sugar trade, and the colonial ties between Glasgow, London, Grenada and Jamaica formed in the mid eighteenth century were crucial to the expansion that followed in the city itself. As Stephen Mullen suggests, early success of local merchants lay in connecting imports and exports, cash flow and domestic industry and Glasgow was at the centre of this exchange.[59] With the decreasing profitability of the tobacco trade after American independence, Glasgow merchants redirected their investment into cotton production, which remained the city's biggest output until the nineteenth century, bringing sustained levels of economic growth. With the downturn cotton's profitability before the mid nineteenth century, Glasgow and nearby Greenock still remained in the centre of production with numerous iron foundries in its close surroundings.[60] The unprecedented population growth brought on by the city's industrial growth resulted in the dramatic worsening of living conditions, unprecedented levels of poverty, disease and mortality. The narrow industrial focus of the city and irregularity of work made its inhabitants vulnerable to the high cost of living and dropping real wages. Mortality rates were growing and life expectancy falling in spite of the national trend

[56] T. M. Devine and Gordon Jackson, *Glasgow* (Manchester, 1995-6), Introduction.
[57] *Ibid.*
[58] Rodger, 'Employment, Wages and Poverty', 25-63.
[59] Mullen, 'A Glasgow-West India Merchant House'.
[60] Anthony Cooke, 'Cotton and the Scottish Highland Clearances: the Development of Spinningdale 1791-1806', *Textile History*, 26:1 (1995), Anthony Cooke, 'The Scottish Cotton Masters, 1780-1914', *Textile History*, 40:1 (2009).

going in the opposite direction.[61] The worsening living conditions and spreading of disease led to the inevitable westward move of the middling sorts embraced by the nineteenth century urban planning that segregated the city by wealth, marking the distinct move towards a class-based society.[62] Glasgow's governing bodies were unable to respond to the rapid transformation, lacking effective infrastructure. By 1800, the Glasgow Police Commission was established with the aim to improve public order as well as sanitation, forming the foundation of the increasingly public concern for the management of urban space and the city's population.

Until the 1730s, Glasgow's network of relief was fragmented, consisting of the sessions, town council, Trades' House and Merchants' House, each providing for a separate number of recipients. The four bodies came together to battle the rising problem of destitution, establishing the Town's Hospital (1731), which became the principal provider of relief (and which will be examined in more detail in Chapter 6). Despite the more centralised system, dissenting churches and friendly societies continued to provide for their own poor, constituting the mosaic of the mixed economy of welfare that the recipients were able to navigate in varied ways.[63] As in Edinburgh, relief was funded primarily through sessions' collections and distributed through parish district areas. Aside from the Hospital, a range of institutions primarily directed at the poor developed in Glasgow during the eighteenth and especially the nineteenth century. Unlike in Edinburgh where vested interests of the well-established medical school warranted the expansion of the medical sector early on, Glasgow's medical institutions did not develop until much later in the century.[64] Generally, the landscape of institutional provision was less populous than in the capital, with a general preference for out-relief. As will be shown in Chapter 6,

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[61] Rodger, 'Employment, Wages and Poverty in the Scottish Cities 1841-1914'; Brian Dicks 'Choice and Constraint: Further Perspectives of Socio-Residential Segregation in Nineteenth Century Glasgow with Particular Reference to its West End', in George Gordon (ed.), *Perspectives of the Scottish City* (Aberdeen: Aberdeen University Press, 1985), 25-63.

[62] Christopher Whatley, Stana Nenadic in *Glasgow* (Manchester, 1995-6).

[63] Tim Hitchcock, 'Unfawfully Begotten on Her Body': Illegitimacy and the Parish Poor in St Luke's Chelsea' in Tim Hitchcock, Petr King, Pamela Sharpe, *Chronicling poverty: the voices and strategies of the English poor, 1640-1800* (London, 1997); Alysa, Levene, *Childcare, health and mortality at the London Foundling Hospital 1741-1800* (Manchester: Manchester University Press, 2007); Samantha Williams, *Unmarried Motherhood in the Metropolis, 1700-1850: Pregnancy, the Poor Law and Provision* (Cambridge, 2018); Jeremy Boulton, 'It Is Extreme Necessity that Makes Me do this': Some 'Survival Strategies' of Pauper Households in London's West End during the Early Eighteenth Century', *International Review of Social History* 45 (2000); Jeremy Boulton, 'Welfare Systems and the Parish Nurse in Early Modern London, 1650-1725', *Family and Community History*, 10 (2007).

[64] Amanda Berry, 'Community Sponsorship and the Hospital Patient in Late Eighteenth-Century England', in Peregrine Horden, Richard Smith (eds.), *The Locus of Care*, (London, 1997); Paul Langford, *A Polite and Commercial People, England 1727-1783*, (Oxford, 1989); Risse, *Hospital Life in Enlightenment Scotland*, ch. 4; Guenter Risse, *Mending Bodies, Saving Souls: A History of Hospitals*, (Oxford, 1999), ch. 5.

this practice continued well into the nineteenth century, when it became increasingly insufficient under the pressures of the 'fevers'.

The care infrastructure of the two cities was vastly different, reflecting their socio-economic contexts. Glasgow dealt with the pauperisation of its labourers much earlier on, leading to its developing a more centralised system of provision. Edinburgh's care infrastructure remained more fragmented and voluntaristic, reflecting the high concentration of philanthropic ventures in the capital. Paradoxically, this meant the greater availability of various bodies that supported more complex welfare strategies. In Glasgow, the sparser network of institutional provision meant lesser opportunities for bargaining, resulting in weaker provision for the local poor.

2.1.2 Demographic Transformation

Alongside urban and industrial developments, the unique demography of Scotland and its contemporary understanding is key in explaining attitudes to providing for the fluctuating population. The nation's population up until the eighteenth century was largely controlled by weather conditions, harvest outcomes and crop successes. As a result, it only experienced sustainable growth by 1760s. By 1710, Scotland had 1,270,000 inhabitants, growing slowly to reach 1,625,002 by 1801, and then rising exponentially to 2,888,742 inhabitants by 1851. Explanations of the phenomenon are inconclusive, as birth rates stagnated and even fell at times in a country with an extremely low sex ratio and low nuptiality levels. Even though immigration was high, especially from Ireland, it was dwarfed by emigration mostly to North America, which continued to shape demographic developments throughout the period and contributed to the generation of populationist approaches to welfare provision. Population increase is thus best explained by falling death rates and an increase in life expectancy shaped by the developments of the medical and care infrastructure, including inoculation, improved sanitation and famine relief.[65] Contemporary discourses on population remain complex and often contradictory, as contemporaries relied heavily on demographic experiences as opposed to quantitative evidence. Its high regional and temporal differentiation has, however, not been fully accounted for by contemporaries or historians.[66] The below graph shows nine counties to represent the demographic trends in the Scottish Highlands (low growth), border area (stagnation/ population decrease) and the central area of Scotland (rapid growth), highlighting the uneven effects of economic and demographic change across the country.

[65] Cook, Donnachie, MacSween, Whatley (eds.) *Modern Scottish History*, ch. 6.
[66] Michael Anderson, 'The Demographic Factor', in *The Oxford Handbook*.

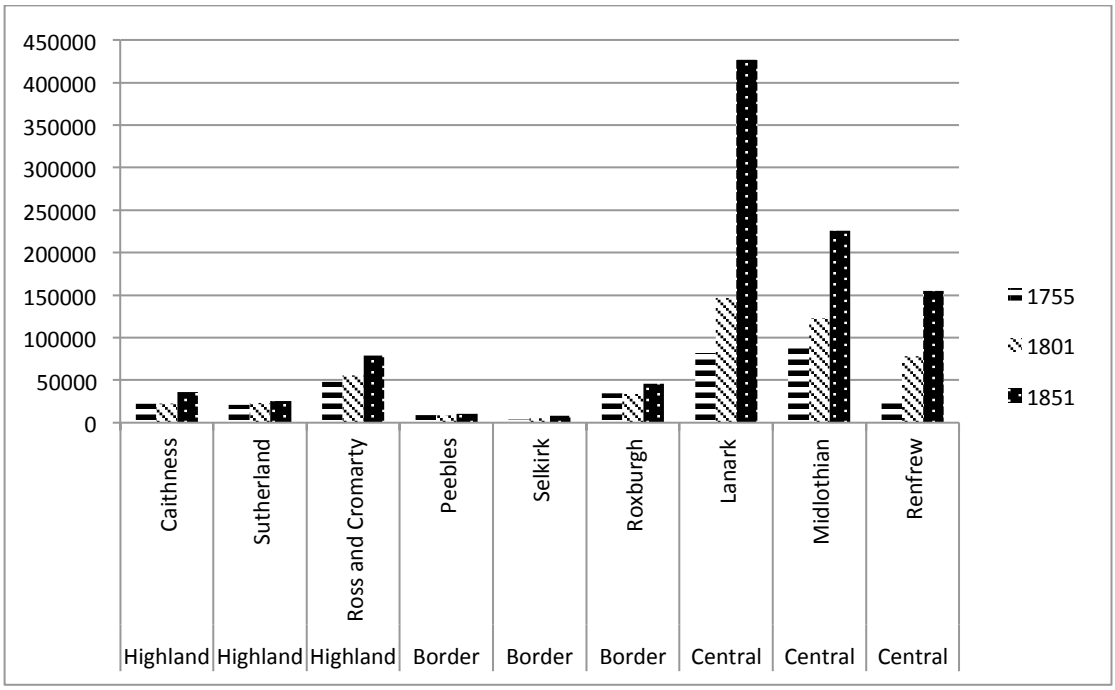

Table 2.1 Population growth in 9 counties, 1755-1851
(Anderson, 'The demographic Factor'; James Gray Kyd (ed.), *Scottish Population Statistics, Including Webster's Analysis of Population 1755*, (Edinburgh, 1952); Parliamentary Papers, 1801, VI, Enumeration; Parliamentary Papers, 1851, VI, Enumeration.)

Along with the general European trend, up until the 1790s, 'improvers' were keen to promote population growth in a direct effort to fuel the economy, especially in the under-populated highlands where the effects of emigration were more pronounced than elsewhere. But by the 1800s, the doctrine of populationism lost momentum, in a climate increasingly concerned with the dangers of overcrowding experienced in the industrial hubs of the Empire.

From a predominantly rural society with only 10 per cent of inhabitants living in towns in the mid eighteenth century, Scotland became one of the most urbanised countries in Europe by 1850, with about 40 per cent living in towns of over 5,000 inhabitants.[67] Urban developments followed the growing emphasis on spaciousness and sanitation reflected in the grid-like cityscapes of the new towns.[68] Living standards in the Lowlands improved during the early decades of industrialisation, yet this was most likely accounted for by greater availability of employment (including for women and children) rather than rising wages or falling living costs.[69] Skilled workers' standards of living were generally rising except during periods of warfare, yet unskilled workers were hit hard by

[67] Whatley, *The Industrial Revolution*, ch. 4.
[68] Cook, Donnachie, MacSween, Whatley (eds.) *Modern Scottish History*, ch. 8; Hamish Fraser, 'Labour and the Changing City', in George Gordon (ed.), *Perspectives of the Scottish City* (Aberdeen, 1985).
[69] Whatley, *The Industrial Revolution in Scotland,* 82-3.

mechanisation and irregular employment, particularly in the industrial towns.[70] During the Napoleonic Wars (1785-1805), the numbers of urban poor grew with returning soldiers, often needing immediate care.[71] As shown in Chapter 6, institutions such as the infirmaries bore the weight of this increased pressure on the care infrastructure, receiving payments from the crown for the soldiers' support. Hospitals established soldiers' and sailors' funds sponsored by the crown, which represented an early example of decentralised state-organised provision for its population.

With the increasing social unease surrounding urban overcrowding, the populationism of the eighteenth century began to wane. In this anxious climate, Thomas Malthus' *Essay on the Principle of Population* (1798) resonated with the changing discourse. With Malthus' clerical background and opposition to centralised poor laws, his theory tapped into Scottish anti-welfarism and approaches to reform inspired by both reason and religion. The English reformer relied heavily on the writing on Smith and Hume on the notions of utility, though his theory was far from the egalitarianism of his Scottish predecessors. Malthus' influence in Scotland was vast across opposing strands of thought. Whilst Malthus himself was opposed to universal provision for the poor, his work directly shaped the views of Alison, the main proponent of poor law reform in Scotland. Following economic and demographic pressures, fears awoken by the French Revolution relating to the power of the poor, alongside the notion of the Malthusian trap that divorced population and economic growth, Scottish understandings of the value of social provision shifted, leading to a significant reformulating of the regimes of care. Instead of a resource to be reformed and utilised, the population, especially that of the poor, was increasingly seen as a problem to be managed, a corrupting element to be avoided - and nowhere more so than in the ever-expanding cities.

2.2 The Changing Regimes of Care

In the context of early modern familialism, care in its material, affective, and embodied forms was viewed as an act performed for the benefit of the cared for and, by extension, their family and community. Care constituted the acts required to enable the biological and social realities of being born, living and dying, growing up, learning, working and contributing to the community. In the early modern sense, this cycle of life had little more meaning than life itself, that is to say, social reproduction was not actively mobilised to generate economic value and thus remained a matter for the individual, their bodies and

[70] *Ibid*, ch. 4.
[71] Cage, *The Scottish Poor Law.*

their immediate collectives. Whist much of care provision was commodified, it was not mobilised as a source of national economic power. The responsibility for care work lied with collectives made up by families, communities and their governing units of parishes, kirk sessions and vertical structures of landowners and their subjects. Throughout the long eighteenth century, care shifted from being primarily an individual/familial concern, to becoming a collective matter. This transition took place through a number of processes, in direct response to the economic change underway and associated demographic transition. Firstly, institutional developments such as the voluntary hospital movement and the increase in charitable provision for children and the old meant an expansion in collective provision for the dispossessed managed by a separate unit especially designated in response to the erosion or absence of organic structures and the desire to fuel economic growth and territorial expansion through the supply of labour capital.

With the emergence of economic nationalism and growth-oriented economic policy, population retention, health and longevity became a matter of national interest. With the emerging empiricism of national statisticians, individual life was valued through the resources expended on social reproduction and the productive potential of the individual's labour that underpinned capitalist structures of production, property ownership and labour. Whilst indissoluble from the commodification of human lives, bodies and labour imposed under systems of Atlantic slavery and forms of indentured labour implemented throughout the Empire, a distinctly domestic stream of thought mapped the developments of labour and human capital investment theory in Scotland. Primarily applied to the poor as the human periphery within the core, theories of reform and human capital investment shaped social policy, care institutions and philanthropic ventures that characterised the landscape of eighteenth-century welfare and poor relief.[72] Simply put, the production and reproduction of human life became a matter of the abstracted collective of the society and state, with the fate of the economy at heart.

With its focus on social policy and provision, this thesis largely studies the social group of 'the poor'. As suggested by Hitchcock and McClure, the treatment of poverty and 'the poor' in any given society is a direct reflection of its values and politics.[73] This thesis adopts their definition of poverty, understood as 'a range of dearths, absences, and inequalities that deprive a human being of the essential ability to live to their full social potential without assistance; a condition that effectively lowers the ceiling of the possible

[72] Nancy Fraser, 'Contradictions of Capital and Care', *New Left Review* 100 (2016).
[73] David Hitchcock and Julia McClure, *The Routledge History of Poverty: c 1450-1800* (London, 2021), xvi.

in a person's life'.[74] 'The poor' are thus a social category impacted by the experience of poverty in varied ways and for varied periods of time. Historically, the poor have never been a fixed or homogenous group, instead constituting a large segment of the population susceptible to downward mobility as a result of varied endo- and exogenous factors. As shown by Tawny Paul, experience or fear of poverty did not only impact the lives of the destitute, also shaping the life-course of the middling sorts.[75] As a result of economic and demographic change, the composition of this group fluctuated, becoming increasingly associated with the urban landscape. By the mid-nineteenth century, the category of 'the poor' became the increasingly homogenised labouring class. The poor were traditionally differentiated between the 'deserving', generally including the old, infirm and orphaned and those unable to work and eligible for relief, and the 'undeserving', that is the able-bodied, perceived as idle or indigent and in the Scottish context denied any form of formalised relief. Instead of only including those in receipt of regular or occasional relief, I use the term 'the poor' to refer to the majority of the population that lacked the security of land ownership, fixed income or a stable occupation, relying on various welfare strategies including casualised paid work, kinship networks, and parochial and institutional support that constituted the makeshift economy. In an economy that overwhelmingly relied on credit, poverty was less determined by access to cash, instead being shaped by a variety of resources and access to credit, denied to the poorest members of society.[76]

Poverty has never been a purely economic phenomenon, combining socio-cultural, moral and religious conditions and experiences of marginalisation as well as forms of identity.[77] Directly shaped by the distribution of wealth, the existence of poverty has always been a political choice, a tool disenfranchising the property-less. As suggested by Meiksins Wood, 'this means, among other things, that people who could be fed are often left to starve' as 'the ethics of 'improvement' in its original sense, in which production is inseparable from profit, is also the ethic of exploitation, poverty, and homelessness'.[78] In the context of this research, poverty is a crucial category of analysis. Questions around who was responsible for the provision of the poor and who was deserving of relief, charity and public benevolence heavily discussed by contemporaries, reveal the structures and regimes of care as well as notions of social obligation. Concepts of poor relief created political structures, in which welfare existed as a tool of provision but also subjugation and

[74] Hitchcock and McClure, *The Routledge History*, xxvii.
[75] Tawny Paul, 'Losing Wealth, Debt and Downward Mobility in Eighteenth-Century England' in Hitchcock and McClure, *The Routledge History*.
[76] *Ibid.*
[77] *Ibid.*
[78] Meiksins Wood, *Origin of Capitalism*, 194.

control. The Christian clause suggesting that 'the poor are always with you' continued to hold. As Henry Home, Lord Kames, a prominent thinker of the Scottish 'improvements' proposed,

> By what unhappy prejudice have people been led to think, that the Author of our nature, so beneficent to his favourite man in every other respect, has abandoned the indigent to famine and death, if municipal law interpose not? We need but inspect the human heart to be convinced, that persons in distress are his peculiar care. Not only has he made it our duty to afford them relief, but has superadded the passion of pity to enforce the performance of that duty.[79]

The role of poverty as a social glue was prominent, though voices of eighteenth-century political economists began to question its utility, starting to view it as an impediment to, rather than a driver of progress.[80] Adam Smith warned against the association between poverty and virtue, suggesting that it was the 'natural effort of every individual to better his own condition', motivated by plenty rather than necessity.[81] He proposed that

> No society can surely be flourishing and happy of which the far greater part of the members are poor and miserable. It is but equity, besides, that they who feed, cloath, and lodge the whole body of the people, should have such a share of the produce of their own labour as to be themselves tolerably well fed, cloathed and lodged.[82]

Smith's equitable approach was not widely adopted, however, with the poor continuously associated with moral shortcomings. Prior to the eighteenth century, systems of poverty management recognised the mixed economy of welfare, providing limited cash and kind payments to the 'deserving' (the young, old and infirm) combined with charity and alms giving and casual labour. The 'undeserving', or the able-bodied poor, were excluded from any formalised relief, being perceived as idle, indigent and morally corrupt. The elimination of poverty remained a fringe political aspiration, however, with evangelism continuing to guide social relations.

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[79] *Sketch,* 531.
[80] Matthew 26:11; Adam Smith, *An Inquiry into the Nature and Causes of the Wealth of Nations* (London, 1776), esp. Book 1; Adam Smith, *The Theory of Moral Sentiments*, Sixth Edition (1790); David Hume, *A Treatise on Human Nature* (1739-40); David Hume, *An Enquiry Concerning the Principles of Morals* (1751); David Hume, *Of Commerce*, in *Political Discourses* (1752).
[81] Berry, *The Idea of Commercial Society,* 82; Smith, *Wealth of Nations,* 417.
[82] Smith, *An Inquiry into the Nature and Causes of the Wealth of Nations,* 1:8, 36.

According to Paul Slack's study of seventeenth-century England, the poor became a subject of reforming projects aimed at harnessing their productive potential.[83] As shown by Donna Andrew, these concepts continued to dominate the landscape of relief throughout the eighteenth century.[84] In the Scottish context, whilst present in the last decades of the seventeenth century, the tendency to conceptualise the population as human and labour capital on a large scale mainly developed during the eighteenth century, and was manifested in reform schemes focused on reform of the population as well as physical landscape. As will be explored in Chapter 6, by the mid-nineteenth century, poverty became primarily a medical category, as opposed to a moral or an economic one, increasingly associated with the danger of contagion. Its understanding as a repercussion for moral failings was increasingly criticised by the medical profession including Alison, who, unlike most contemporaries had first-hand experience of the deprivation endured by poor urban dwellers. By the mid-nineteenth century, Smith's emphasis on universal human betterment laid the foundations of ethics that argued for a rights-based form of welfare provision. Inevitably, this changing understanding of poverty shaped both who was included in the category of 'the poor', and how they were provided for, reformed and managed. Whilst the Scottish system shared commonalities with the English and European regimes, it was unique in combining Presbyterianism with an emphasis on rationalism and commercial ventures.[85] With the clashing strands of evangelicals, political economists and social engineers, the landscape of social policy and provision was fragmented, reflecting the experimental nature of philanthropic ventures.

For reformers like Gairdner, Kames or Hopetoun, the generation of and provision for human life thus equalled an investment in future growth on a national and imperial scale, subsuming the labours of social reproduction under the efforts to stimulate the economy. Social cohesion, starting from the family and localised community and accruing to the social polity formed the underpinning of progress. Traditionally, it was fostered through ties of reciprocal obligation across social strata and the life cycle, and this notion continued to dominate eighteenth-century discourse. Ideals of natural affection and neighbourly obligation drove the laissez-faire approach to social policy and traditional Scottish anti-welfarism. According to Kames, the 'exercise of benevolence to the distressed is our firmest guard against the encroachments of selfishness: if that guard be withdrawn, selfishness will prevail, and become the ruling passion'.[86]

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[83] Paul Slack, *From Reformation to Improvement: Public Welfare in Early Modern England* (Oxford, 1999).
[84] Andrew, *Philanthropy and Police.*
[85] Bujokova and Desportes, 'Poor Relief as 'Improvement'.
[86] *Sketch,* 531.

Opposed to the English poor laws he viewed as 'oppressive' as well as 'grossly unjust', Kames' approach was rooted in traditional laissez-faire that was supported by the majority of Scots with the exception of political economists such as Smith and Hume. He was rather disinclined to express support for institutional provision, especially in case of children, who 'require the tenderness of a mother, during the period of infantine diseases; and are far from being safe in the hands of mercenaries, who study nothing but their own ease and interest'.[87] Traditionally, fostering lone children in families was generally prioritised over institutional care. Foster families were thought able to provide a caring environment for orphaned and abandoned children and as such were seen as in no way inferior to biological ones.[88] Payments administered to foster parents were rarely seen as preventing loving care of their foster children and were simply allowing this system to operate, monetary earnings and love of children being complimentary motivations for foster parents.[89] Whilst reservations against people only accepting foster children to gain the fees were widespread and resembled the broader debates about 'hireling' nurses and baby farmers, these were to be prevented by careful selection of families and nurses rather than abolishing the practices altogether.

In spite of general opposition to institutionalised forms of provision in orphanages or workhouses, branded as a 'nursery of diseases, fostered by dirtiness and crouding', the eighteenth-century urban space was reshaped by institutions of social and medical provision, reform and control. Institutional provision was sanctioned by the idea of population driven growth, contributing to the removal of welfare from familial to collective responsibility. Whilst initially run as private ventures by local entrepreneurs, these institutions were increasingly subsumed under municipal administrations, forming the basis for the centralizing system of urban care infrastructure. Especially in Edinburgh and Glasgow, infirmaries and orphan hospitals developed alongside workhouses, houses of correction and Bridewells, locking together the strands of provision of control previously operated by parochial networks.

Kames, like the majority of Scots, alleged that organised relief should foster independence, and its recipients should be promptly restored to the path of industry. He believed that outside of a workhouse,

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[87] *Ibid*.
[88] Christine Kelly, 'Reforming Juvenile Justice in Nineteenth-Century Scotland: The Subversion of the Scottish Day Industrial School Movement', *Crime, History and Societies*, 20:2 (2016); Helen, J. MacDonald, 'Boarding-out and the Scottish Poor Law, 1845-1914', *Scottish Historical Review*, 75:200, Part 2 (1996); Philip Seed, 'Should any Child be Placed in Care? The Forgotten Great Debate 1841-74', *British Journal of Social Work*, 3:3 (1973).
[89] *Sketch,* 531.

> They [the poor] are laid under the necessity of working with as much assiduity as ever; and as the sum given them in charity is at their own disposal, they are careful to lay it out in the most frugal manner. If by parsimony they can save any small part, it is their own; and the hope of encreasing this little stock, supports their spirits and redoubles their industry. They live innocently and comfortably, because they live industriously; and industry, as every one knows, is the chief pleasure of life to those who have acquired the habit of being constantly employ'd.[90]

'Improvement' discourse was divided on utilitarian poverty politics, but united on the subject of anti-welfarism. Smith, unlike Kames, stressed the role of individual betterment as a mechanism improving the human lot, turning away from the traditional Christian emphasis on the usefulness of poverty. He favoured high wages for labour and criticised the lack of rule of law that shaped the inequality between the haves and the have-nots. Unlike Kames, he believed in motivation by plenty rather than the avoidance of misery, articulating a capabilities approach to human liberty. Ultimately, however, his more liberal approach also opposed any form of legal assessment or centralised welfare, suggesting that, within an equitable legal system, poverty should be eliminated.

Smith's egalitarianism had little practical effect on social welfare in his lifetime, remaining in the realm of social theory rather than practice. His work, however, shaped the attitudes of early nineteenth-century reformers such as Alison. Whilst opposed to a legalistic approach to social provision, the justice ethics prominent in his work alongside that of Hume formed the basis of calls for a rights-based poor law that recognised the social as well as individual repercussions of poverty. With the exacerbation of the miserable living conditions of the urban poor, the welfare laissez-faire simply became inadequate, resulting in growing support for a centralised system.

By the end of the eighteenth century, Malthusianism, pauperisation and increasingly frequent 'fever' epidemics proved a strain on the reformism of the century prior. Institutional medical provision was expanded to include patients beyond paupers and its organisation was more closely tied to the municipal management of funds. The poor were to be controlled rather than reformed and their numbers curtailed as opposed to transformed into a labour force no longer needed in great numbers owing to rapid mechanisation of key sectors of production. Care and social reproduction remained at the forefront of economic policy, however, only less so as a form of capital formation and more as a way of efficient population management. The focus remained on the collective, abstracted from the early modern community and embodied by the nineteenth century

[90] *Ibid.*

fiscal state.[91]

By 1815, the adequacy of the old poor law was increasingly challenged and so it is especially in this period that the poor law debates provide an invaluable window into the expanding notion of the duty of care, primarily motivated by economic and medical concerns, within the context of social policy. Traditionalists called for a return to parochialism and voluntarism, suggesting that compulsory assessments ruined the principle of charity.[92] The leading voice was the Reverend Thomas Chalmers, who advocated for the promotion of charity and moral education of the poor as ways of solving the 'problem' of pauperism. Chalmers was a proponent of Malthusianism, an anti-revolution traditionalist who saw the retreat to the old and good as a way of avoiding further social dislocation and pressures on the status quo of social and political order. He saw a solution in applying the logic of parish social relations and welfare economies to the urban space. He identified a leadership vacuum in urban communities in the absence of local landowning elites and aimed to reintroduce a simulation of traditional paternalism.[93] Chalmers was strongly against the increasing administrative centralisation of urban space and desired 'parishes in the town [to] be as unentangled with each other as parishes in the country'.[94] He thought the traditional parish to be 'a field where the patronage and custom of the one party are met by the gratitude and good will of the other' and through the assimilation of towns into the parish system this principle could be expanded further. Eventually, he argued, 'ties of kindliness will be multiplied between the wealthy and labouring classes of our city, the wide and melancholy gulf of suspicion between them will come at length to be filled up by the attentions of a soft and pleasing fellowship'.[95] He believed that Christian virtue alone would lead to the relief of the poor, proposing that 'this, and this alone, will smooth all the asperities and equalise all the vicissitudes of fortune, to which a manufacturing population is liable'.[96] He saw combatting poverty and begging embedded in the Elizabethan Poor Laws as unchristian and a way of negatively reshaping the divinely ordained social order.

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[91] Mary Poovey, *Making a Social Body: A British Cultural Formation, 1830-1864* (Chicago, 1994)
[92] Thomas Chalmers, *Statement in Regard to the Pauperism of Glasgow, from the experience of the Last Eight Years* (Glasgow, 1823); Thomas Chalmers, *The Christian and Civic Economy of Large Towns* (Glasgow, 1823).
[93] John McCaffrey, 'Thomas Chalmers and Social Change', *The Scottish Historical Review*, 60:169 (1981), 38.
[94] *Dr. Chalmers and the Poor Laws: A Comparison of Scotch and English Pauperism and Evidence before the Committee of the House of Commons with Preface by Mrs. George Kerr Introduction by Miss Grace Chalmers Wood* (Edinburgh, 1911), 44.
[95] McCaffrey, 'Thomas Chalmers', 47.
[96] *Dr. Chalmers and the Poor Laws*, 75.

Benevolence and Christian charity directed at the deserving poor were 'the only true sources of their independence and comfort'.[97]

The undercurrent of his proposed reform was curbing the expenditure of the decentralised relief system pressured by population growth through institutionalising a simulation of traditional networks of support. In spite of his general laissez-faire approach, he was a believer in state-provided education that would afford the poor tools to better themselves and gain independence in the long-run, similar to the view promoted across orphan institutions as shown in Chapter 5. His thesis employed a socio-cultural rather than material conceptualisation of poverty, seen as simply preventable by improving the morals of the poor, which would in turn transform their material circumstance. By extension, Chalmers' theory lent itself well to the rhetoric suggesting that the poor themselves were responsible for their destitution, that underpinned policies such as the workhouse test widely implemented in England.[98] At the same time, he opposed motions for legislating a strictly parochial system that intended to ban formal assessments, thinking such laws a breach to parishes' independence.

Whilst Chalmers' approach was widely accepted, in 1818, the General Assembly of the Church of Scotland collated a report on the workings of the poor laws, which largely condemned compulsory assessments, suggesting that such policy 'multiplies the number of paupers, by debasing and corrupting one class of the population, and leading to an extravagant expenditure in supporting them, it unjustly and unnecessarily oppresses the other'.[99] This view was held in spite of evidence to the contrary, betraying the lasting sentiment of anti-welfarism as the deciding principle behind welfare policy.[100] The sentiment prevailed into the 1820s and 1830s when motions to return to the decentralised parish systems were repeatedly made in parliament, though opposition to this stance was rising. As suggested by Cage, despite the lasting opposition to assessments, most Scots were not in favour of legally-enforced parochialism either. In 1839, another report was launched, which brought to the mainstream the inadequacy of parochial systems of relief, suggesting that 'the difficulty in many parishes of maintaining the poor by means of the collections made at the churches, has been greatly augmented by the rapid increase of population in the country, without a corresponding increase of the ecclesiastical

[97] *Ibid*. 75.
[98] Poovey, *Making a Social Body*; McCaffrey, 'Thomas Chalmers'.
[99] Third Report from the Select Committee on the Poor Laws with an appendix containing Returns from the General Assembly of the Church of Scotland, 1818, 31.
[100] Cage, *The Scottish Poor Law*, 228.

Establishment'.[101] Even though the report itself concluded that assessment-based relief was more costly than voluntarism, it nonetheless drew awareness of the wider population to the state of the poor, bringing support to the argument made by medical men such as Alison and William Buchanan before him, that a more comprehensible system of relief was necessary to counter the ever-expanding epidemics of 'fever'.

Alison was Chalmers' most prominent opponent as well as a prolific writer on the subject, publishing widely on the consequences of poverty.[102] With Dugald Steward as his godfather, he was bred in the tradition of the Scottish Enlightenment with its emphasis on liberty, justice and benevolence.[103] Through his medical work he came into close contact with the afflicted poor and began to develop his theory on the relationship between poverty and disease, arguing for the greater danger of contagion and fatality as a result of poor living conditions. In the 1840s, he became one of the chief advocates of the poor law reforms taking a critical stance towards persisting anti-welfarism. Whilst belonging to the Scottish liberal tradition, his 1840s work shows a departure towards legalism not quite articulated by others. He went against the ideal of human independence, which he saw as abstracted from human biology. In other words, in sickness and in health, each individual was always dependent on others for their social reproductive needs, placing the question of care provision at the centre of state policy. He wrote,

> The great error, lies in arguing as if there were no dependence but dependence on the law; and therefore as if all who are kept off the poor-rate are independent. Whenever any individual of our species is not provided for, either by his own labour, or by the labour of his ancestors, or of his immediate relations, he is in a political sense dependent, and the moral and political dangers affecting his character, or the good of the country, which are to be apprehended from the losses of his independence, are already incurred.[104]

His stance elucidates the changing demographic and economic landscape within which he worked and the gradual shift from populationism and individual-centred reformism of the

[101] Report by a Committee of the General Assembly on the Management of the Poor in Scotland, 1839, 5.
[102] Alison, *Observations on the Management of the Poor;* William Pulteney Alison, 'Illustrations of the Practical Operation of the Scottish System of the Management of the Poor'*, Q.J. of the Statistical Society of London,* (1840); William Pulteney Alison, *Observations on the Generation of Fever', in Reports on the Sanitary Condition of the Labouring population of Scotland* (London, 1842)
[103] Hamlin, *Public Health and Social Justice;* William Pulteney Alison, 'On the Destitution and Morality in some of the Large Towns in Scotland', *Journal of the Statistical Society of London*, 5, (1842).
[104] Chris Hamlin, 'William Pulteney Alison, the Scottish Philosophy, and the Making of a Political Medicine', *Journal of the History of Medicine and Allied Sciences*, 61:2 (2006), 173.

early eighteenth century to the centralised social justice of the mid-nineteenth. He criticised the Scottish relief system as inefficient and inadequate, especially in dealing with outbreaks of infectious disease. He made a clear distinction between the lacking 'state' provision and the exceptional 'voluntary' sector, though he believed it to be an antiquated remnant of a former regime. Urban centres such as Glasgow, he argued, were 'a nucleus of crime, filth and pestilence, existing in the centre of the second city of the empire'.[105] As suggested by Christopher Hamlin, 'his solution was a Scottish version of the English poor law: it would recognize a right to relief, perhaps in conjunction with some needs test; would be administered by a professional staff, including a paid medical staff; and would be supported by rates'.[106] His route to this solution led through his medical treatment of poverty seen as a cause rather than a consequence of disease, through the ailments of overcrowding, malnutrition and poor sanitation. He saw 'the repeated recurrence of extensive epidemic fever, as a clear indication of great previous suffering among the poor' and believed that rights-based relief was the only efficient way of relieving poverty, in stark opposition to the reformist approach through the pursuit of Christian virtue.[107] He acknowledged the Scottish dislike of formal relief seen as 'breaking down the spirit of independence among the poor' as well as the Malthusian critique of assessment-based relief, though refuted both. He believed that through a rights-based system a greater harmony 'where peace be preserved, property protected and industry encouraged' could be achieved, showing the changing attitudes towards poor relief amongst some Scots. Crucially, his beliefs were based in the demographic developments of his time, suggesting that voluntary charity was ineffective in an urbanised anonymised society where a large proportion of the population lacked sufficient means of support. His conception of sufficient relief was one in which people were able to claim 'that bounty as a right, secured to them by a provident and benevolent laws, the application of which to themselves they can prove', echoing the work of Smith.[108] He believed that poverty was undesirable and soluble, thus arguing against the traditional view that held poverty as useful social glue.[109]

Alison was not alone in his beliefs as evident in the adoption of the New Poor Laws, which aimed to establish a legalistic system of relief, albeit only nominally for some time. The shift from voluntarism to legalism is notable, however, and represents a point at which a new regime of care commenced. Alison's thesis hints at the formation of new

[105] William Pulteney Alison, *Observations on the Management of the Poor in Scotland* (Glasgow, 1840), 14.
[106] Hamlin, *Public Health and Social Justice,* 78-9.
[107] Alison, *Observations on the Management of the Poor,* 18, 32.
[108] *Ibid*. 101, 115, 108.
[109] Hamlin, 'William Pulteney Alison', 35.

narratives of the state as a provider, in response to the disruption of vertical networks of patronage, especially in the urban space.[110] Unlike Chalmers who hoped to return to parochialism, Alison wanted to depart from the notion of vertical dependency altogether. His writing resonates with the newly articulated right to provision and care, unbound from social networks and informal welfare structures. Inherently urban, his thesis demonstrates the nascent idea of the polity as an abstracted social formation, divorced from community and tangible forms of dependency, here rooted in the notion of legal rights as opposed to embodied reciprocity. Placing health and biological humanity at the heart of policy was a novel approach, however, and not one generally accepted in Scotland or elsewhere.

Fundamentally, the discord over who in fact was responsible for the work of social reproduction, the individual and their immediate kinship group, or the body politic, that is the municipality and increasingly the state, was at the heart of the poor law debates which in turn demonstrate the change in care regimes. With the state of the 'fevers' becoming a major concern of city dwellers, compulsory provision for the poor, seen as a preventative measure, became more acceptable to the better off. In 1842, an official government report was launched into the state of poor relief, later underpinning the reform Act. Additionally, the membership of the established Kirk, especially after the Disruption of 1843 that resulted in two-fifths of the clergy joining the Free Church led by Chalmers, decreased significantly, resulting in the inadequacy of church collections to cover even the basic of necessities for the growing number of the poor. With the funds of the Free Church being unbound by regulation, Chalmers' reluctance to expend much on relief meant that a large proportion of their funds was directed elsewhere.[111] Paradoxically, despite his opposition to legalism and welfarism, Chalmers thus contributed to the formation of the Amendment Act.

Following the Disruption of 1843, the Established Church had been unable to provide the previous standard of relief owing to the dramatic decline in collections. A commission was appointed in 1844, producing a report on the state of the poor laws and its proposed reform. The report exposed the levels of poverty and destitution across the country, making a case for reform. It maintained Scottish opposition to providing relief to the able-bodied as injurious to industry, and proposed the provision of employment to the unemployed instead of cash or kind payments, mirroring the traditional belief in the reforming properties of labour. The report stressed the local variedness of circumstances and standards of living and recommended a blending of assessments with voluntary charity fully dealt by the kirk sessions. Importantly, the report argued for extending medical relief,

[110] McCaffrey, 'Thomas Chalmers'.
[111] Cage, *The Scottish Poor Law*, 246.

both in recognition of the sick poor as 'proper objects' as well as with the aim of preventing the spread of contagion. As Chapter 6 will show, the recognition of living conditions as the underlining factor of high contagion and mortality rates was generally acknowledged, following the campaigns of Alison. The report thus directly reflected public health developments, expanding the role of medical provision within the aggregate of relief. It proposed setting up a network of workhouses thought better equipped to deal with the complexities of relief provision, representing a move toward centralisation.[112] Additionally, it suggested changing the framework of settlement, moving towards a centrally administered system.[113]

The Amendment Act proposed in April 1845 did not change the classification of eligibility, continuing to exclude the able-bodied. Its main tenet was instituting the Board of Supervision, the first centralised authority to oversee the administration of relief and accepting appeals from recipients.[114] Whilst an assessment was not compulsory, 448 parishes out of the total 870 implemented it (compared to only 230 before the Act) and overall expenditure on relief increased across the country. The historiographical consensus has been that the Act constituted little practical change, continuing to exclude the able-bodied and only providing for the old, infirm and orphaned.[115] Contrarily, I argue that whilst not leading to a significant practical change *in the first instance*, the Act demonstrated a philosophical shift towards centralisation, legalism and reconceptualization of provision as an individual right, drawing on earlier notions of justice ethics articulated by Smith and Hume, embedding the notion of the providing state in law. Additionally, in the growing absence of horizontal and vertical kinship relations, it moved the provision of care, cure and relief from the realm of the family and community, to becoming a concern of the body politic, representing a key shift in Scotland's regime of care.

2.3 Conclusion

The period between 1720s and 1840s was one of transformation for Scotland. Whilst much has been written about the nation's economic, demographic and socio-spatial change, less attention has been paid to the economy of social reproduction that underpinned these changes. The aim of this thesis is to highlight the varied ways in which the relations of care and social reproduction became subject to the processes of first mercantile and

[112] Report from Her majesty's Commissioners for Inquiring into the Administration and Practical Operation of the Poor Laws in Scotland, 1844; Cage, *The Scottish Poor Law*.
[113] Poor Law Report, 1844.
[114] TD894/1Scottish Poor Law legislature.
[115] Mitchison, *The Old Poor Law*; Cage, *The Scottish Poor Law*, 272.

increasingly industrial capitalism, resulting in a transition from a care regime based in parochial familialism to one characterised by centralisation and legalism. There had always been a mixed economy of welfare, with care provision distributed amongst various paid and unpaid providers. In the early modern world, however, this provision was organised by the individual, the family or the community based in kinship or cohabitation. Over the long eighteenth century, the provision of care had first become a form of investment in human capital, seen as the greatest generator of economic capital, thus fuelling economic growth. In line with the 'improvers' emphasis on reform and the linear teleology of progress, the work of social reproduction became a public concern. By the end of the century, the value of human life and the work of its generation and sustenance had transformed again. With rapid urbanisation, overcrowding and spreading of contagious 'fevers', populationism gave way to Malthusianism, turning the focus from reforming and utilising the population to its control and management. Symptomatic of this change was the New Poor Law of 1845, representing a move towards centralised rights-based system of welfare provision, laying the groundwork for a broader welfare state of a century later. Crucially, this was not a transition from a system that relied primarily on informal and/or domestic care provision to one that placed care in the public domain of the state. Instead, much of care work had always taken place in public spaces, distributed across individual, and communities, markets and institutions, operated by private providers and entrepreneurs and charitable establishment. So whilst care continued to be distributed amongst the varied actors of the care diamond, it was its *perceived value* and its incorporation into political economy, urban planning and the nineteenth-century fiscal state that shifted as a result of the socio-economic and demographic transition of the nation.

In this chapter, I have demonstrated the links between care regimes and their contexts. The chapters that follow offer a range of examples of care provision as a diverse practice across different spaces, illuminating its distribution across the care diamond. I highlight the numerous ways in which care was understood, noticed and valued by contemporaries as a social, cultural and an economic factor, thus contradicting the binary opposition between production and reproduction that lies at the heart of mainstream economics. Situating care at the centre of the welfare state, social policy and institutional expansion, I outline the growing preoccupation of the body politic with social reproduction and its cost. Historically, care provision and care work have always been included in economic and administrative planning, by communities, cities and states, making their omission from present-day systems of economic accounting ever more baffling. Histories of care are not linear, as this thesis aims to highlight. Emphasising the historicity of care as both a practice and a phenomenon, the following chapter offers a discussion of the

language of care, focusing on *care words* and their text-contexts, and developing a meta-language with which care in eighteenth-century Scotland is studied.

3 Historicising the Meanings of Care

3.1 The Language of Care

Building on the contextual discussion of the preceding chapter, this chapter turns to a close scrutiny of the 'language of care' in eighteenth century Scotland gleaned from a range of records. It maintains that the study of words, their etymology, gendering, and direct as well as broader meanings is a key step towards unravelling the practices and experiences they describe. Because 'without meaning, there is no experience; without a process of signification, there is no meaning'.[1]

In her article about the emotions of Victorian motherhood, Emma Griffin demonstrates how language shaped the ways in which familial relations were articulated and thought about. Looking at working class families in the late Victorian period, she notes the absence of a 'ready-made language' of love and affection leading to such emotions being rarely verbalised. She demonstrates alternative ways of expressing maternal 'love' and its descriptions in contemporary autobiographies through qualities such as kindness and sympathy, but also good housekeeping and hard work ensuring the family's subsistence. The seeming reserve and emphasis on the material over the emotional in working class mothering is thus attributed to the specific discourse or 'emotional regime', which in turn shapes the emotional experiences of individuals.[2]

Emotional regimes are transmitted through language, which, in a broadly Chomskian sense, gains and conveys meanings through communication and the social environments within which it is used. Taking historical language at face value can thus lead to a misinterpretation of the meanings behind the words uttered. According to Thomas Kuhn, it is this 'taxonomic incommensurability' across temporal and paradigm shifts, that historians have neglected to attend to in their attempts to comprehend the sociocultural specificities of the periods studied.[3] Without understanding the specific socio-historical context, however, the illocutionary function of any utterance simply does not carry. Some more neutral language uses may remain unaltered across time, i.e. cooking a stew and eating it will mean a broadly similar activity despite technological, culinary and consumer developments. Others, and especially those existing in specific socio-cultural and

[1] Joan W. Scott, 'Gender: A Useful Category of Historical Analysis', *The American Historical Review,* 91:5 (1986), 1063.
[2] Emma Griffin, 'The Emotions of Motherhood: Love, Culture, and Poverty in Victorian Britain', *American Historical Review* (2018), 60-85.
[3] David Harley, 'Rhetoric and the Social Construction of Sickness and Healing', *Social History of Medicine*, 12:3, (1999), 409, P. Horwich (ed.), *World Changes: Thomas Kuhn and the Nature of Science* (Cambridge, 1993).

emotional regimes, will change as they interact with and mirror the changes of such regimes. Care inevitably falls into the latter category and its language is complicated by notions of emotions, responsibilities, needs and value, as well as hierarchies of gender, age, race and status. The GaW project shows the intersection of these hierarchies and the complex distribution of caring work with more skilled caring done by household heads and more onerous tasks being left to servants and younger persons. Drawing on the model of the subsistence economy, they demonstrate how paid and unpaid caring tasks intersected, with both categories including skilled medical work, everyday maintenance of persons, child and elderly care as well as arduous washing of linens and bodies or searching of corpses. Returning to the importance of language, they highlight that whilst many people did the same tasks, the meanings attached to them differed depending on who performed them, as with the gendering of work and occupational identities.[4] Drawing on the intersecting concepts of care work and work more broadly, this chapter uses language as a gateway to unravelling these intertwined aspects of care and their social, cultural, emotive and economic environs.

In her work on eighteenth-century notions of 'family', Naomi Tadmor develops a method that informs the analysis conducted here. In order to study the overlapping concepts of family, she scrutinises the language used in contemporary prose in order to glean direct meanings of the word 'family' from the immediate context within which it is uttered. She draws a distinction between two levels of content within the works she studies. Firstly, she uses the term 'word-content' to denote the direct meanings of the language in which these works are written, and places it in opposition to 'text-content', meaning the broader content/subject of the works consulted. She maintains that whilst the works themselves may not be representative of the societies that produce and consume them (they are, after all, works of fiction), the language that they use is broadly understood, used and reproduced by contemporaries and thus can help us unravel direct historical meanings of the words uttered. Similarly, using the immediate contexts of the words in order to infer their meanings can yield better results than 'relying on isolated examples detached from their contexts'.[5]

This chapter will use contemporary English and Scots language dictionaries to offer definitions of the words used to describe *care*. These definitions will be compared and expanded by a study of the 'word-content' in contemporary published sources, namely the

[4] Maria Ågren, *Making a Living, Making a Difference: Gender and Work in Early Modern European Society* (Oxford, 2017), ch. 5.
[5] Naomi Tadmor, 'The Concept of the Household-Family in Eighteenth-Century England', *Past and Present*, 151 (1996), 116.

Statistical Accounts of Scotland (SA) and various Scottish newspapers. The varied nature of these sources will provide a broad base for the analysis of the contemporary 'language of care'. Whilst my research focuses on areas of urban Scotland, the first two chapters of this thesis draw on broader Scottish sources, to establish a contextual framework for the more focused study of urban practices of care. It is argued that in spite of increasing cultural and socio-economic differences between the urbanising and rural spaces, there was a widely recognisable linguistic culture shared by the English- and Scots-speaking population of Scotland, which informs the enquiry that ensues.

The definitions that follow are cited from two of the most influential English language dictionaries published in the eighteenth century and the first Scottish language dictionary. Nathan Bailey's *An Universal Etymological English Dictionary* was first published in 1721 and subsequently reprinted in 30 editions (the one quoted here is an edition from 1763). It was the most commonly used dictionary of the eighteenth century and the first publication to include common use words, although it largely resembles the numerous early modern dictionaries of 'hard words'. The second English language dictionary quoted is Samuel Johnson's *A Dictionary of the English Language* first published in 1755. Johnson's dictionary became the first comprehensive dictionary of the English language in its common use and remained extremely popular until at least 1884 when the *Oxford English Dictionary* was published. The editions cited here are the first publication and a reprint from 1828 and is a combined publication of Johnson's *Dictionary* and John Walker's *A Critical Pronunciation Dictionary* first published in 1791. The third publication, John Jamieson's *Etymological Dictionary of the Scottish Language* was the first complete dictionary of Scots published in several editions between 1808 and 1910. Jamieson's dictionary remains a landmark publication and an important contribution to Scots lexicography.[6] The edition cited here is from 1808. The three dictionaries have been selected to precede the completion of the New SA but leave enough time apart to allow for a comparison. The nature of the two English sources, with Bailey's *Dictionary* focusing on 'hard words' whilst adding some common words and Johnson and Walker's publication being a fairly comprehensive dictionary of the English language, does not lend itself to a direct comparison between the entries included. Inevitably, the words discussed here being in common use might not be included in much detail in either publication and dictionaries alone do not provide a comprehensive source for the word analysis intended here. They will be used accordingly to open the discussion of words contextualised within the SAs and newspapers, and their purpose here is to illustrate some uses of the words studied,

[6] John Jamieson, *Jamieson's Etymological Dictionary of the Scots Language* (Edinburgh, 1808), available online at: http://www.scotsdictionary.com/.

rather than offer their definitions. Jamieson's dictionary was aimed at creating a comprehensive account of Scots and thus contains common as well as hard words.[7]

The principal sources for the 'text-content' analysis are the SAs, which prove a rich source for the study of language use. The Old Statistical Account (OSA), commissioned as 'an inquiry into the state of a country, for the purpose of ascertaining the quantum of happiness enjoyed by its inhabitants, and the means of its future improvement', was first published in 1791 and continued throughout the decade.[8] It was commissioned by Sir John Sinclair, the MP for Caithness and an avid agricultural 'improver', as an empirical study of Scotland compiled by local ministers on the basis of a set of questions about local history, climate, geography, demography and economy. As such it contains largely unedited accounts of local landscapes, populations and customs condensed into census-like information about every parish in Scotland alongside qualitative description of local populations and their customs. It is a product of contemporary rationalism and empiricism as well as the broader culture of 'improvement'. Therefore, it is by no means a neutral account, and the attention paid to local economy, demography and management of poor relief betrays a strong political interest. The New Statistical Account (NSA) was launched in 1834 and published in two reissues, the second of which is used here (1845). Whilst drawing on the principal ideas of the OSA, it was increasingly standardised and systematic, losing some of the idiosyncratic richness of its earlier counterpart. It was compiled by local ministers with additional comments from local prominent figures, but the more structured framework meant that the final reports were more uniform. Whilst potentially less rich than the original OSA, the NSA presents a great opportunity in portraying the great changes Scottish society experienced since the publication of the OSA, and both Accounts are thus of great value. Evidently, the two Accounts offer different qualities to be explored in linguistic terms. Whilst the OSA provides a wide array of linguistic variations across Scotland, the NSA affords a snapshot of a more standardised official language used at the time. In relations to direct meanings of the words explored here, these disparities are not overly significant. However, when the immediate context of the words explored is taken into account, interesting observations can be made about changing care regimes across the long eighteenth century on the basis of differences between the two Accounts.[9]

The last series of sources cited in this chapter are leading Scottish newspapers published between the years 1700 and 1850. The examples cited here originate from the

[7] *Ibid.*
[8] John Sinclair, Statistical Accounts of Scotland, EDINA, Edinburgh: University of Edinburgh.
[9] 'Scotland Accounted for: An Introduction to the 'Old' (1791-1799), And The New (1834-1845) Statistical Accounts of Scotland' (OSA, NSA), John Sinclair, Statistical Accounts of Scotland, EDINA, Edinburgh.

Caledonian Mercury, Glasgow Herald and *The Scotsman*. *The Edinburgh Evening Standard* and *The Scots Magazine, Glasgow Courier North British Daily Mail* were also consulted. Newspapers are a rich source as they cover a broad range of topics and during the period studied were increasingly available to a growing number of people. Although skewed towards commercially attractive texts, the language they use is varied as they were aimed at varied audiences and include texts from multiple authors. The wide array of publications used here and their specific genres also mean an expansion of the language captured. Similarly to the Accounts, therefore, whilst newspapers may not offer an exact depiction of the realities they report on, their word-content offers a unique opportunity to explore direct meanings of words and their immediate contexts. They are a key source used throughout the thesis and also form the source-base for Chapter 4.

Drawing on the sources introduced here, this chapter will firstly explore a set of historical and present day dictionary definitions of the words *care* and *to care*. It will then survey the uses of these words in the Accounts and newspapers and determine the 'word-content' of these terms within a broader textual context. It will survey a range of 'meanings of care' based on an analysis of the SAs, complimented by newspapers. It will then move on to discussing common synonyms of *care* and their etymologies to capture the broad range of the 'language of care'. When 'care' is italicised throughout the text, it refers to the word in its noun and verb forms. When it is not, it means care in a broader sense, as practice, a concept or a phenomenon.

3.1.1 Etymology of Care

In today's Standard English section of the Cambridge Dictionary, *care* is ascribed a number of meanings. The first meaning cited is 'Care (noun) as protection', i.e. 'the process of protecting someone or something and providing what that person or thing needs'. This is then divided up into 'take care of sb/sth', 'in care' and 'care in the community', the latter two referring to institutionalised systems of care of dependents (children, mentally ill). The second definition cited is 'Care (noun) as attention', i.e. attention paid to activities, tasks etc. The third definition is 'Care (noun) as deal with', i.e. provide, secure, organise, '*take care of sth'*. The last noun form of the word is 'Care … as a feeling of worry or anxiety'. The two verbal forms are care 'as worry', as in 'who cares?' and care 'as want', as in 'do you care for a pudding?' These definitions could be synthesised as follows.[10] The primary meanings of the term *care* in present day English

[10] 'Care' in the Cambridge Dictionary, https://dictionary.cambridge.org/dictionary/english/care.

refer to interpersonal, medical, institutional care and are preoccupied with provision, thus insinuating a relationship of dependency and/or need (this is also applicable to non-human beings but rarely cited amongst the examples). They are highly relational and encompass any notion of caring *about* and caring *for* when referring to a person or a being. By contrast, further meanings of the term are less relational and refer to carrying out tasks, worrying about a situation or desiring services, activities and things.

The variedness of meanings of *care* seems oddly haphazard and suggests a complex etymology of the term. The word *care* (noun, verb) can be traced back to Old English as *caru, cearu*, meaning 'sorrow, anxiety, grief', very similar to the proto-Germanic *karō*, meaning 'lament, grief, care' and Old Saxon *kara*, meaning 'grief'.[11] *Positive* meanings of the word such as 'have an inclination'; 'have fondness for' only seem to have developed around the mid sixteenth century in contrast to *care*'s original *negative* connotations, presumably expressing the affliction or anguish one encounters as a result of both positive *and/or* negative emotions. Both these contradictory meanings seem to have coexisted up until today, yet have been overshadowed by the more frequent association of *care*, both as a noun or a verb, with provision, protection or attention.[12] The seeming opposition, from a present day point of view, between the highly affective meaning of the word and the physical and material sense that came to predominate, partly explains the tension we feel when discussing care from both angles. This tension is reflected in the present day binary of caring *about* (as in loving, being concerned with) and caring *for* (providing, tending), which often appears irreconcilable. This binary is also entrenched in feminist theory, the field where much of theorising of care is situated. For example Joan Tronto's *Caring Democracy*, which clearly distinguishes between 'caring about' describing an emotional investment or attachment and 'caring for' referring to the hands-on aspects of care.[13] Whilst much recent scholarship on care calls for a broader and more nuanced approach, not least in order to battle the emotional and material repercussions of romanticising care work, this opposition between physical and affective aspects of caring has not been deconstructed.[14]

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[11] Douglas Harper, *Online Etymology Dictionary* (2001-2021), https://www.etymonline.com/search?q=care.
[12] *Ibid.*
[13] Joan Tronto, *Caring Democracy: Markets, Equality and Justice*, (New York, 2013); The Care Collective, *The Care Manifesto, The Politics of Interdependence*, (London, 2020).
[14] Paula England, Nancy Folbre, 'The Cost for Caring', *Annals*, AAPSS, 561 (1999); Folbre, N., 'Measuring Care: Gender, Empowerment, and the Care Economy', *Journal of Human Development*, 7:2 (2006); Nancy Folbre, 'Reforming Care', *Politics and Society*, 36:3 (2008); Nancy Folbre, Julie A. Nelson, 'For Love or Money- Or Both', *Journal of Economic Perspectives'*, 14:4 (2000).

In line with Griffin's emotional turn as well as the above dichotomy, Katie Barclay's work on eighteenth century Scotland seeks to historicize notions of love and how they manifest in various forms of care. She asks '[w]hen does economic provision or the intimate labours of child rearing become love? When does caring *for* become caring *about*?' thus echoing the ubiquitous opposition between the two.[15] She answers by linking the dynamics of materiality and affect with gender, class, and race as well as spatial and temporal contexts of any individuals' reality, thus really questioning the assumed naturalness of caring relations. She continues to point out the close link between caring *about* and caring *for* in eighteenth century Scotland, referring to the social constructedness of 'love' and its contemporary manifestation in material provision, education and physical care as opposed to its primarily affective dimension as it is seen today. Barclay's chronology is important here, resonating with my findings about the primacy of material as opposed to affective care in the long eighteenth century.

Returning to the etymology of the word, we also see the close interlink, or a causal relationship between the two meanings, thus exposing the historicity of the binary. In contemporary sources, caring *for* thus emerges as the result of caring *about*, in a parental, familial sense of love or 'natural affection', a biblical sense of 'Thou shalt love thy neighbour as thyself', or in a more abstract sense of shared humanity reflected in charity, poor relief and proto-welfare systems organised by communities.[16] The binary becomes naturalised with a growing emphasis on loving and tender care, especially as performed by mothers entrenched in Victorian middle-class epistemologies constructed outwith the necessity to provide.[17] Following a Marxist dialectic, the opposition between the material and the spiritual/affective emerged in the late nineteenth century from bourgeois idealisation of the middle class family, with the tender mother, or the angel in the home, and the resulting condemnation of the working classes' 'inability' to live up to said ideal.[18] As this chapter shows, a closer scrutiny of the language of care provides for a better understanding of the relationship between the two prior to its nineteenth-century developments, demonstrating the complex socio-linguistic history of care.

The search for definitions of the word *care* in the *Universal Etymological English Dictionary* composed by Nathan Bailey in 1763 yields only two results shedding some light on the development of the meanings of *care* since the Middle Ages. According to this

[15] Griffin, 'The Emotions of Motherhood', pp. 60-85; Katie Barclay, 'Love, Care and the Illegitimate Child in Eighteenth c. Scotland', *Transactions of the Royal Historical Society*, 29 (2019), 108.
[16] English Standard Version Bible (2001), Matthew 19.19.
[17] L. Davidoff, C. Hall, *Family Fortunes: Men and Women of the English Middle Class, 1780-1850* (London, 2002).
[18] Karl Marx, *Capital: A Critique of Political Economy*, Vol. 1 (London, 2002).

publication, *care* (noun) can mean 'heed, cautiousness', but also 'a fine linen cloth formerly laid over the new married couple kneeling'.[19] The first definition resembles our current understanding of the term as well as its medieval counterpart, even though it has shed its strictly negative connotation. The second meaning has become obsolete and seems a rather colloquial expression unrelated to its regular use. The common verb form of *care* is not directly defined despite its usage in the periods before and after, most likely reflecting the publication's focus on 'hard words'.[20] Despite the limitedness of the direct entries on *care* and their definitions, the word itself appears time and again throughout the publication. It is used to define 'Asspzer [Assizer] of Weights and Measures' as 'an Officer who has the Care and Oversight of those Matters'; 'one who takes care of the Beds and Lodgings of Travellers' when defining 'Chamberlain *of an Inn*; or as in 'To Wreck' meaning 'to think of, to reflect, to care for, or value'.[21] The richness of meanings ranging from responsibility, through to looking after, to the emotions of caring *for* is striking, demonstrating the complex etymology of the term in turn reflecting the multifaceted history of the meanings of care.

The original 1755 Johnson's *Dictionary of the English Language* has no entry on *care* despite aiming to include common as well as difficult words, yet the word *care* is used countless times throughout the publication. The quotation from John Dryden used to define *babe*, for example, '[t]he *babe* had all that infant care beguiles,
And early knew his mother in her smiles', evidences the contemporary use of the term in the complex interlink of the emotive, physical and material.[22] Whilst the initial meaning suggesting 'anxiety' is preserved, as in 'there are our past sins to wound us, our present cares to distract us', the meanings of the word care in this publication are manifold, despite the word wanting an entry of its own.[23]

In the expanded version of the *Dictionary of the English Language* published in 1828, *care* receives a direct entry showing a wider array of meanings as well as a greater similarity with the current usage of the word. In this publication, *care* (noun) means 'Solicitude, caution, regards, the object of care'. *To care* (verb) is also included and defined as 'To be anxious, to be inclined, to be affected with'. Moreover, a rather outmoded *Care-crazed* (adj.) appears with the definition 'Broken with care', and the words *Careful* (adj.) 'Anxious, provident, watchful, subject to perturbations' and *Careless* (adj.)

[19] Nathan Bailey, *An Universal Etymological English Dictionary* (London, 1763), 142.
[20] *Ibid.*
[21] Bailey, *An Universal Etymological English Dictionary*, 88, 171, 1001.
[22] Samuel Johnson, *A Dictionary of the English Language* (Digital Edition of the 1755 publication, Edited by Brandi Besalke, 2014) online service: https://johnsonsdictionaryonline.com/babe/.
[23] *Ibid*.

'Having no care, cheerful, undisturbed, unheeding, thoughtless, unmoved by' are also included. This later dictionary entry is indicative of a significant broadening of the term in a grammatical and semantic sense. It allows for the blending of positive and negative connotations traceable to the Middle Ages in 'to be inclined' and 'to be anxious', whilst allowing for the emotional underpinnings of such perturbations. The term *care-crazed* accentuates this connection between anguish and passion, hinting at the feeling of distress as a result of *care*, again broadening the affective dimension of the word. Alongside including a verb form, it also quotes two adjectives, again showing the broadening of the term and its greater proliferation. The meanings encompassed in the direct definitions are further expanded by searching for occurrences of the word throughout the publication, such as the entry on '*Guardian* n. s.' defined as 'one that has the care of an orphan; one to whom the care and preservation of anything is committed'.[24] Similarly, '*Keeping* n. s.' is defined as 'Charge; custody; care to preserve; preservation; guard'.[25] An entry on '*To Look* v. n.' includes '*To look after*' and '*To look to*' defined as 'To attend; to take care of' and 'To watch; to take care of' respectively.[26] As opposed to the definitions preoccupied with care as 'anxiety', 'regard' or 'perturbation', the practical uses of the word describe providing for and looking after, most prominently in the sense of preservation and/or attendance, once again underlining the materiality of caring.

The first edition of Jamieson's publication includes an entry on '*To Care. V. Cair. Care Bed Lair*', defined as 'a disconsolate situation; q. lying in the bed of care.' 'Care bed', it is added, 'is a phrase of considerable antiquity, being used by Thomas of Ercildoune. Three yer in care bed lay'.[27] This entry is intriguing in its direct linking of care and sickness, with the term 'care bed' replacing the more common 'sick bed', defined by the labours of caring as opposed to the state of unhealth.

Much like the earlier English language entries, Jamieson's dictionary does not contain a definition of the verb form, despite it being mentioned. Throughout the publication, the stem word care is mentioned 611 times, showing the range of meanings of the term used in parallel with 'trouble, toil, or care' and 'care, sorrow', but also 'to tend, to take care of' or 'tender care' and 'love and care'.[28] As shown in an excerpt from Jamieson's Popular Ballads, the meaning of care related to provision is clearly recognised:

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[24] R. S. Jameson, *A Dictionary of the English Language by Samuel Johnson, LL. D. and John Walker, with the Pronunciation Greatly Simplified and on an Entirely New Plan and with the Addition of Several Thousand Words*, 2nd ed. (London, 1828), 327.
[25] *Ibid,* 413.
[26] *Ibid,* 439.
[27] Jamieson, *Jamieson's Etymological Dictionary*, 259.
[28] Jamieson, *Jamieson's Etymological Dictionary*, 135, 106, 79, 257.

But gae your wa's, Bessie, tak on ye,
And see wha'll tak care o'ye now;
E'en gae wi' the Bogle, my bonnie-
It's a browst your ain daffery did brew.[29]

Interestingly, the relationality of *care* implied by its present day definition, is completely absent in the 1763 definitions, despite being evident in the practical uses of the word throughout the dictionary, yet is included in the 1828 publication through the use of 'object of care' and the expression *care-crazed*. Similarly, the Scots dictionary shows the linking of *care* with sickness and health, hinting at the physicality of care that is absent from the English language definitions. Whilst neither of the English language definitions relate to the sense of providing, protecting and tending the needs of another, the Scots dictionary's allusion to sick-care seems prevalent. A principal meaning of the term today, this use of the word also appears from the uses of the word across the dictionaries. This dissonance between the ways in which *care words* are formally defined across time, and across the English/Scots publications, as well as used in practice, is striking and warrants a more in-depth enquiry into the nature of these linguistic disparities. In order to establish direct meanings of *care*, I shall turn to its practical use in contemporary sources, capturing the breadth absent in the dictionaries.

3.1.2 Care *in the Statistical Accounts of Scotland*

In order to flesh out the language of care that emerges from the dictionaries, I have looked to the SAs to glean evidence of how the word *care* had been used by contemporaries across Scotland. First, I have searched the SAs and input the various mentions of *care* into a database, which allowed me to analyse the manifold meanings of the word uttered in different contexts. Ultimately, the search yielded 1008 mentions of the stem word *care* across the two collections of Accounts, which have been categorised on the basis of their meanings, and then quantified (Table 3.1). Subsequently, in order to expand on the textual matrix, I have looked to the online British Newspaper Archive and searched for the mentions of *care* in newspapers published in Edinburgh and Glasgow between the years

[29] Jamieson, *Jamieson's Etymological Dictionary*, 225.
English translation, thanks to Finn Manders:
'But go on your way, Bessie,
Take on you,
And see who will take care of you now,
Go off with the faeries my girl,
It's a brew your own foolery has brewed.'

1700 and 1850 with specific attention paid to the years of publication of the SAs (1790-95, 1845) to test the representativeness of the language used in the SAs and potentially expand on the meanings of care yielded by the initial search. The term *care* is ubiquitous in the newspapers, yielding a broad variety of examples closely mirroring uses of the word in the Accounts. Through this method, I have managed to gather a wide array of uses of the word. The heterogeneous nature of both sources in addition to the dictionaries quoted above ensures a high level of representativeness of the language.

Meaning of *care*	**Frq.**
Attention, responsibility, work	312
Care of crops, animals, things	198
Careful, diligent	181
Care of humans	115
Religious, pastoral care	88
Effort, toil	72
Care of the poor	46
Trouble, pains	11

Table 3.1 Meanings of care in the Statistical Accounts of Scotland
(John Sinclair, Statistical Accounts of Scotland, EDINA, Edinburgh)

The initial search of the two sets of Accounts has shown interesting results that expand the definitions of *care* presented in the dictionaries. The most represented use of the word falls into the broad category which includes 'care as attention, responsibility or interest' (312 mentions across the Accounts)[30] reflected in a number of instances of administrative organisation such as 'registers are kept with care'. The second most represented category is 'care taken of animals, crops or land' (198). In this case *care* is understood as active 'looking after' such as when the price of sheep breeding was discussed in Kirkwall in 1793, with the observation that the sheep 'turn to little account, as there is so little care taken of them, that they are allowed to run wild in the hills'.[31] Likewise, in the Scots dictionary, animal care is notably represented with entries such as 'Hen-Wyfe, s. A woman who takes care of the poultry about the house of a person of

[30] The number in brackets after each meaning in this section designates the frequency of its mentions in the Accounts.
[31] OSA, Kirkwall, 1793, 544.

rank'.[32] The applicability of the term to providing for animals and humans alike is crucial here, reflecting the breadth of affective relations that are blended with a sense of responsibility, duty and oversight of the provider towards the receiver. Even more broadly, care of crops and estates encompass human and human-animal relations, in which one party recognises their duty of care towards those under their authority and oversight. Whilst this research does not focus on human-animal relations, including caring amongst humans in a wider, extra-human framework of providing for the needs of others is nonetheless crucial. Equally, this broader understanding of care once again highlights its rootedness in labour and economic relations as well as affective ones. Third, the word 'careful' (181) is also highly represented.

Fourth, 'care taken of humans' (115) expressed in affective, educational as well as material and physical, including medical terms is expressed frequently. It is this category that this chapter focuses on. The fifth category refers to *care* in a 'religious, pastoral or paternalistic' sense (88) such as when in 1795 an elite man from Peterculter refused to adhere to the strict discipline imposed by the parish priest and 'found means to get himself and his dependents put under the care of the neighbouring priest'.[33] This use of the word was more common in the newspapers, predominantly referring to the royals' or landowners' paternalistic relationship to their subjects such as 'your Majesty's paternal regard and watchful care for the rights, interests, and welfare of your faithful people' used in a 1790 parliamentary report.[34] *Care* used in reference to 'effort or toil' is also used frequently (72). Even more so this category predominates in the newspapers, often in the context of political, commercial and administrative matters. Next, 'care of the poor' (46) is frequently represented and, like poor relief, is used as a colloquial expression. Alongside 'care taken of humans', I draw on 'care of the poor' in this analysis. Care used to refer to 'troubles or pains' is represented 11 times.

The varied contexts in which 'care taken of humans' is expressed, demonstrates the complex loci in which caring takes place. To draw some examples, the 1798 Account from Kilmadock includes a discussion on the topic of disease and inoculation, which was often refused on the grounds of superstition or parents' reluctance to inflict pain on infants. 'This extreme care and anxiety is a strong mark of parental fondness and love; but experience is the strongest argument, and nothing ought sooner to conquer ancient prejudices'.[35] Concurrently, *care* also meant educational provision and mentorship as used in the 1796

[32] Jamieson, *Jamieson's Etymological Dictionary*, 629.
[33] OSA, Peterculter, 1795, 392.
[34] 'House of Commons', *Caledonian Mercury*, 4.12. 1790, 3.
[35] OSA, Kilmadock 1798, 51.

Account from Scone describing the upbringing of the Earl of Mansfield who, 'after having been sometime under the care of a private tutor, received the rudiments of his education'.[36] More so than in the Accounts, *care* in relation to education is largely present in the newspapers with references to the upbringing of prominent individuals, advice to parents and nurses, and public debates on the education of poor children. In 1790 Caroline Montgomery described the 'zeal of the Tutor who had the care of my brothers' in the *Scots Magazine*, whilst a *Caledonian Mercury* article from 1791 on 'Happy Union' in marriage assumed that '[n]othing so effectually charms the mind into a settled esteem as concurrence in an employment so beneficent, so delightful, as the care or education of our own offspring'.[37]

Across the Accounts, *care* of humans often appears in the immediate context of work, paid and unpaid, carried out by household members, predominantly women, both within and beyond the domestic setting, and mostly represented in its physical or material rather than affective forms. In Dornock, 1792, family expenses generally exceeded the earnings of labouring men, yet were supplemented by

> The wife's industry, by her working in hay-time and harvest, when she can earn about L.1:10s. and by her spinning through winter and spring, when she may gain from 1s. to 1s. 6d. per week, besides taking care of her family.[38]

Unpaid care, spinning as part of the putting-out system, and agricultural subsistence production all constituted the various aspects of the makeshift economy practiced by household members in an effort to optimise their collective welfare. Categorising subsistence and market-oriented work alongside one another is an important indicator of the absence of the paid/unpaid binary, instead confirming the understanding of work through the activity performed as opposed to its monetisation.[39] Similarly, in Tealing in 1792, referring to the earnings of a day labourer's family, 'if they are all well, his wife, besides taking care of her family, may earn a shilling a week by spinning; nay, provided they have a cow, which is generally the case, she may earn other two shillings in the same space by the sale of butter for three months in the year'.[40] As highlighted in Chapter 2, wives' housework and family care formed part of the subsistence economy consisting of a variety of tasks only some of which carried a monetised value. As demonstrated, the

[36] OSA, Scone, 1796, 80.
[37] 'History of Lady Caroline Montgomery Concluded', *The Scots Magazine*, 1.6. 1790, 270; 'Happy Union', *Caledonian Mercury*, 10.1. 1791, 3.
[38] OSA, Dornock, 1792, 21.
[39] Ågren, *Making a Living*.
[40] OSA, Tealing, 1792, 110.

composition of these women's everyday tasks was conditioned by the season, the availability of spinning work, and the possession of livestock, as well as the number of children and their state of health. These tasks alongside the labour of the husband, children and domestic servants constituted the aggregate of the household economy and were organised according to need and availability of individual household members. In such cases, reproductive work, healthcare and material provision largely overlapped with housework, indicating the varied perception of care across contexts. Albeit gendered, care and housework positioned alongside the myriad ways of making a living seem less hierarchical, overlapping with the range of labour engaged in by household members. They appear contingent and adaptable, practiced as opposed to emotionally experienced, despite the affective value attached. The concept of 'natural affection' as stemming from responsibility towards another being is once again invoked.

Alongside the Accounts, newspapers contain a range of examples in which care taken of humans overlapped with work. Newspaper advertisements were such examples that show the vast commercial sector of care. They contain a wide range of adverts placed by servants, wet or dry nurses and sick-nurses, calls for job seekers to register in such capacities to registry offices, or private individuals seeking all sorts of paid care provision. Rarely mentioning *care* explicitly, these adverts draw on the more commercialised language of nursing or body service. Interestingly, the following example includes all of the above.

> **TO INVALID GENTLEMEN**
> **SITUATION WANTED**
>
> **BY** a Person long accustomed to act as Body Servant to Gentlemen, and who during nine years, was Superintendent of the Asylum for Indigent Old Men. He can make himself useful in many capacities to any Gentlemen requiring care and nursing. He will furnish ample testimonials of character and fitness from Noblemen, Clergymen, Medical and other Gentlemen of the highest respectability—Apply to A. C. 256, High Street, Glasgow, 22 January, 1847.
> N.B. no objection to a Situation in the Country.[41]

Illustrating the broad dimensions of bodywork, the term 'body servant' used in the advert encompasses the physical dimension of caring and gives a rare glimpse into such work provided by men, challenging the expectations that care was gendered female.[42] It

[41] Advertisement, *Glasgow Herald*, 22.1. 1847, 2.
[42] Mary Fissell, 'Women, Health and Healing in Early Modern Europe', *Bulletin of the History of Medicine*, 82:1 (2008), 1-17; Mary Fissell, 'Remaking the Maternal Body', *Journal of the History of Sexuality*, 26:1 (2017).

uses both 'care' and 'nursing', drawing on the growing differentiation in the nineteenth century between medical care and care as washing, tending, dressing, and more broadly providing for the body. These adverts were ubiquitous and bring invaluable insights into the practices of paid care.

As will be shown in the following chapter, newspaper advertisements are a useful source in demonstrating the overlap between varied forms of care and bodywork, including practices of healing and medicine. Medical developments were a popular subject in the newspapers and there are numerous mentions of *care* as an umbrella term with words such as *cure, attend,* and *nurse* when describing more specialised practices. In a 1792 article about the Edinburgh Lunatic Asylum, it was stated that 'the cure of lunatics, whose circumstances enable them to pay for their maintenance and treatment in the Asylum […] may be conducted under the care of any of the members of the Royal College of Physicians or Surgeons of Edinburgh', using *cure* to denote medical or therapeutic treatment, whilst *care* in this case can be interpreted as oversight, expertise or more broadly as attendance, marking the increasing division between the two.[43]

Going back to the SAs, practices of medicine are subsumed under the term *care,* without the separation that appears in the newspapers. In 1845, the enumerator in Lochwinnoch wrote, 'I have been furnished with an account of the patients and diseases which came under the care of the surgeon here, who had the greater part of the practice in this place'.[44] The 1845 Account from Aberdeen includes a lengthy discussion of how public dispensaries were funded, explaining that 'for several years, there was a midwife attached to each district, to whom was assigned care of all ordinary cases, (for which a small allowance was made according to the number of cases)'.[45]

Alongside 'care taken of humans', 'care of the poor' (46) is central to my enquiry. Drawing mostly on the material aspect of care, it is very much an extension of the interpersonal and medical forms of care described above and is situated in both domestic and institutionalised settings and operated by families, communities and parishes and increasingly relegated to institutions and centralised systems of provision. It often relates to the care of poor children as mentioned in the 1797 Account from Aberdeen when discussing maintenance of 'poor orphans, who had no relations to take care of them'.[46] The 1845 Tullynessle Account describes the relief system and concludes that 'at present, the

[43] 'Proposal for Establishing a Lunatic Asylum', *Caledonian Mercury*, 11.2., 1792, 3.
[44] NSA, Lochwinnoch, 1845, 40.
[45] NSA, Aberdeen, 1845, 90.
[46] OSA, Aberdeen, 1797, 190; Deborah Harkness, 'A View from the Streets: Women and Medical Work in Elizabethan London', *Bulletin of the History of Medicine*, 82:1 (2008), 52-85, Harkness' work suggests a close interlink between the two, we are seeing a shift here.

parochial machinery for the care of the poor is in full and undisturbed operation. Long may it continue so'.[47] Similarly to sick care, simple *care* is a sufficient descriptor of a multifaceted and highly organised (in a practical as well as ideological sense) practice comprising outdoor and indoor relief, medical care, educational provision as well as control and the coerced labour of the poor.

Especially notable in the language of the Accounts compiled in 1845 are the normative and political debates surrounding responsibilities for the care of the poor heightened during the New Poor Law reforms. Whilst the traditional narrative of idle and deserving poor is very much present throughout both the OSA and NSA, the language used to describe affective dimensions of care is rather varied, thus providing an impetus for exploring its chronology. The 1797 Account from Roxburgh offers a glimpse into the workings of poor relief prior to the New Poor Law in the parish whilst shedding some light on the tensions over the responsibilities for the poor's maintenance.

> It is painful indeed, to see parents worn out with the toil and care of rearing a family, sometimes applying for public aid; while the very children they have nourished and brought up, will not give a mite to relieve their distress. The public, say they, is obliged to do it. This is the apology many make for neglecting to obey one of the first laws of nature, while they frequently lavish away a considerable part of their earnings upon the vanities of life. On this account some have thought there should be no law to force public charity, unless to oblige such as are in ability to support their indigent relations, especially children their parents.[48]

The notions of family ties conditioning care were strongly ingrained, with expectations of reciprocity, care in return for care. Accordingly, public funds were to be drawn from only to supplement eroded or broken down familial and kinship forms of provision, and were curtailed by a series of checks preventing misuse. Poor relief was nonetheless seen as a duty shared by the community, and a sense of obligation, albeit limited, is present throughout the Accounts. Occasionally, however, a sense of affective deficiency is mentioned in relation to publicly provided care such as in the 1793 account from Caerlaverock, which claimed that parish relief was inadequate in providing emotional care to the elderly in saying that the parish cannot 'make up to them the want of tender assiduity, which proves the cordial of age and poverty, and which natural affection alone can administer'.[49] More commonly, however, the 'law of nature' mentioned in the

[47] NSA, Tullynessle, Aberdeen, 1845, 468.
[48] OSA, Roxburgh, 1797, 121.
[49] OSA, Caerlaverock, 1793, 29.

Roxburgh extract seems to refer to the mutuality of the obligation for material, not affective care.

In the 1845 Accounts, the binary between paid/material and unpaid/affective care appears more present suggesting a deeper entrenchment of the binary than in the OSA. An example from Alford discusses general solidarity towards the poor in the parish suggesting 'it has occurred only rarely, in some peculiar cases, that the kirk-sessions have needed to hire nurses for the sick paupers; for all around them watch them with an affectionate care that could admit of no purchase and be compensated by no earthly reward; and the poorest of all are as liberal of these last valuable services as any other persons'.[50] The 1845 Account from Caerlaverock uses the same narrative as in 1793, betraying a level of standardisation, but also suggesting local continuity in the perception of purposes of poor relief.[51] Both examples closely resemble the binary that contrasted care provided out of love and/or neighbourliness seen as superior to care provided out of duty and/or for pay. It thus suggests a growing tension between 'loving' and 'loveless' care already notable in the OSA and fully apparent in its newer counterpart. The sets of continuities across the two, despite the notable shift in care regimes and care infrastructure, attest to the on-going significance of familial and community care and natural affection as building blocks of social cohesion, necessary for individual subsistence as well as collective welfare. Family, broadly understood, was still where care was to take place, although increasingly with the presence of a centralised overseer. The Accounts provide a glimpse into debates on centralisation in the midst of growing public expenditure; professionalization and institutionalisation of much care provision; and persisting sentimentalisation of 'loving' and 'tender' care especially in the context of mothering.

Lastly, *care* was also used, although less frequently, as a rhetorical tool, such as in 'love and care', 'care and sorrow', 'trouble, pains' or signifying one's 'lack of care'. Whilst most of these meanings were equally represented across the two sets of Accounts, the use of *care* as 'care of the poor' predominated in the OSA (32 in OSA/14 in NSA), whilst 'religious, pastoral care' and 'careful, diligent' were more frequently used in the NSA (59 in NSA/29 in OSA and 129 in NSA /52 in OSA respectively).

The newspapers largely mirror the direct meanings of the word in the Accounts, despite the broader contexts within which *care* is uttered. They contain numerous mentions of the word in reference to carefulness and diligence, work or toil. Its use denoting paternalistic relations was even more pronounced than in the Accounts, showing the linguistic similarities between describing family relations and socio-political hierarchies.

[50] NSA, Alford, 1845, 522.
[51] NSA, Caerlaverock, 1845, 360.

The uses of the word referring to animal and human care confirm the findings from the Accounts providing a still broader platform for the study of the language of care. The meanings relating to anxiety, trouble as well as attention remain constant between the Accounts, newspapers and historical dictionaries and the association between *care* and positive emotions, such as love, and negative ones, such as sorrow can be linked to the 1828 definition of the word. Moreover, the sources help us expand on the 1828 expression 'object of care' through the use of direct examples of 'care taken of humans, animals and inanimate objects' as well as 'providential and pastoral care' and 'care of the poor' and 'medical care'. As demonstrated in an article published in the *Scots Magazine* in 1792, care in its varied forms is largely interlinked through its linguistic denominators. The article retells a story of a rural childhood of a prominent librarian. In the space of just four paragraphs, it mentions the man's taking 'care of his poultry' and being trusted with the 'care of six cows' and his falling sick and nearly dying but for 'the care of a poor shepherd' 'aided by the strength of his constitution'.[52] Acts of animal keeping, nursing and convalescent care being described through identical terms once again points towards the embededness of the practical/physical acts of care-giving in the contemporary meanings of the word and provides further context for the study of care, bringing us back to depicting care as work.

The language of *care* that is manifest in the sources shows the broad meanings of the term, pertaining to provision for the needs of humans or animals or the keeping of crops as largely determined by a concern for a responsibility towards one's kin, dependents or estates. Increasingly, care was becoming formalised, institutionalised and also politicised, particularly in relation to poor relief and childcare. The varied meanings of the word sketch out a picture of care as a practice that is contingent, shaped by senses of responsibility, obligation as well as 'natural affection'. Throughout this analysis, care as an activity is rooted in the physical, material *and* affective, but also the political and economic that are closely linked rather than mutually exclusive, and reveals the embededness of caring practices within the fabric of coexisting hierarchies and chains of dependency.

3.1.3 Care *Synonyms*

Drawing on the above analysis, I identify a range of synonyms that appear in the sources alongside *care*. The verbs *to provide, to maintain, to tend,* and *to nurse* are most represented and their direct meanings seem a lot more straightforwardly linked to material

[52] 'Valentine Jamerai Duval', *The Scots Magazine*, 1.1. 1792, 9.

and physical aspects of caring than the word *care* which is fraught with ambiguities.

A simple search for these words in contemporary dictionaries reveals interesting results. Firstly, in the 1763 dictionary, the term *to provide* is explained as follows:

> To Provide [pourvoir F providere L] to furnish with, take care of, prepare
>
> Provision, any thing got procured which is necessary for the subsistence of life, a providing or taking care of.[53]

Similarly, the 1828 dictionary includes the following entry:

> To Provide: v. a. To procure beforehand, to get ready, to prepare, to furnish, to supply, to stipulate, to make conditional limitation, to treasure up for some future occasion, *to provide against*, to take measure for counteracting or escaping any ill, *to provide for*, to take care of beforehand, *provided that*, upon these terms, this stipulation being made.[54]

The Scots dictionary contains *to provide* in its English language definitions, mirroring the above meanings such as in 'the neighbour will come and offer him those implements which he ought to provide for himself', or 'supported by the bounty of another, I do not honourably provide for myself as I have done formerly'.[55]

Largely preoccupied with preparation, provision and subsistence in a very material sense, the two available definitions include the clause 'take care of' as synonymous with providing. The relational aspect of the word captured by the present day *care* is fully articulated and suddenly the expression 'take care of' appears directly linked to the current use of the term. Providing and 'taking care of' here undoubtedly captures the varied dynamics of dependency and capacity, yet appears very material, largely unencumbered by the more conceptual and affective dimensions of *care* as we read it today. In the present day dictionary, *provide* (verb) is simply defined as 'to give someone something that they need', closely mirroring the emphasis on the material expressed by the historical definitions of the term. Interestingly, the present day definition offers a much narrower understanding of the term and its direct linking to 'take care of' is not included.[56] Although fraught with mistrust of welfarism, the Westerkirk account of 1794 included multiple uses of *to provide* and their literal meanings. It maintained that

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[53] Bailey, *An Universal Etymological English Dictionary*, 672.
[54] Jameson, *A Dictionary of the English Language*, 578.
[55] Jamieson, *Jamieson's Etymological Dictionary*, 182, 278.
[56] Provide in the Cambridge Dictionary https://dictionary.cambridge.org/dictionary/english/provide.

> This rapid increase of poor's rates may indeed be somewhat alarming to those by whom the assessment is paid. Trusting to these rates, individuals are not so solicitous, perhaps, as they otherwise would be, to make provision for a time of sickness, a season of dearth, or the indigence of old age; and this mode of providing for the poor may serve to lessen that attention to parents, and that desire to provide for their comfortable subsistence, which are so much the duty of, and so very becoming in children.[57]

Here, *to provide* is used to describe material provision by families, institutions as well as oneself thus expressing the many relationships involved and understood to form the aggregate of material and by extension physical care that comprised the mixed economy of welfare. It also closely relates to the political debates surrounding care and provision already alluded to earlier in this chapter. The newspapers contain thousands of mentions of *to provide*, mostly mirroring its meanings discernible from the Accounts and dictionaries. A *Caledonian Mercury* article about the New Lanark mill that declared 'this sight never fails to excite the most agreeable sensations in all who have an opportunity of seeing so great a number of orphans, so comfortably provided for, and by industry rendered useful to themselves and their country'.[58] These snippets further evidence the multiple 'providers' responsible for material care in one way or another forming a part of the aggregate of the care diamond. Similarly, they highlight welfare development as integral to the 'improvement' project that paired provision and control as tools of human capital investment. As this chapter continues to demonstrate, the text-context of *care words* is often the discourse on poor relief. Outside of the networks of traditional familialism, the poor were perceived as objects of public provision. It is this public aspect that places the poor at the centre of care in a political and an economic sense, which lies at the heart of this study.

Most closely linked to *to provide* as it appears in the Accounts is *to maintain*, in the dictionaries defined as follows,

> To Maintain: [maintenir F], to give a livelihood to, to keep in repair, to uphold, to make good a thing affirmed.[59]

> To Maintain: v. a. to preserve, to keep, to defend, to hold out, to vindicate, to justify, to continue, to keep up, to support the expense of, to support with the

[57] OSA, Westerkirk, 1794, 523.
[58] 'A Pleasing Instance of Health', *Caledonian Mercury*, 10.1. 1795, 3.
[59] Bailey, *An Universal Etymological English Dictionary*, 516.

convenience of life, to preserve from failure, to support by argument, to assert as a tenet.[60]

Similarly to *to provide, to maintain* does not have a direct equivalent in Scots, but is widely used throughout the publication, such as in 'these they give to every one that will give them money to maintain them'.[61]

According to the two dictionary definitions, *to maintain* thus refers to practical upkeep and support, often in relation to material things, property or land, and it is also extended to the act of providing a livelihood. It also refers to a sense of continuation or an expression of one's belief or conviction in 'to uphold' or 'to justify'.[62] In the present day English dictionary, the four meanings detected from their historical counterparts appear nearly identical, demonstrating a sense of linguistic continuity also detectable in *to provide*.[63] In the Accounts this is reflected in a literal sense of providing for a family as well as more indirect keeping of servants and apprentices. In the 1792 Account from Torphichen, 'a married man, with common prudence, is at no difficulty to maintain and bring up his children, if he keeps his health, along with the industry of the mother'.[64] Maintaining here refers to material provision for a family through the joint earnings of the husband and wife. Similarly to *to care* and *to provide, to maintain* is also used to refer to 'maintenance of the poor' at the expense of the parish. In the 1792 Account from the parish of Maybole, the enumerator remarks on the high number of poor dependent on relief. He continued, 'it may be said, that in this parish the poor maintain the poor. Few of the principal heritors reside in the parish; and nothing is given by them, in the way of donation, to the poor, who are maintained wholly by the collections made at the church door, upon Sunday'.[65] In this case 'maintained' is used to designate material provision in the 'maintained by collections' whilst also describing a sense of dependency and responsibility in 'poor maintain the poor'. The newspapers are equally filled with the word and alongside its common use in relation to the upkeep of properties and infrastructures, it primarily designates material provision, such as in the commercial anecdote published in 1795, which includes a conversation between a lord asking his daughter's suitor 'how he intended, if he married his daughter, to maintain her?'[66]

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[60] Jameson, *A Dictionary of the English Language*, 446.
[61] Jamieson, *Jamieson's Etymological Dictionary*, 52.
[62] Bailey, *An Universal Etymological English Dictionary*, 516; Jameson, *A Dictionary of the English Language*, 446.
[63] Maintain in the Cambridge Dictionary https://dictionary.cambridge.org/dictionary/english/maintain.
[64] OSA, Torphichen, 1792, 471.
[65] OSA, Maybole, 1792, 223.
[66] 'Commercial Anecdote', *The Scots Magazine*, 1.8. 1795, 12.

Taking as a point of departure the expression 'take care of' the verb *to tend* emerges from the eighteenth-century dictionary. It is defined as:

> To Tend, to incline or move towards, to draw or aim at, to look to, to take care of, to wait upon.[67]

Again mirroring the relationality outlined above in the 'to look to' and 'to take care of' meanings, *to tend* also suggests a new dimension of the caring relationship by adding 'to wait upon', derived from the French *attendre* (to wait), which is used to denote an often hierarchical act of service. Interestingly, *to tend* is followed by the term 'A Tender' meaning: '[attendre F] a Nurse which looks to sick persons', for the first time in the dictionaries bringing a medical dimension of care to the fore.[68] The early nineteenth-century publication also includes the term and its varied meanings:

> To Tend: v. a. to watch, to guard, to accompany as an assistant or defender, to attend, to accompany, to be attentive to,
> To Tend: v. n. to move towards a certain point or place, to be directed to any end or purpose, to aim at, to contribute, to wait, to expect, to attend
> Tendance: n. s. attendance, state of expectation, persons attendant, attendance, act of waiting, care, act of tending
> Tenderness: n. s. incl. cautious care.[69]

Whilst the term to tend does not have a Scots definition, an equivalent of 'To Weit, v. n. […] in a secondary sense, to take care of, curare, providere', mirrors the above meanings of the English *to tend* and *to wait*, *to wait upon*.

Whist the verb forms follow more directly the original French translation of *attendre* (to wait), the nouns Tendance and Tenderness offer more insights into the interpersonal relations around providing care, tending one's needs, attending another. Through the inclusion of sick care and attendance, it broadens the material dimension of *to provide* by adding an explicitly physical aspect of caring, possibly entwined with hierarchical relations of status on one hand and physical dependency on the other. Furthermore, *to tend* appears to have preserved its double meaning over time with the current definition being 'to be likely to behave in a particular way or have a particular characteristic' and 'to care for something or someone'.[70] The Scots *to weit* echoes these complex dynamics of caring, hinting at relations of nursing and curing with the latin

[67] Bailey, *An Universal Etymological English Dictionary*, 842.
[68] *Ibid*, 842.
[69] Jameson, *A Dictionary of the English Language*, 732.
[70] Tend in the Cambridge Dictionary https://dictionary.cambridge.org/dictionary/english/tend.

curare. In the Accounts, the first meaning is mirrored with its uses such as the 1845 'how far these changes tend to the comforts and benefit of society may be questioned'.[71] Tending in the sense of taking care of or providing is only used in relation to sheep and cattle such as in 1793 'while engaged in tending their sheep they have long intervals of leisure', once again stressing the need to look beyond human relations when defining care.[72] Similarly, tend in the newspapers is primarily synonymous with 'lead to', 'result in', and its uses such as in 'a mother [may] tend her helpless infants' are sparse.[73]

Lastly, building on the sick care provision hinted at in the usage of *to tend*, the term *to nurse* (and derived words) has been included, broadening the array of meanings of *care* and drawing on the use of the word in relation to healthcare in the Accounts. The 1763 dictionary reads as follows:

> A Nurse [nourrice F, nutrix L], one who takes care of persons sick, children, etc.
> To Nurse [nourrir F, nutrire L] to take care of, to nourish, feed etc.
> Nursery, the room where children are nursed, also the person nursed, or a plot of ground for raising trees or plants.[74]

In 1828 this was expanded to:

> Nurse: n. s. A woman that has the care of another's child, a woman that has care of a sick person, One who breeds, educates or protects
> To Nurse: v. a. To bring up a child or anything young, to feed, to keep, to maintain, to tend the sick, to pamper, to foment, to encourage
> Nurser: n. s. One that nurses, a promoter, a fomenter
> Nursery: n. s. The act or office of nursing, that which is the object of a nurse's care, a plantation of young trees to be transplanted to other ground, place where young children are nursed and brought up, the place or state where anything is fostered or brought up
> Nursling n. s. One nursed up, a foundling.[75]

The Scots dictionary is rather concise, providing a single entry:

> Nuris, s. A nurse. V. Noyris.
> Or
> Bairns-woman, s. A child's maid, a drynurse
> Or

[71] NSA, Lesmahago, 1845, 34.
[72] OSA, Minnigaff, 1793, 60.
[73] 'Public Dispensary of Edinburgh', *Caledonian Mercury*, 15.2. 1794, 4.
[74] Bailey, *An Universal Etymological English Dictionary*, 580.
[75] Jameson, *A Dictionary of the English Language*, 497.

> Milk-woman, s. A wet nurse; *a green milk woman*, one whose milk is fresh, who has been recently delivered of a child, S.B.[76]

The term is used widely throughout the dictionary, primarily in the noun form of *nurse*, referring to a childcare provider or a nursing mother.

As with *to provide*, the 1763 publication defines *to nurse* as an act of 'taking care of', whilst also adding the literal translation of the French *nourrir*, which signifies nourishing, feeding, nurturing. One who performs such an act is thus described as *a nurse*, again defined in a close relationship to the French term *la nourrice,* both grammatically and semantically gendered as feminine, as one who nourishes, provides care, here specifically caring for the sick and children, again implying a relationship of dependency. As Margaret Pelling suggests, the nebulous *nurse* was used to designate a variety of caring practices, again signifying the interconnectedness of different forms of caring.[77] The association between nurturing and sick care is interesting and dates to the Middle Ages, despite being completely absent from the French original, in which *la nourrice* only denotes a nurturer (in French, medical nurse is referred to as *infirmier* (m) and *infirmière* (f) derived from the Latin *in-firmus* (sick, impotent), similarly to the English term *infirmary*). Although absent from the etymological study of the term, the medieval and early modern association between food preparation and healing, feeding and tending described by Fissell is made manifest within the common usage of the expression and thus mirrors contemporary social practices of caring and curing understood in their interrelatedness.[78]

Whilst the definition of *to nurse* seems fairly unaltered in 1828 including feeding, nurturing, childcare and sick-care, the term *nurse* becomes feminised in case of both of its common meanings as a childcare provider and a sick/medical care provider. The emphasis on childcare provision is even stronger in the Scots dictionary, enhanced by the variety of Scots terms specifically used to designate a childcare provider. Rather interestingly, the publication also cites the more obsolete term *nurser*, yet again definable as a care provider, yet without the strict gendering of *nurse*. Both historical dictionaries also relate nursing to tree planting, thus rooting the meaning in the act of nursing itself rather than the relationality involved in interpersonal caring relations.[79]

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[76] Jamieson, *Jamieson's Etymological Dictionary*, 163. 110, 114.
[77] Margaret Pelling, *The Common Lot, Sickness, Medical Occupations and the Urban Poor in Early Modern England* (Harlow, 1998), ch. 8.
[78] Fissell, 'Women, Health and Healing in Early Modern Europe', 1-17; Fissell, 'Remaking the Maternal Body', 114-139.
[79] Bailey, *An Universal Etymological English Dictionary*, 580; Jameson, *A Dictionary of the English Language*, 497.

Returning to the Cambridge Dictionary of Modern English shows an interesting development. Whilst the noun form of *nurse* continues to signify 'a person whose job is to care for people who are ill or injured, especially in a hospital', the linguistic gendering in this case has diminished, mirroring the increasing numbers of men employed in nursing and the growing tendency to avoid gender specific occupational denominators. Yet, the second meaning ascribed to the word, although designated as old-fashioned, is 'a woman employed to take care of a young child or children', nearly exactly the same as its nineteenth century counterpart in the preservation of its gendering. The verb form of *nurse* is primarily defined as either 'to care for a person or an animal while they are ill', 'to spend a lot of time taking care of something as it grows or develops' or 'when a woman nurses a baby, she feeds it with milk from her breast'.[80] According to the dictionary, therefore, *nurse* continues to denote sick care or childcare in both its noun and verb forms, however, its original meaning of provision, nurturing and more broadly caring has largely diminished. It reflects the growing division between practices of nursing rooted in diet, subsistence, watching and attending, and medicine on one hand, and practices of childcare on the other.

The Accounts, despite only mentioning the stem *nurs* 76 times, show the great richness of nursing practices. The verb form is frequently used to refer to childcare in families or by paid nurses (with rare specification such as wet-nurse or dry nurse). The 1795 Account from Assynt makes observations about family structures noting that,

> The Highland girls of this parish for the most part marry at the age betwixt 16 and 22 years; the lads at that betwixt 20 and 25. There are some instances of women bearing children to the age of 50 years at least. It is no uncommon sight to see a grandmother give her breast to her own grandchild to suckle. Some fond mothers nurse their children for two years. Other mothers nurse their infants for three.[81]

All terms 'nurse', 'suckle' and 'give breast' designate feeding. The pervasiveness of paid childcare is reflected across the Accounts, such as in 1795 in Firth and Stennes referring to twin births among the 'very poorest people, and who required parochial collections to assist them in getting them nursed'.[82] The noun *nurse* is used in reference to both a child carer and a health carer, sometime designated by the term 'sick nurse'. For example, in 1845 Crathie, the poor rates counted 'sometimes to the amount of 1s 3d, but

[80] Nurse in the Cambridge Dictionary: https://dictionary.cambridge.org/dictionary/english/nurse.
[81] OSA, Assynt, 1795, 207.
[82] NSA, Firth and Stenness, 1795, 129.

not more than at the rate of 1s 6d per week, except where a sick nurse is requisite'.[83] Nursing is also used to describe animals feeding and caring for their young, such as in 1796 in Strathblane, 'if any ewe happens to lose her lamb, she is confined in a house, with a twin lamb taken from another, for two nights; by which time, she becomes attached to it and nurses it as her own'.[84] More broadly, the Account of Kirkinner from 1792 when referring to the poor living conditions suffered by the labouring classes, who 'while they toil for the present generation, they rear, nurse and educate labourers, artisans and defenders for the succeeding' thus capturing the broader sense of nursing as providing for, bringing up.[85] More broadly still, the Cross and Burness Account from 1845 uses *nursing* as synonymous with support as it refers to reforms implemented by a landowner to better his tenants' conditions in order to maximise productivity, such as 'moderate allowance for improvements, a little nursing, and care in helping the small tenants to dispose of their produce to advantage'.[86]

Similarly to *maintaining* and *providing*, a large part of activities described as *nursing* are defined through clearly discernible hierarchies in material and/or familial terms, or as a result of dependency and/or need. This is clear in relationships between parents and children, masters and servants, landowners and tenants as well as kings and their subjects (used more rhetorically) outlined above. Contrastingly, however, 'sick nursing', 'wet or dry nursing' or simply 'nursing' as attending are troubled by conflicting relationships of the dependency of the recipient and the material gain/subsistence of the provider. In 1791 in Dalmeny, the wives of day labourers were 'occasionally employed by the farmers on the fields; at other times, besides earning something by spinning, washing &c. they frequently nurse children which turns to great emolument'.[87] Whilst still referring to childcare, 'nursing children' is also described as a form of gainful employment carried out alongside other work and indispensable for the family economy of many contemporaries. Like *caring* as explained earlier in this chapter, the immediate context in which *nursing* is used, that is alongside washing, spinning and farm work, inevitably signals its conceptualisation as work, adding a less evident dimension to the immediate meanings of the word.

Unlike the Accounts, the newspapers include countless mentions of the word *nurse*, largely in its commercial and institutionalised dimensions likely to be captured by this source. They mostly confirm the meanings gleaned from the Accounts. Most frequently the

[83] NSA, Crathie, 1845, 654.
[84] OSA, Strathblane, 1796, 596.
[85] OSA, Kirkinner, 1792, 146.
[86] NSA, Cross and Burness, 1845, 98.
[87] OSA, Dalmeny, 1791, 234.

word is used to describe medical care (verb) carried out by independent and institutional staff or the staff themselves (noun). The 1818 report on the affairs of the Royal Infirmary of Edinburgh shows the contemporary understanding of hospital nursing work and its status. In stating that 'unless the rate of wages paid to Nurses shall exceed that of ordinary domestic servants in the middle classes of society, it will be impossible to draw into this laborious and disagreeable line of service, any individuals, but such as from character and habits are nearly unfit for every other'.[88] In but a sentence this report reveals the positioning of nursing work in the same category with domestic service whilst also noting its demanding and disagreeable nature which, it is argued, should be remunerated to attract skilled and suitable employees. It reveals the ways in which such work is valued in the society, contributing to the enquiry about the value of care work. The following chapters draw on the ambiguity of care as an occupational category, highlighting its overlap with more readily recognised types of work.

Secondly, *nursing*'s links to childcare and feeding are strongly represented in both familial and commodified capacities. The popular advert for Rowland's Kalydor recommends the ointment as affording a 'soothing relief to Ladies nursing their offspring' here using the verb to signify maternal breastfeeding.[89] Contrastingly, the term *nurse* is often used to denote a paid carer in various settings, shedding light on the contemporary meaning of the word as an occupational denominator as well as a practice of paid foster mothering whilst also revealing the networks within which the practice was organised. In an 1814 Glasgow case of child abandonment, the child was found 'and taken to the Town's Hospital; from whence it was given out to a nurse. The unnatural mother was not discovered till Saturday; when as a young girl, daughter of the nurse, was carrying the child along Clyde Street, she was accosted by a woman who said she was the child's mother', illuminating the number of individuals and institutions involved in many caring arrangements. [90]

Scrutinising the Accounts and newspapers for direct meanings of *caring* and *nursing* as both paid and unpaid activities and forms of work thus helps us break away from the binary of the paid and unpaid forms of work and captures the element of continuity between these practices carried out as part of the mixed economy of welfare. The diverse uses of *nursing*, its changing meanings over time and the varied textual contexts within which the word is used, thus bring the discussion full circle to the word

[88] 'Royal Infirmary', *Caledonian Mercury*, 28.3. 1818, 4; see Ch 6.
[89] 'Rowland's Kalydor', *Caledonian Mercury*, 22.12, 1810, 3.
[90] 'Short News', *Caledonian Mercury*, 3.12. 1814, 3.

care, similarly filled with complex meanings the relationship of which is centre stage of this thesis.

3.2 Conclusion

As shown through examples drawn from historical dictionaries, Statistical Accounts and newspapers, practices of care are veiled under myriad words and their changing meanings. This chapter has explored the word *to care/care* alongside its synonyms *to provide, to maintain, to tend* and *to nurse*, which collectively encompass the various aspects of caring and are strongly linked to nurturing, feeding and sustaining the lives of others as well as one's own. In the long eighteenth century, the meanings of *car*e were less differentiated, not yet imbued with the political dimension of the welfare state. Whilst the tension between the material and affective was beginning to form, reflecting the development in the discourse on the family on one hand and poor relief on the other, it was not yet set in stone. For most contemporaries, caring about equalled caring for, because material circumstances mattered and providing the necessities for one's life was readily understood as an act of love, responsibility as well as obligation. As shown by the examples cited here, care, paid and unpaid, was understood as a form of labour, constituting a key part of the economy of makeshift. Lastly, care was never a fixed practice, nor was it assumed to take place in a singular space. Instead it was dispersed, carried out by whoever was available, within the home, the wider community and increasingly also the institutional space, alongside paid work, leisure and a range of tasks that constituted the lives of contemporaries. This chapter has set out to argue that a close scrutiny of historical meanings of words and their immediate contexts can shed new light on the practices these words describe as well as the socio-cultural fabric within which they exist. Conducting a systematic analysis of the language used by contemporaries not only allows for a better understanding of the sources at hand, but also reveals a lot about the practices mirrored in their linguistic descriptions and their gendering; as well as the norms, beliefs, politics and economics that shape them, because, in the words of Thomas Blackwell, 'every kind of writing, […] depends upon the Manners of the Age'.[91] The remainder of the thesis builds on the analysis of eighteenth-century meanings of care, which enables me to better capture the myriad ways in which care is practiced, experienced and valued.

[91] Christopher Berry, *The Idea of Commercial Society in the Scottish Enlightenment* (Edinburgh, 2014), 197.

4 'None regardless of reputation will be treated with': Markets, Currencies and the value of Care work in the Urban Space[1]

> **TO THE PUBLIC.**
> **MRS LAIDLAW, MIDWIFE,** Clamshell Land near the Cross, Edinburgh, takes this method of informing the Public, That she continues to receive PREGNANT WOMEN as Boarders or Lodgers, whose situation requires secrecy, if they have letters from some person of respectability, or are recommended, as none regardless of reputation will be received.- Mrs Laidlaw provides Nurses in Town or Country for the Children; or, if more agreeable to those concerned, they may be relieved of the Child altogether, on paying a sum for that purpose. As Mrs Laidlaw has practiced nineteen years in Edinburgh, she hopes for the continuance of the confidence the Public has been pleased to confer upon her.- Address for Mrs Laidlaw, midwife. No. 9, south side High Street, Edinburgh, where post-paid letters will be attended to.
> Edinburgh, Sept. 7. 1805.
> - Nurses and Servants provided with places as usual.[2]

The above advert was placed in the *Caledonian Mercury* by Mrs Helen Laidlaw, an Edinburgh midwife. Mrs Laidlaw practiced midwifery between 1784 and 1837, as suggested by her numerous adverts and listings in the Post Office Directories, a subscription list where Edinburgh residents shared their personal and business details. She advertised widely across the Scottish and English press, appearing in London, Newcastle, Cumbernauld, Edinburgh, Inverness, Aberdeen and Perth, promising secrecy to her clients, who likely travelled from afar, wanting to return unencumbered by their new-born children. By the late eighteenth century, Edinburgh had become a medical metropolis with large numbers of men and women practitioners advertising their services through various channels, and in the given context Mrs Laidlaw does not appear unusual. It is the frequency and numerousness of Mrs Laidlaw's advertisements that provide a window into her career as a medical entrepreneur that make her stand out, making her a starting point of this chapter. Focusing on relations of care labour, its gendering and status, this chapter examines commercial practices of care and their public advertising. Carrying forward the focus on extra-familial care, this chapter complicates the public/private binary by highlighting the myriad forms of paid non-kin care situated in the domestic environment, which could also function as a semi-institutional space. This chapter offers further evidence highlighting the vastness of the paid care sector, often extending into the domestic space. With the question of what determines the value of care at the core of this

[1] *Caledonian Mercury*, 27.7. 1800, 1.
[2] *Caledonian Mercury*, 7.9. 1805, 1.

chapter, I aim to highlight that it is not the care work performed in its physical, emotional, material or medical sense, but rather its socioeconomic value derived from the relationship between the provider and the receiver and the monetary exchange through which it is organised. Evidence of caring relations is less patchy then once assumed, though still irregular and difficult to systematise. I use glimpses of paid care relationships as ways of understanding the socio-cultural and sometimes monetary value of care within the overlapping frameworks of health, domestic service and bodywork, thus highlighting the variedness of care work. This chapter examines commercial care mediated through newspaper advertising. Advertising is understood as only one of the ways in which the care sector was mediated, alongside professional and personal networks, private recommendations and complex systems of trust. Focusing on the market axis of the care diamond, I highlight its interconnectedness with institutions, communities and the family, once again emphasising the limitations of the paid/unpaid and public/private binaries.

I aim to expand on existing historiographies of commercial medicine and healthcare, to encompass the broader care sector. The relationship between health, consumption and the market has been explored by historians since the 1980s who have departed from the rigid history of medicine that only recognised surgeons, physicians and apothecaries as 'regular' practitioners, denigrating the diverse and numerous practices of healing as irregular or quack.[3] The resulting 'medical marketplace' narrative recognised the agency of the individual practitioner and the patient, who participated in an unregulated market exchange where one was free to offer and the other to buy an assortment of diagnoses, services, remedies and recipes.[4] Challenged since for overly exaggerating the commodified and unregulated nature of medicine in the long eighteenth century and underappreciating the involvement of the fiscal state in medical developments, it sat well with the late 1980s de Vriesian emphasis on the 'fetishism of goods' allegedly taking hold

[3] R. Colin Jones, 'The Great Chain of Buying: Medical Advertisement, the Bourgeois Public Sphere, and the Origins of the French Revolution', *The American Historical Review*, 101:1, 1996; Roy Porter, *Health for Sale: Quackery in England 1660-1850* (Manchester, 1989); R. Porter, *Disease, Medicine and Society in England, 1550–1860,* second edition (Cambridge, 1993); R. Porter and D. Porter, *In Sickness and in Health: The British Experience, 1650-1850* (London, 1988); R. Porter and J Brewer, *Consumption and the World of Goods* (London, 1994); R. Porter, L. Grenshaw, *The Hospital in History* (London, 1989); Margaret Pelling, *The Common Lot, Sickness, Medical Occupations and the Urban Poor in Early Modern England* (Harlow, 1998); Mark Jenner, Patrick Wallis, Introduction to: *Medicine and the Market in England and its Colonies, c.1450-c.1850* (Basingstoke, 2007); Mary Fissell, 'Women, Health and Healing in Early Modern Europe', *Bulletin of the History of Medicine*, 82:1 (2008); Mary Fissell, 'Remaking the Maternal Body', *Journal of the History of Sexuality*, 26:1 (2017); Mary Fissell, 'The Marketplace of Print' in Mark Jenner, Patrick Wallis, *Medicine and the Market in England and its Colonies, c.1450- c.1850* (Basingstoke, 2007).

[4] Porter, *Health for Sale*; Porter, *Disease, Medicine and Society*; Porter and Porter, *In Sickness and in Health*; R. Porter and J Brewer, *Consumption*; Jenner, Wallis, 'Introduction'.

of the psyches of contemporaries.[5] As suggested by Jenner and Wallis, the juxtaposition it made between 'professional' and domestic medicine needs revisiting, suggesting their strong interrelatedness, oftentimes carried out through engagement with the market by individuals, families and households as consumers, and a broad range of providers.[6] Equally, the growth in institutional provision in which context the pauper patient can hardly be seen as a free agent of capitalist exchange, calls for a broadening of this model.

The medical market, of course, was culturally and socially embedded, stressing the need for situating the medical sector within a broader moral economy as best described by Craig Muldrew.[7] Crucially for the context of this thesis, the medical market encompassing the orthodox and fringe practices of healing, cures and remedies, did not exist in separation from the provision of nursing and convalescent care, various forms of body work such as washing, cleaning, tending, and the majority of childcare, household labour, as well as domestic service, that all constituted the mixed economy of welfare.[8] The nature of medicine described by Fissell as 'expectant' rather than interventionist, void of the division between care and cure, healing and nursing, calls for a more inclusive approach.[9] Whilst the more strictly 'medicalised' (from a present day perspective) aspects of care work and their marketed forms of the mixed economy of welfare have been richly documented by historians, it is the more neglected subject of care in its myriad forms this thesis explores.[10] This chapter thus focuses on the breadth of the commercialised care sector in its heterogeneity, expanding on the limited approach to care as neatly situated within the contexts of medicine, social welfare or the family. Through examining a body of newspaper adverts placed by servants, body workers and various care providers in the Scottish urban space, the aim of this chapter is to first explore the lives and careers of those who worked in market-oriented care provision, and second, the ways in which their work was valued within the market-based exchange.

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[5] Erica Charters, *Disease, war and the Imperial State: The Welfare of the British Armed Forces during the Seven Year's War* (Chicago, 2014); Jan de Vries, *The Industrious Revolution: Consumer Behaviour and the Household Economy 1650 to the Present* (Cambridge, 2008); Jan de Vries, 'The Industrial Revolution and the industrious revolution', *Journal of Economic History,* 54:2 (1994); Porter, *Health for Sale,* 41.

[6] Jenner, Wallis, 'Introduction'.

[7] Jenner, Wallis, 'Introduction'; Craig Muldrew, *The Economy of Obligation: The Culture of Credit and Social Relations in Early Modern England* (London, 1998).

[8] David R. Green, Alastair Owens, 'Introduction: Family Welfare and the Welfare Family', in Green and Owens (eds.), *Family Welfare: Gender, Property, and Inheritance Since the Seventeenth Century* (Santa Barbara, 2004).

[9] Fissell, 'Women, Health and Healing in Early Modern Europe'; Fissell, 'Remaking the Maternal Body'; Fissell, 'The Marketplace of Print'.

[10] Porter, *Health for Sale*; Porter, *Disease, Medicine and Society*; Porter and Porter, *In Sickness and in Health*; Mark Jenner, Patrick Wallis, 'Introduction'.

As shown by Fissell, the world of health and healing was increasingly interconnected with the market of print, with medical books and tracts seen as an extension of practice.[11] Advertisements placed by practitioners were integral to the expansion of medical print and thus reveal the relationship between these two burgeoning sectors. Notwithstanding growing access to, and consumption of the public press in Scotland, surprisingly little has been written on its role in the proliferation of medical knowledge and practice.[12] Helen Dingwall's work highlights the importance of the press in the intellectual, institutional and cultural contexts of Edinburgh, which shaped the commercialised practices of medicine within and without the walls of the city's many medical institutions. Through the medium of the press, she argues, medical developments, practices and ventures of individual practitioners and institutions were both shared and shaped by the interested public as consumers of the medical discourse as well as purchasers of the services offered.[13] Crucially, however, the Scottish cities never reached the level of commercialisation and anonymisation of market exchange pictured by the London-based scholarship of the medical marketplace and urban economies more broadly. Equally, the role of newspaper advertising was different in the Scottish context where networks of personalised trust predominated throughout the long eighteenth century. The adverts studied here thus represent only a small segment of the larger care sector, exposing those practitioners who, much like Mrs Laidlaw, directed their attention to clientele outwith their immediate circles, aiming to reach a broader Scottish, or British audience, offer expert or specialised services, or facilitate the promise of anonymity to their clientele. Contrariwise, adverts placed by more precarious workers, such as wet-nurses and body servants, who likely used this channel in the absence of personal contacts with people who could help them procure employment, show the entrenchment of the medium within the local social fabric, as a facilitator of cross-class labour relations between middle and upper class employers and those seeking service-based occupations. As such, newspaper advertising should not be discounted as a source only used by those hoping to escape local networks of trust and control, serving also as an increasingly democratic tool waged workers utilised to navigate the job market in the growing absence of traditional networks of patronage and overlordship.

The first section of this chapter interrogates the various forms of care and bodywork facilitated through newspaper advertising. It focuses on the gendered

[11] Fissell, 'The Marketplace of Print'.
[12] Hannah Barker, *Newspapers and English Society, 1695-1855* (London, 2000), Helen M. Dingwall, 'To Be Insert in the Mercury': Medical Practitioners and the Press in Eighteenth-Century Edinburgh', *The Society for the History of Medicine*, 14:1 (2000), 24.
[13] Dingwall, 'To Be Insert in the Mercury'.

experiences of work within the care sector, challenging the perception of care labour as exclusively women's work. Additionally, it explores the varying relations of status and class within caring relations by highlighting the numerous ways in which care work existed as a well-paid occupation. Situating the work of landladies and innkeepers, educators and governors alongside more precarious care providers, I once again highlight the contingent valuing of care on the context within which it took place. Using a case study approach, the second section of this chapter explores the careers of two midwives, Mrs Helen Laidlaw and Mrs Ann Alexander, who chose the medium of newspaper adverts as a way of building a wider client base. It situates their practice within the broader context of urban midwifery in Edinburgh and Aberdeen, aiming to better understand the varied entrepreneurial strategies and client-practitioner relations within the urban care sector.

4.1 The Marketplace of Print: The Care Sector through Newspaper Advertising

> **MANCHESTER INFIRMARY, DISPENSARY, LUNATIC HOSPITAL, & ASYLUM.**
> **WANTED**
> A HOUSE SURGEON to these Charities; a Gentleman not under twenty-one years of age, who shall have served an Apprenticeship to a respectable surgeon, and have attended one course of Anatomical and Chirurgical Lectures. He will be expected to assist the Surgeons at operations, and in dressing their patients, to take care of accidents, in the absence of the Surgeon of the week, and to visit the patients when the Surgeons cannot attend.
> He will be entitled to see the whole practice of the house, and will be allowed board and lodging in the house, but no salary.
> Application may be made by letter (post-paid) addressed to the Secretary. By order of the Board,
> W. TOPLIS, Jun. Secretary.[14]

Across Britain, the eighteenth century saw a great proliferation of the press with many provincial newspapers being circulated. Alongside London and world affairs copied mostly from London based titles, most regional publications consisted of local news, reports and articles alongside a large section dedicated to advertisements and notices. Advertisements by trades- and crafts-people offering their goods and services, employers seeking employees and apprentices and individuals seeking work formed a large part of the notices page, amongst a rich market of second hand goods, public events, announcements and collections, real estate as well as passenger or cargo ship voyages across the Atlantic. Advertisements by private practitioners counting medical men, alternative health

[14] *Caledonian Mercury*, 17.8. 1809, 3.

practitioners, midwives as well as producers of various pharmacopoeia were prolific in the absence of regulation until the late nineteenth century. Boundaries between healthcare and other trades and services remained indistinct with alliances formed between producers of remedies, their agents and printers, and coffee house owners who took part in selling remedies as well as providing a space in which healing practices could be carried out.[15] They appeared alongside the adverts placed by the growing number of institutions such as the one above. The *Caledonian Mercury* advert sought a junior medical man for the Manchester Infirmary established in 1752 in exchange for the provision of bed and board. The absence of a salary was common in roles perceived as apprenticeships, thought to reward their holders with the skill necessary for advancing their careers as private practitioners and senior medical men employed by institutions. Candidates from across Britain were expected to express interest in the post that would mean relocation and residence in an institutional setting. Newspaper advertising became a key instrument of expanding the pool of suitable candidates for institutional roles, which transcended local employment networks based on acquaintance, trust and permanence of residence. Equally, they situate institutional employment within the broader care market, showing the movement of labour between institutional, private and domestic forms of care.

As suggested by Hannah Barker, in rapidly industrialising towns, traditional moral economies were gradually being replaced by abstract capacities of institutions and anonymised systems of referrals and warrantees[16] The early modern credit economy that relied on trust, reputation and stable social networks ensuring accountability was being eroded by population increase, urbanisation and greater mobility across the life cycle, but also the expansion of the social institutions in need of a greater labour supply and an increasing emphasis on the quality of candidates for executive posts.[17] With institutions only providing for poor local inhabitants, however, the majority of care provision in urban Scotland continued to be sourced via more tangible networks of professional association, acquaintance and physical proximity. In Scotland, Edinburgh was at the heart of medical developments, especially in the institutional and learned contexts of the University and the Medical Faculty as well as the Colleges of Surgeons and Physicians. Unsurprisingly, with the high concentration of medical practitioners, the city became a destination for those

[15] Patrick Wallis, 'Consumption, Retailing and Medicine in Early-Modern London', *Economic History Review*, 16:1 (2008); P. S. Brown, 'Medicines Advertised in Eighteenth-Century Bath Newspapers', *Medical History*, 19:4 (1975).
[16] Barker, *Newspapers and English Society,* Hannah Barker, 'Medical Advertising and trust in late Georgian England', *Urban History*, 3 (2009).
[17] Natasha Glaisyer, 'Calculating Credibility: Print Culture, Trust and Economic Figures in Early Eighteenth-Century England', *Economic History Review*, 60:4 (2007).

seeking expert advice and provision.[18] High demand for trained practitioners was accompanied by a large market for care labour associated with the nursing and convalescent needs of many who came to the city to purchase medical care. Commercial healing and care provision were by no means a reserve of the capital, however, as shown by the regional press in cities such as Glasgow, Aberdeen, Dundee and Perth. Across urban Scotland, travelling to receive treatment or purchase pharmacopoeia was widespread. Equally, those looking for employment in the care sector, in institutional posts as well as through private arrangements, were generally willing to relocate. Newspaper adverts offered access to a British, rather than Scottish audience, with Scottish newspapers reflecting the Britain-wide job market that emerged in the post-Union climate.[19] Practitioners of different specialisms relied on the work of one another, with surgeons requiring the labour of nurses to provide convalescent care, often in residential capacities, who in turn employed domestic servants, cleaners, washers, char women and layers-out, whose bodywork was essential to the functioning of urban private proto-clinics. Additionally, the urban care market was facilitated by a network of semi-permanent lodging providers who enabled the mobility of those travelling to receive care, but also those working in the care sector or training in medical professions. Offering bed and board, washing and cleaning, the importance of landladies in accounting for the labour of social reproduction in the urban space cannot be overstated.

The markets of cities like Edinburgh, Glasgow or Aberdeen experienced a concurrence of thick and thin forms of commercial trust, represented by social networks on the one hand and newspaper advertising on the other. Whilst institutions like the municipal infirmaries represent the most anonymised strands of the care sector in terms of both labour organisation and care provision, they were firmly rooted in the moral economy via their sources of funding and public accountability as well as systems of patient admissions. Therefore, whilst advertising became an increasingly available and affordable option, local practitioners continued to rely on reputation and the locality of their work. In spite of its visibility, the reach of medical and care advertising should not be overstated as the care sector was organised through a variety of channels, albeit less traceable. The inclusion of traditional markers of credibility, citing recommendations from medical men and people of rank, personal testimonies and providing signatures as markers of warranty in adverts shows the importance of thick forms of trust, emulated rather than eroded by advertising. It

[18] Dingwall, 'To Be Insert in the Mercury'; Daisy Cunynghame, 'The Role of the Edinburgh, Kelso, and Newcastle Dispensaries in Charitable Relief, 1776-1810' PhD Thesis, School of History, Classics and Archaeology, The University of Edinburgh (2020).
[19] Hamish Mathison, 'Tropes of Promotion and Wellbeing: Advertisement and the Eighteenth-Century Scottish Periodical Press', *Prose Studies*, 21:2 (1998).

is this emulating of other forms of market mechanisms and the increasingly democratising urban care sector that I hope to draw out, following the adverts to capture glimpses of the social realities they reveal.[20]

Whilst recognised by historians as symptomatic of a broader trend of commercial medical practices developing over the course of the century, medical adverts have been rarely read alongside those placed by domestic servants, wet-nurses and body-workers, in spite of the overlap between the various forms of care work purchased through the means of newspaper advertising. This distinction appears logical when focusing on the status of the provider, with the much greater autonomy, financial security and authority enjoyed by independent practitioners, demarcating those engaged in healing or midwifery from individuals providing bodywork and domestic service associated with low skill and low status. Additionally, the gendering of much of commercialised healthcare as male, in spite of the ample evidence of female medical entrepreneurs, stands in contrast with the perception of domestic service as a female domain, albeit again easily contradicted by the countless examples of men employed in service. When the focus shifts to the reality and physical experience of care labour and bodywork, however, its interrelatedness with the markets for healthcare and domestic service become prominent. Crucially, therefore, not the work itself, but its assumed (and monetary) value marks the division between caring and curing embedded in the historiography of the medical marketplace and medical advertising. It is the value and status of care and bodywork that changes, with the work itself remaining constant, performed as part of varied occupations or outwith formalised work relations altogether. Especially pronounced in the work of private carers, the lines between domestic service and nursing, tending and pain relief habitually associated with healthcare rather than service appear at best blurred.

4.1.1 Gendered Bodies, Gendered Labour

By such examples as the below advert from May 1846 published in the *Glasgow Herald*, the compartmentalised notions of healthcare and service are brought into question.

> A Stout Active **YOUNG MAN**, to attend upon an Invalid.
> He will be required to act as Servant and Nurse.
> Apply by letter, free, to Dr. Robertson, West Nile Street, or personally, from 5 to 6 P.M.[21] (GLA)

[20] Colin Jones, 'The Great Chain of Buying: Medical Advertisement, the Bourgeois Public Sphere, and the Origins of the French Revolution', *American Historical Review*, 101:1 (1996); Barker, *Newspapers and English Society;* Hannah Barker, 'Medical Advertising'.

The work of Laura Gowing and Carolyn Steedman highlights the centrality of bodywork to domestic service for the upper classes, with the servant/provider's access to the corporeality, privacy and vulnerability of the bodies of the employer/receiver contrasted with the profoundly disembodying experience of the work.[22] In spite of the materiality and physically demanding nature of much bodywork, it is the disregard for the provider's bodily experience alongside requirements placed on their body that characterise so much of commercialised care work. The description of the 'Stout Active Young Man' sought in the above advert points towards the innateness, embodied and gendered propensity for caring, nursing and tending to the body of another, hinting at the work of lifting, washing and dressing the weakened body of the receiver. Communicated through the contact of Dr. Robertson, the advert betrays the connectedness of the receiver, the medical man and the prospective care provider, once again highlighting the variedness of the broader care sector.

The first example below, already familiar from Chapter 3, was placed in 1847 in the *Glasgow Herald* by a care provider seeking employment. Private care arrangements were closely tied to institutional provision well established by the mid-nineteenth century. Experience alongside physical ability and character references represented the main currencies of the market for care work, again resonating with the market for both domestic service and institutional care work. Greater purchase on the title of specialised rather than general service (here notably linked to bodywork) through experience or professional training enabled providers to market their services to the better off, here again encompassed under the marker of respectability.

> **TO INVALID GENTLEMEN.**
> **SITUATION WANTED**
> BY a Person long accustomed to act as Body Servant to Gentleman, and who, during nine years, was Superintendent of the Asylum for Indigent Old Men. He can make himself useful in many capacities to any Gentleman requiring care and nursing.
> Noblemen, Clergymen, Medical and other Gentlemen of the highest respectability.- Apply to A.C., 256, High Street.
> Glasgow, 224 January, 1847
> N.B. No objection to a Situation in the Country.[23] (GLA)

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[21] *Glasgow Herald*, 18.5. 1846, 2.
[22] Laura Gowing, *Common Bodies, Women, Touch and Power in Seventeenth-Century England* (New Haven, 2003); Carolyn Steedman, *Labours Lost, Domestic Service and the Making of Modern England* (Cambridge, 2009).
[23] *Glasgow Herald*, 22.1. 1847, 2.

WANTED IMMEDIATELY AN Active YOUNG MAN as FOOTMAN, principally to attend as body servant to a lame gentleman. Besides honesty and sobriety, he must be particularly recommended for civility and good temper, and be able to read and write.
Apply to Mr Davidson, confectioner, 47, Frederick Street.[24]

WANTED,
At the Term of Whitsunday,
AN Experienced SERVANT out of Livery, to act as Butler, General House and Body Servant, where a Boy is kept.
Testimonials as to sobriety, honesty, civility, and fitness for the place, to be left with Mr WILLIAMSON, Chemist, 141, Union Street.
Aberdeen, 2d March, 1847.[25]

The use of the term body servant is not unusual in the sample, referring most commonly to male personal attendants. As shown in the above examples, it was often used in reference to a carer for a disabled person, but could also refer to a personal servant, valet, or attendant, especially in the military context. With the responsibilities of a personal attendant to dress, wash and groom their employer, the roles of a valet or man-servant to an able bodied person would converge significantly with a body servant employed to care for a disabled person. The emphasis on 'civility' and education hint at the close proximity and intimate relationship between the receiver and provider, generating expectations placed on the provider's qualifications for the role. As recently shown by Alannah Tomkins, male caring and nursing took many forms, and especially in masculinised spaces of the armed and naval forces, bodywork was performed within the bounds of male homo-sociability, networks of professional hierarchies as well as in sick chambers.[26] The male caring body seems voided of desire and reproductive capacity, precisely because of the transgressive homo-erotic potential of the space in which so much of male caring took place. As shown by the above examples, expectations of male bodies were constructed around attributes such as strength, youth and physical prowess, often linked to the restraining of the bodies of others, written about in relation to male nurses and asylum workers.[27] The requirements of male carers were, however, rarely limited to their

[24] *Edinburg Evening Courant*, 2.2. 1832, 1.
[25] *Aberdeen Press and Journal*, 2.3.1847, 2.
[26] Alannah Tomkins, 'Male Nurses in England and Europe Before 1820: Beyond the Madhouse' (forthcoming).
[27] Tomkins, 'Male Nurses'; see also: L. Culvert, '"A More Careful Tender Nurse Cannot be than My Dear Husband": Reassessing the Role of Men in Pregnancy and Childbirth in Ulster, 1780-1838', *Journal of Family History* 42:1 (2017); C. Schwamm, 'Hegemonic Masculinity and the

physicality, as highlighted by the desirability of reading and writing skills mentioned in the third advert.

In Susan Ferrier's novel *Marriage* published in 1818, the relationship between the 'gentleman invalid', his carer and the rest of the household is exemplified. Sir Sampson Maclaughlan, an older disabled gentleman appears throughout the book alongside the family's man-servant nicknamed Philistine, who is frequently seen following the orders of Lady Maclaughlan regarding her husband's care. 'Here, Philistine, wrap up Sir Sampson, and put him in. Get along, my love', 'Oh, and an excellent thing it is; I make Philistine rub Sir Sampson every morning and night', or 'Leave him to Philistine, he's in very good hands when he's in Philistine's', Lady Maclaughlan proclaims, highlighting the physicality of the care Sampson received at the hands of his servant.[28] Philistine is depicted in the act of tending to the health and pain relief of Sampson, removing his clothing, carrying his belongings as well as keeping him company. 'Sir Sampson […] having been seized with a violent fit of coughing on his entrance, had now sunk back, seemingly quite exhausted, while the Philistine was endeavouring to disencumber him of his military accoutrements.'[29] The snippets of the rapport between Sampson and Philistine are reminiscent of the isolated sociability between the carer and the cared for, engaged in a personal relationship in which the physical dependency of the cared for is contrasted with the material dependency of the paid carer. On many occasions, however, Ferrier placed this rapport in the midst of the household's bustle, with Philistine merely following orders as opposed to providing skilled and agential labour. Caring for Sampson is relegated as only one of his duties as a valet, that include his roles as a doorman, footman and a general attendant. Lady Maclaughlan's use of 'love' when demanding Philistine's attention highlights the servant's relationship with the household members beyond Sampson, that could be read as familiarity, paternalism, an infantilising form of address directed at one's subordinate, or a combination of these. Moreover, the care and body work performed by Philistine for Sampson becomes a segment of the varied household duties split between the domestic staff, recognised for its physical dimension, with the affective aspect obscured by its mundaneness. Aside from such varied responsibilities, male care work is shown to combine physical, often strength-based tasks with companionship, fostering an intimate, albeit hierarchical relationship between the carer and the cared for.

Gender Gap in Caregiving: the Contentious Presence of West German Men in Nursing since around 1970', in P. Pfutsch (ed.), *Marketplace, Power, Prestige. The healthcare professions' struggle for recognition (19th-20th century)* (Stuttgart, 2019); L.D. Smith, 'Behind Closed Doors; Lunatic Asylum Keepers, 1800-60', *Social History of Medicine* 1: 3 (1988); C.E. O'Lynn and R.E. Tranbarger (eds.), *Men in Nursing: History, Challenges and Opportunities* (New York, 2007).

[28] Susan Ferrier, *Marriage* (London, 2017), 129, 110.

[29] *Ibid*, 109.

Although the newspapers reveal the rich landscape of male caring, adverts seeking female servants and carers, or those placed by women in pursuit of such employment, remain far more common. Equally, placing requirements on the bodies of female carers, they facilitated both the bodily and disembodying experience of much paid care work. Unlike the adverts for male carers, female carers were habitually hired *for* their reproductive bodies, rarely placing expectations on other skills and capabilities. As shown by Marisa Rhodes, advertising by and for wet-nurses in eighteenth-century London and Philadelphia was deeply rooted in the commodification of the female reproductive body, notions of ownership of another's body, and the blending of embodied and affective labour.[30] Expectations regarding the nurses' health, youth, country living, but also the size and shape of the breast, and colour, taste and scent of their breast milk, were readily verbalised in newspaper adverts. The age of the nurses' milk rather than their children was often mentioned, erasing thereby the very experiences of pregnancies, childbirths and lives that existed outside of the wet-nursing care chains.

The case reports and letters of William Cullen, a prominent Scottish practitioner, reveal similar rhetoric within medical practice. In advising Mr Pearse regarding his son's care, Cullen proposed to 'let care be taken of the nurses diet, keeping her entirely from Animal food; it is good both for Nurse & Child to have them both frequently in fresh Air', echoing the contemporary notions of corrupting elements transmitted through the body of the nurse to the nurseling.[31] Mirroring closely the advice literature penned by male obstetricians such as William Cadogan and William Buchan these adverts and reports of medical practice existed in a vast economy reliant on living bodies of others to provide the physical labours of childcare. Wet-nursing, whilst relying on the physicality of the care work provided, was rather different from the male care work discussed above, and highly contingent on the arrangements within which it took place. When situated in the nurse's home, often organised by parishes and foundling institutions, the relationship between the nurse and the nurseling was characterised by the child's complete physical dependency on the feeding, carrying, holding and tending of the paid nurse. The value of the child's life was determined by the pay the nurse received for its upkeep, and whilst ties of affection often formed between nurses and infants, monetary exchange remained the underlying principle of the relationship. Albeit highlighted by the medical literature on childcare and breast-feeding warning against 'mercenary nurses', the juxtaposition between money and love was not widespread, with paid care being an important part of the economy of

[30] Marissa C. Rhodes, 'Domestic Vulnerabilities: Reading Families and Bodies into Eighteenth-Century Anglo-Atlantic Wet Nurse Advertisements', *Journal of Family History,* 40 (2015).
[31] Letter from William Cullen to Mr J. Rudd, 15 July 1776, in *Cullen Project Online*, ref. 3867.

makeshifts practiced by many poor families by outsourcing childcare as well as receiving nurselings into their care. Despite the diversity of care arrangements, their organisation through the channels of adverts, registry offices or private networks as well as the varying demarcation between the carer and the receiver by socio-economic status, it is once again the reality, both physical and affective, of the care labour that proves the common denominator.

Contrarily, in wealthier households, the practice of employing live-in nurses priced the child's life as requisite of a specialised carer, whose body rather than care became the commodity exchanged for pay. The commodification of maternal bodies of nurses juxtaposed by the abnegation of their motherhood, their own children, many of whom had died, appears in stark contrast to the body of the male carer, voided of both sexual desire and its reproductive potential in his relation to the often male and often disabled, care receiver. However, it is by bringing these very different caring relations together that the reality of bodywork as a diverse experience and practice is brought to light.

Wet-nursing adverts such as the examples below were abundant in the Scottish context. In spite of the general assumptions by historians that putting-out wet-nursing practices were practically obsolete by the nineteenth century, these adverts offer evidence of the continued variety of available arrangements organised around the patterns of familial cohabitation, marital relations and illegitimacy as well as high rates of child mortality.[32] Incorporated into familial welfare strategies and economies of makeshift, wet-nursing practices ranged across arrangements classed as domestic service as well as fostering in which the child of another was integrated into the nurse's family, in varying degrees of permanence. Reliance on tradespeople as well as medical practitioners in liaising between nurses and parents brings us back to the advert placed by Mrs Laidlaw, hinting at the vast networks of carers who organised their labour via personal acquaintances and other channels that leave few written traces for the historian. The papers of James Douglas, a Scottish physician and anatomist residing in London contain at least three letters soliciting a 'wet-nurse's place' for women seeking such employment. One unnamed woman wrote to seek his aid in procuring employment, suggesting 'I being a Woman that has but few acquaintance and none therefore to recommend me but am

[32] Valerie Fildes, *Breasts, Bottles and Babies, A History of Infant Feeding* (Edinburgh, 1986); Valerie Fildes, *Wet Nursing, A History from Antiquity to the Present* (Edinburgh, 1988); Rachel Trubowitz, 'But Blood Whitened': Nursing Mothers and Others in Early Modern Britain', in Naomi J. Miller and Naomi Yavneh (eds), *Maternal Measures: Figuring Caregiving in the Early Modern Period* (Aldershot, 2000); Alexandra Shepard, 'The Pleasures and Pains of Breastfeeding in England c. 1600-c.1800' in M. J. Braddick, J. Innes (eds.), *Suffering and Happiness in England 1550-1850: Narratives and Representations: A collection to honour Paul Slack* (Oxford, 2017); Rhodes, 'Domestic Vulnerabilities'.

desirous to get into a wet nurses place'.[33] Similarly, the Scottish anatomist William Hunter, Douglas's mentee and attendant to the Lying-in Hospital in London kept a list of women hoping to find employment as wet-nurses or take in a child to nurse, along with their ages, number of children and a brief description of their breasts.[34] Through his work in the Hospital largely catering to the needs of poor mothers, he came into contact with many women seeking work in the care and domestic service sector. As a prominent private practitioner, he likewise attended better-off women desirous of wet-nurses and childcare providers. His ability to mediate the cross-class care chains that underpinned most wet-nursing arrangements thus rested on his own practice, knowledge and social networks that emerged from his engagement in the care sector.[35] Again, the overlap of institutional and private medicine, nursing and casualised care work is brought to light through the networks of practitioners who relied on each other's labour.

> **(1815) WET NURSE WANTED.**
>
> **WANTED** immediately, for a Lady**, A WET NURSE**.-She must be a strong healthy woman, not above 28 years of age, her second or third child. The milk not above two months old.
> A person from the country would be preferred, and as an unexceptionable character will be required, none need apply who cannot produce testimonials of the same.
> Personal application only will be attended to, and received by Mrs Steele, confectioner, Prince's Street, Edinburgh.[36]

> **(1844) AS WET NURSE**.
> A Respectable **YOUNG WOMAN**, who has lost her own infant, would be glad to take one to Nurse. The situation where she lives is open and healthy, and every care and attention might be depended on. Should this, however, meet the observation of those who wish a person in their own house, she would have no objection to engage out.
> Address Doctor Duncan, Helensburgh.[37]

> **NURSING WANTED.**
> **WANTED**, into her own House, 25 Warwick Street, Laurieston (up one stair), by a healthy **MARRIED WOMAN**, whose Child is dead, a **CHILD to NURSE**. Milk two days' old. Respectable references can be given.
> Glasgow, 25th December, 1848.[38]

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[33] GUSC, GB 247 MS Hunter D63/19, letter unsigned, to James Douglas, 17--.
[34] GUSC, GB 247 MS Hunter 500 (V.8.3), Lying-in Hospital Book, No. 1, 17--.
[35] Similarly, the work of R. Mander reveals the importance of personal networks: 'The Wet Nurse in Nineteenth-century Edinburgh', *Proceedings Royal College Physicians Edinburgh*, 30 (2000).
[36] *Caledonian Mercury*, 22.5. 1815, 1.
[37] *Glasgow Herald*, 26.7. 1844, 2.
[38] *Glasgow Herald*, 25.12. 1848, 2.

As shown in the below adverts from 1774 and 1800 respectively placed in the *Caledonian Mercury*, domestic servants, childcare providers as well as sick-nurses sought employment via similar routes of established networks of employers as well as more anonymised registry offices and newspaper adverts. Character references and previous employers' recommendations were the principal currencies of the market for domestic workers performing various duties. Not the work itself, but rather the worker's access to their employer's domestic space, their material possessions, physical bodies and private lives were requisite proof of character, especially so when hired via the anonymised method of advertising. Much has been written about the growing anxieties about the lower class employee within the middle class home, with the increased emphasis on privacy and controlled sociability located in the drawing rooms and parlours of the long eighteenth century, vastly different from the permeable early modern household.[39] The class disparity between the carer and the cared for in much of commercialised care is a key element largely absent from familial and community forms of care, and also much of institutional provision where servants and nurses often shared socio-economic background with treated patients. It is the complexity of caring relations across class and gendered hierarchies that needs highlighting.

> **A NEW REGISTRY OFFICE**
> **For SERVANTS, Wet and Dry NURSES, &c.**
> By **JOHN WATSON** Shoemaker, first stair above the foot of Scot's close, opposite the Meal-market, Cowgate:
> Who keeps a Book for entering the names of Male and Female **SERVANTS** out of place, Wet and Dry **NURSES**, &c. wherein he records their various qualifications, characters, and places of abode, &c. at Sixpence each.
> Masters and Mistresses who want Servants particularly qualified may have their name entered in a separate Book, which will be allotted for that purpose, at the same price.
> **JOHN WATSON** embraces this opportunity of returning thanks to all his customers, who have hitherto favoured him with their employment in the way of his business; and begs leave to inform the public, that he continues to make and sell as formerly, all sorts of **BOOTS** and **SHOES**, at the lowest prices.
> Commission from the country, in either of the above branches, will be punctually answered.[40]

> **SERVANTS.**

[39] Steedman, *Labours Lost*; Carolyn Steedman, *Master and Servant: Love and Labour in the English Industrial Age* (Cambridge, 2007).
[40] *Caledonian Mercury*, 4.7. 1774, 3.

> **MEN SERVANTS** of all stations Women Servants of every Station, Wet and Sick Nurses, and Sewsters for Families, well recommended, by applying to **Mrs CLERK,** Netherbow, will be provided for on the shortest notice; and letters from the country, post paid, will be pointedly attended to, directed to her, Netherbow, Edinburgh, where Mrs Grant formerly resided.[41]

Again, the adverts available to us represent the segment of the job-market populated by new migrants to Scottish cities or those newly engaged in part-time caring, obscuring the networks of medical men and midwives, sick nurses and wet-nurses as well as domestics employed through ways that left few written records. Those truly unable to draw on acquaintances as suggested by the unnamed correspondent to James Douglas would likely have been found on registers held by tradespeople such as Mrs Clerk and John Watson below, with the register holders functioning as the point of contact for both parties. Grouped along the lines of the space in which their work took place, many care providers and various domestic workers such as Philistine whose employment these registers solicited were employed on similar terms and often resided with their employers, albeit temporarily in the case of sick and lying-in nurses or providers of palliative care. The distinction between the work of servants and nurses in private domestic space remains blurred.

4.1.2 'Board, Lodging and Education': Residential Arrangements and Care Work

Alongside more direct care arrangements shown above, newspaper adverts also served as a channel facilitating residential arrangements, often including the provision of board and other forms of care. The work of landladies, lodging house and inn-keepers resembles the work of private carers and establishments such as the one run by Mrs Laidlaw, where medical and nursing care overlapped with the provision of lodging. As shown by the four examples below, providing housing and food, but also washing and cleaning, either directly or through delegating such work to servants and char and washer women was integral to the work of lodging providers. Generally lacking the access to the physical body of the receiver, in the absence of an immediate care need in a stricter sense, such work has been rarely linked to the provision of care, and even less so, cure. Landladies were, however, the first to furnish medicines and ointments in the incidence of their tenants falling ill, often providing necessary care or delegating such work to servants and hired nurses. Rental arrangements varied and many landladies chose to absent themselves from

[41] *Caledonian Mercury*, 8.3. 1800, 1.

the lives and ills of their lodgers. For others, however, such work extended beyond silent cohabitation. With the status of most lodging providers as homeowners, the image of the economically disadvantaged care provider is once again brought into question. Largely feminised, room-letting represented yet another avenue for women to gain a living through care provision in its myriad forms. The silent domestic work of social reproduction provided by landladies thus offers another way of challenging the association of such work with familial contexts and unpaid labour relations.

> **FURNISHED LODGINGS AND BOARD.**
> MRS. LESLIE has taken that large and convenient house where Collector Cock lived, in the Shiprow, facing the Shorebrae, and lets Furnished Lodgings; will also be happy to dine a few single Gentlemen.
> Every attention will be paid to the convenience of lodgers, &c. The house will be ready the 8th inst.[42]

> **BOARD AND LODGING.**
> A GENTEEL FAMILY, in a house within itself, within three minutes walk of the College, could accommodate ONE or TWO YOUNG GENTLEMEN with BOARD and LODGING. Terms moderate.
> Inquire at the Caledonian Mercury Office.[43]

> **BOARD AND LODGING.**
> A LADY who resides in a well aired and convenient situation on the South Side of Glasgow, can accommodate THREE or FOUR YOUNG LADIES with LODGING, and also with BOARD if required.
> Letters addressed K.L.M., Herald Office, will be attended to.[44]

Outsourcing of socially reproductive necessities was integral to the organisation of vocational training in apprenticeships and residential education, in institutional as well as private settings, especially in cities like Edinburgh and Glasgow, renowned as educational centres. In Edinburgh, many women residing in close proximity to the University and the Dispensary provided housing for medical students. Mrs Millard, Mrs Ramsay, Mrs Humes and Mrs Oliver all residing in Richmond Street, opposite the Dispensary, provided rooms for students enrolled in midwifery courses offered by Alexander Hamilton, the Edinburgh Professor of Midwifery. Appearing time and again as the contact addresses of various of Hamilton's students over several years, these women were integral to the care economy of the faculty, providing the labour of social reproduction for the junior medical men who

[42] *Aberdeen Press and Journal*, 3.6. 1799, 1.
[43] *Caledonian Mercury*, 9.11. 1811, 3.
[44] *Glasgow Herald*, 2.10. 1820, 2.

relocated to the city to receive training and work hours of unpaid labour in the infirmary and dispensary as students, trainees, clerks and dressers.[45] With students commencing their degrees in their teenage years, they were unaccustomed to independent living, joining the universities immediately after leaving parental homes or boarding schools, where their socially reproductive needs were met through the labour of others, often paid service staff. The women who housed them were thus responsible for more than simple room-letting, engaging in looking after and bringing up their young boarders. Viewing the labour provided by the women as landladies and the men as junior medical practitioners in conjunction, as constitutive of the same care infrastructure, demonstrates the circularity and locality of care and its rootedness in the urban economy. Additionally, contrasting the *paid* female reproductive labour of landladies, with the *unpaid* labour of trainee medical men, challenges the binary between the traditional iterations of such work as on the one hand female, low or unpaid, domestic, familial vs. on the other hand male, well remunerated, public, extra-familial. The relationship between these various types of care labour thus bring into focus their dependence on one another, whilst challenging traditional gendered assumptions about varied types of care work.

In private educational arrangements as offered by Mr Barlas and Mr Strachan in the adverts below, the provision of bed, board and 'unremitting care' was integral to the regime supporting the pupils' capacity for learning. Equally, in employment and apprenticeship contracts, bed and board was provided as a form of remuneration, but also a way of maximising employees' time at work and vocational training, echoing the regime of residential institutions where staff were required to live in their place of work as a way of securing their maximal time commitment to their employment. In such arrangements, the employer became the care provider, and the care provision a form of remuneration and a mechanism of efficiency rather than a service to be purchased. The value of reproductive work is thus again defined by the relationship between the provider and the receiver, yet again determined by the status of both.

> **BOARD AND EDUCATION.**
> MR. W. BARLAS is desirous of receiving ONE or TWO YOUNG GENTLEMEN as BOARDERS, and will give his unremitting care and attention to the superintendence of their education, along with the Day Pupils at present under his Tuition.
> Particulars of terms, together with the most satisfactory references, will be furnished on application.
> Kameston Cottage,

[45] RCPE, DEP/HAM 1-3.

Millport, by Largs, Oct. 10th.[46]

BOARD, LODGING, AND EDUCATION.
MR. J. STRACHAN, TEACHER of ENGLISH, WRITING, ARITHMETIC, MATHEMATICS, and GEOGRAPHY, respectfully intimates, that he will, on MONDAY the 27th day of July, Re-Open his ACADEMY, 17, Queen Street; and on the Evening of the same day, he will Open a Class from 5 to 6, or from 6 to 7, at his own House, 22, Kidd Lane, for giving instructions in ARITHMETIC, ALGEBRA, TRIGONOMETRY, EUCLID'S ELEMENTS OF GEOMETRY, &C.
MR S. has accommodation for a few additional BOARDERS: also, a FURNISHED PARLOUR and BED-ROOM to Let.-The most satisfactory reference, if required, can be given.
The School Fees and other Terms are very moderate.
22, Kidd Lane, Aberdeen. 14th July, 1835.[47]

WANTED
AN APPRENTICE to a SURGEON in the Country, where Board and Lodging may be had on moderate terms.
Apply to Mr William Reid, Merchant, Union Street, Aberdeen.[48]

Through the medium of newspaper advertising, the heterogeneous nature of the care sector is made apparent. When placed together, domestic service and body service, wet-nursing, institutional and personal attendance as well as letting lodgings all encompass elements of care, social reproduction and bodywork. The claims placed on the body of the provider are contrasted by the failure to recognise their labour as work. This contradiction underpins the crisis tendency of extractive capitalism as conceptualised by present day feminist scholarship, which associates the undervaluing of much bodywork with its feminisation.[49] In the long eighteenth-century context, however, care work, domestic labour and the various forms of bodywork, were clearly recognised as work, frequently paid, and often done outside of the home and by non-familial carers. Whilst some care workers such as domestic servants and wet-nurses experienced exploitation, denigration and undervaluing of their labour, others, such as medical practitioners, educators and, to an extent, lodging providers, gained status, independence and considerable profit through work in the care sector. Whilst the status of care work varied with its receiver, provider and the relationship

[46] *Glasgow Herald*, 12.10. 1849, 2.
[47] *Aberdeen Press and Journal*, 15.7. 1835, 3.
[48] *Ibid*, 20.8. 1823, 2.
[49] See for example: Carol Wolkowitz, *Bodies at Work* (London, 2006); Carol Wolkowitz 'The Social Relations of Body Work', *Work, Employment and Society,* 16:3 (2002); Linda McDowell, 'Gender, Work, Employment and Society: Feminist Reflections on Continuity and Change', *Work, Employment and Society* 28:5 (2014); Tiina Vaittinen, 'The Power of the Vulnerable Body: A New Political Understanding of Care', *International Feminist Journal of Politics*, 17:1 (2015).

between them, the practice of providing and receiving care remained largely constant. It is this continuity, therefore, this chapter tries to capture by bringing together instances of care work across occupational denominators and social strata. Much care work was done alongside other types of labour, lacking a designated space. Whilst newspaper advertisements only expose a tip of the iceberg of the myriad formal and informal practices of care, they nonetheless prove useful in the pursuit of understanding its commercialised practices. Recognising the potential danger of over-extending the degree of commodification through focusing on this particular source, they are useful in both their literal sense in revealing the practices offered, as well as opening a window into the changing language around care provision. The remainder of this chapter draws on adverts to investigate the lives and careers of two female practitioners, who were able to build independent establishments and gain considerable fortunes and economic independence through work in the care sector. Building on the above examples, it maps the continuities of care labour between public institutions, domestic spaces and private care businesses, highlighting their interrelatedness.

4.2 Care Entrepreneurship and the Practice of Midwifery

Historiography on midwifery in the long eighteenth century centres on its assumed transition from a feminised community-based practice rooted in the innate and embodied understanding of pregnancy and childbirth to an increasingly medicalised sub-field of general medicine, practiced largely by male physicians.[50] Through its expansion within the institutionalised space of the university and the infirmary, midwifery is set alongside the growing compartmentalisation of medicine and the subsequent establishment of specialised institutions, in this case the lying-in and maternity hospitals. Whilst *man-midwives* were not uncommon in the seventeenth century, their practice was generally associated with emergency interventions in childbirth, or the emerging field of gynaecology, both increasingly lucrative specialisms.[51] Increasingly, the man-midwife, or accoucheur, gained the favour of the better-off, who paid the premium for the marketed skill and promise of

[50] See for example: Adrian Wilson, 'Midwifery in the 'Medical Marketplace'' in Jenner and Wallis, *Medicine and the Market in England and its Colonies, c.1450- c.1850* (Basingstoke, 2007); Adrian Wilson, Ritual and Conflict: The Social Relations of Childbirth in Early modern England (London, 2013); Adrian Wilson, The Making of Man-Midwifery (Cambridge, 1995); Leigh Whaley, Women and the Practice of Medical Care in Early Modern Europe (London, 2012); Lisa Forman Cody, 'Mothers, Midwives and Mysteries' in *Birthing the Nation: Sex, Science, and the Conception of Eighteenth Century Britons* (Oxford, 2005); Barbara E. Mortimer, 'The Nurse in Edinburgh c.1760-1860: The impact of commerce and professionalisation', PhD Thesis, School of History, Classics and Archaeology, The University of Edinburgh (2001).
[51] Cody, 'Mothers, Midwives and Mysteries'.

pain management.[52] As Lisa Forman Cody notes, medicalization of midwifery was linked to early eighteenth-century populationism, with greater attention paid to infant and child mortality and associated emphasis on population retention through charities such as the Foundling Hospital.[53] As highlighted in Chapter 2, the discussions around care were central to the economic thought of the Scottish 'Improvements', via the subjects of mortality and population growth as well as pauperisation, education and sanitation of the fever-troubled urban space.[54] Male midwifery was thus integral to the increased empirical and medical approaches to the public sphere with its top down interventionism and social control. Prominent in the popular press via ubiquitous adverts and obstetric manuals, as well as satirical depictions, the often tartan-garbed man-midwife was a symbol of the world turned upside down via the reversal of gendered order.[55]

Fig. 4.1 Isaac Cruikshank, A Man Midwife, 1793

Whilst the figure of the male-midwife became increasingly prominent, women practitioners remained active participants in the field of midwifery, especially amongst the

[52] Lisa Forman Cody, 'The Politics of Reproduction: From Midwives' Alternative Public Sphere to the Public Spectacle of Man-Midwifery', *Eighteenth Century Studies*, 32:4 (1999).
[53] *Ibid*. 484.
[54] Cody, 'Mothers, Midwives and Mysteries'; Cody, 'The Politics of Reproduction'.
[55] Cody, 'Mothers, Midwives and Mysteries', 11.

middling sorts unable to afford the fashionable accoucheur whilst also not qualifying to receive gratuitous care in the voluntary hospitals.[56] As shown by Elizabeth Ritchie, in rural communities, female midwives retained the status of community elders, or wise-women, posing as arbiters of social cohesion and control, as well as practitioners well into the nineteenth century. In the absence of specialised practitioners in remote communities, their role expanded beyond caring for women in childbirth.[57] Even in institutional spaces, female midwives continued to be employed, with the lying-in hospitals being the only medical institutions in which the matron was expected to be a trained practitioner as well as a housekeeper. The records of William Hunter demonstrate the nature of male midwifery as an interventionist emergency practice with female midwives continuing to assist in most deliveries.[58]

In 1694 the Edinburgh Town Council introduced licensing of midwives intended for rooting local midwives more closely within the parish systems of controlling birth rates and illegitimacy, though little evidence exists of the system actually being upheld.[59] By 1726, the University appointed a Professor in Midwifery responsible for offering training courses for midwives issued with a certificate upon completion. Glasgow and Aberdeen introduced similar teaching programmes in 1740 and 1758 respectively. Such attempts at regulation and institutional education were absent in the English context, hinting at the European connections of the Scottish medical schools. Whilst midwives were able to practice without the certificate, the licensing initiative provides evidence of the growing tendency to regulate and formalise the practice, as well as the midwives' efforts to adapt to the climate of professionalization, thus gaining credibility and competitiveness in the urban market. Midwifery lectures for paying students, both female and male, were publicised in the newspapers especially the *Scots Magazine* and the *Caledonian Mercury*, demonstrating the business aspect of the venture that brought considerable revenue to the professors delivering the course.[60] Thomas Young, the professor of midwifery between 1756 and 1783, marketed the course as a viable career option for respectable women, with the tuition fees of nearly 10 guineas as a considerable investment.[61] As shown by the example of Mrs Laidlaw, a career in midwifery could indeed turn into considerable profit. As indicated by Barbara Mortimer, the status of individual midwives varied depending on the place of their work, institutional or parish affiliation or private practice. Undoubtedly, however, women

[56] Cody, 'The Politics of Reproduction'.
[57] Elizabeth Ritchie, 'The Township, the Pregnant Girl and the Church: Community Dynamics, Gender and Social Control in Early Nineteenth-Century Scotland', *Northern Scotland,* 10:1 (2019).
[58] GUSC, GB 247 MS Hunter 500 (V.8.3), Lying-in Hospital Book, No. 1, 17--.
[59] Mortimer, 'The Nurse in Edinburgh c.1760-1860', 189.
[60] *Ibid*, 190.
[61] *Ibid*, 184.

who trained in midwifery were able to make a living as autonomous practitioners, gaining financial security and professional independence. With midwifery becoming part of the medical curriculum at the University, midwifery lectures ceased to be profitable and the numbers of female graduates decreased by 1820s. Whilst they continued well into the nineteenth century, the attention of the medical men was directed elsewhere.[62]

The Edinburgh Post Office Directories contain the addresses of many midwives who chose to advertise their services through this channel, though are an unreliable source to ascertain how many midwives there were in total, given the voluntary nature of listings and their fluctuation (fig 4.1).[63] Aside from this inconsistency, the number of women who described themselves as midwives in the directories was in steady decline in the early nineteenth century, testifying to the greater specialisation of female, as well as male practitioners, and medicalization of childbirth in the urban space.[64] The directories were used by a limited number of male practitioners until early 1800s, when a greater number of surgeons appear in the listings (fig 4.2).[65] This upsurge can be attributed to the democratising access to university trained private practitioners outwith traditional networks of healing and domestic medicine.

Year	1774	1784	1794	1805	1820	1837	1853
Number of Midwives	15	64	18	11	21	78	59

Table 4.1 Midwives in Edinburgh Directories
(Williamson's directory for the City of Edinburgh, Canongate, Leith and suburbs, 1774, 1784, 1794, 1805, 1820, 1837, 1853)

Year	1805	1820	1837	1853
Surgeons in Directories	32	99	217	161

Table 4.2 Surgeons in Edinburgh Directories
(Williamson's directory for the City of Edinburgh, Canongate, Leith and suburbs, 1774, 1784, 1794, 1805, 1820, 1837, 1853)

Unlike the directories, newspapers across Britain offer countless references to female midwives, alongside men-midwives, desiring to advertise, but also to notify their potential clientele of their relocation or retirement, or passing their practice on to another, demonstrating the rootedness of the popular press within a broader network of information

[62] *Ibid*, 206-9.
[63] Scottish Post Office Directory, Edinburgh, 1774, 1784, 1794, 1805, 1820, 1837, 1853.
[64] Mortimer, 'The Nurse in Edinburgh', 221-2.
[65] Scottish Post Office Directory, 1805, 1820, 1837, 1853.

circulation facilitated through various written and oral means. Mortimer's work emphasised the entrepreneurship of female care providers in Edinburgh in the late eighteenth and early nineteenth centuries, challenging the traditional juxtaposition made by historians between male and female practitioners in the context of medical professionalization[66] Drawing on the entrepreneurial ventures of Mrs Laidlaw and Mrs Alexander, I aim to expand on Mortimer's work, by showing examples of women as independent practitioners, but also owners and managers of private establishments in the care sector, modelled upon the emerging institutional provision of care. These two women were the only two midwives who advertised over a longer period of time and to broader audiences, in a way that enabled me to get a sense of the services they provided and the establishments they run. This chapter thus turns to the lives and careers of Mrs Laidlaw, based in Edinburgh and Mrs Alexander from Aberdeen, as examples of private care entrepreneurs in the Scottish urban care market.

4.2.1 Mrs Laidlaw, Care Entrepreneurship and the Edinburgh Market

Mrs Helen Laidlaw first appeared in the records in 1784, when she first started practicing midwifery and listed her practice in the Edinburgh Post Office Directories. Interestingly, her name and address in the directories were cited alongside another midwife, also called Mrs Laidlaw, one residing in Burnett's Close and the other in the Head of Horse Wynd, both in the Edinburgh Old Town.[67] A midwife named Mrs Laidlaw also appeared in obituaries published in the *London Star* in February 1814 and the *Sun* in March 1814, amongst other newspapers. The obituaries commemorated a midwife living in the village of Sanquhar in Dumfriesshire and assisting in over 1400 childbirths in over fifty years of her practice.[68] According to the information from these obituaries, this Mrs Laidlaw trained in midwifery in Edinburgh and was certified in 1761. She practiced in the village until the age of 86 and died aged 88, in January 1814.[69] Described as a 'respectable widow', it is possible that she was also a mother, that is, the mother of Helen, who, born around 1750 was twenty years her junior and possibly brought into the profession by her

[66] Mortimer, 'The Nurse in Edinburgh'; see also: Anne Summers, ''The Mysterious Demise of Sarah Gamp: The Domiciliary Nurse and Her Detractors, c. 1830-1860', *Victorian Studies*, 32:3 (1989); Sue Hawkins, *Nursing and Women's Labour in the Nineteenth Century: The Quest for Independence* (London, 2010); Sue Hawkins, 'From Maid to Matron: nursing as a route to social advancement in nineteenth-century England', *Women's History Review*, 19:1 (2010); Barbara Mortimer, *New Directions in Nursing History* (London, 2004).
[67] Scottish Post Office Directory, 1773-1776, 1784-1785, Mrs Laidlaw.
[68] *Star (London),* 17.2.1814, 4; *Sun (London)*, 5.3.1814, 4.
[69] *Ibid.*

mother, then also living in Edinburgh, though this information remains speculative. The two women lived and practiced in Edinburgh in the 1780s and 90s, after which period only one midwife named Mrs Laidlaw remains in the directories, likely due to Mrs Laidlaw senior's removal to Sanquhar. Whether Helen inherited her trade from her mother or not, she began practicing around the age of 34, roughly the same age as Mrs Laidlaw senior twenty years earlier. She worked in Edinburgh for 53 years until her death in 1837. She continued to advertise in the directories, and from 1801, also in the British press, where I have been able to identify over 90 of her adverts. Helen Laidlaw's commitment to self-promotion as well as her predilection for litigation enabled me to reconstruct a clear trajectory of her business ventures, which alongside midwifery and childcare related services, included shop keeping, liquor dealing and real estate.

In the context of this chapter, my interest in her life and career is twofold. First, as a female practitioner and care entrepreneur, her story offers evidence of the varied avenues enabling women to benefit from the commercialised nature of care in the late-eighteenth and early-nineteenth centuries. Secondly, the size and scope of her establishment, as will be shown, offers an example of a private proto-clinic that combined the provision of home-based care with a larger scale establishment, which, through the employment of a number of staff and gradual spatial expansion, enabled Mrs Laidlaw to diversify her services and make a considerable profit. Her business model, which combined private provision with an institutional model of care, demonstrates her ability to combine traditional midwifery practice with an increasingly centralising, institutionalising and efficiency-oriented model, symptomatic of the expansion of the public care sector. Mirroring the new formats of care provision, entrepreneurs such as Mrs Laidlaw adapted their businesses to fit the growing public demand and confidence in institutional authorities, whilst remaining rooted within the moral economy operating on the principles of trust, recommendations and elite endorsement. The language of Mrs Laidlaw's adverts mirrors the importance of public support to practitioners, highlighting the complex ways of reaching potential clientele.

At the start of her career, Mrs Laidlaw appears to have lived and worked in rented premises in Edinburgh's Old Town, moving to the convenient location in close proximity of the infirmary, No. 1 Infirmary Street, in 1800, where she leased a three-bedroom property with a kitchen and a front shop at £16 per annum. Around the same time, she also rented a small shop nearby from Colin Lauder Esq, where she set herself up as a grocer and an ale vendor next to a woollen drapers' who subsequently brought her to court for

damaging their shop front.[70] In this first recorded instance of her presence in a court of law, she described herself as a midwife and a solvent citizen of Edinburgh, demonstrating a strong occupational identity derived from her work in the care sector.[71] In February of the following year, she placed her first advert in the London based *Morning Chronicle*, offering to 'pay the utmost attention to such Ladies as are properly recommended and with retirement', whilst also continuing to 'keep a Register Office for Nurses and Servants who can procure proper Certificates of their Character'. Additionally, she offered to provide nurses for children 'in town or country' and 'nurses for lying-in Ladies' and 'furnish children's clothes'. With all her services, she promised that the 'greatest secrecy can be depended on whenever she is entrusted with a person whose case requires it'.[72] Her broad range of services reflected the complex needs of a woman giving birth and seeking subsequent care and childcare provision, undoubtedly earning a premium for securing all that was needed at once. Her decision to advertise in London prior to Edinburgh reflects the wider circulation of London based papers, reaching readership across Britain. Additionally, however, it shows her orientation towards a clientele further afield, likely coming to Edinburgh to conceal a pregnancy and potentially leave their often illegitimate children behind, temporarily or *altogether*, as suggested in her 1804 advert cited in the introduction to this Chapter.

By 1803 Mrs Laidlaw moved to an 'airy' house in Bristol Port, near the Meadow Walk, where she only stayed for two years. By 1805, she purchased a five-bedroom apartment with a kitchen and a shop on Clamshell Land, a three-storey townhouse located on No. 150 High Street, where she remained until 1816.[73] During this time, she also purchased a three-room house with a front shop on No. 3 Tobago Street valued at £105 in 1813, where she ran her registry office before later renting it out at £12 per annum.[74] Her Tobago Street property brought her to court again in a suit against a potential buyer, John Aldie, who had a change of heart and refused to purchase the property after closing the deal. The midwife won the case and damages of £25 in addition to Aldie's agreeing to purchase the property.[75] Residing now in the larger property on the Royal Mile, she continued to 'receive pregnant women as Boarders or Lodgers, whose situation requires a

[70] Edinburgh Dean of Guild Court, Box 1800/18, 19.6.1800, Thomson and Hutchison against Helen Laidlaw.
[71] *Ibid.*
[72] *Morning Chronicle*, 2. 2. 1801, 1.
[73] Scottish Post Office Directory, 1816, Mrs Laidlaw; Advertisement, *Caledonian Mercury*, 27.7. 1809, 1, Advertisement, Caledonian Mercury, 12.10. 1820,1.
[74] *Newcastle Courant*, 9. 7. 1803, 3; *Aberdeen Press and Journal*, 24. 7. 1816; *Caledonian Mercury*, 29.3. 1817, 1; NRS CS36/18/50, Laidlaw vs. Aldie.
[75] NRS CS36/18/50,Laidlaw vs. Aldie.

few months or weeks retirement'.[76] With a vision of relocating to a 'self-contained house in the vicinity of Edinburgh, or within a few miles, with a garden or a piece of ground', she began to advertise for a new property. In 1817, she moved to her new premises on No. 8 Summerhall, where she remained until her death in 1837. The new house was 'self-contained within a Garden, and Iron Railing in front'.[77] The property was furnished with a cold-water bath available to residents as well as paying customers at the cost of 1d per visit.[78]

Mrs Laidlaw's adverts varied greatly over the 36 years of her advertising, though the double emphasis on respectability and secrecy was made repeatedly. Examining their content, language and services offered, alongside the geographical scope of her advertising reveals a lot about her potential clientele and the way in which she diversified her services and subsequently marketed them to a varied audience. Her early adverts placed in London and Newcastle titles emphasise flexibility and discretion alongside the great variety of services offered. Her 1803 advert in the *Newcastle Courant* highlighted that she 'continues to let Lodgings, and practise Midwifery, *and particularly to receive lying-in Women who wish Concealment,* if they have any respectable Person to recommend them, as none else will be treated with' (original emphasis). She also offered to 'attend Ladies in their own Houses, and provide Milk or Night Nurses. Children put out to Board in Town or Country; or if more agreeable to those concerned, a Sum of Money will be taken to relieve the Parents altogether'.[79] Being the only case in which she offered to care for pregnant women in their own homes, Mrs Laidlaw was likely able to abandon the practice as her clientele grew and as she obtained larger premises in which to provide lodging. Whilst most births took place in the mother's homes, Mrs Laidlaw's practice appears unusual, suggesting that the women who sought her aid were not local, relying on her pledge of discretion, probably for an enhanced fee. Her orientation towards this type of clientele also explains her reliance on the press as a means of communicating outwith traditional oral networks of care upon which most midwives operated, providing for mostly local women they knew personally.

The notion of respectability, featuring in all of Mrs Laidlaw's adverts, functioned as a replacement of the trust afforded by acquaintance and neighbourliness, a warranty that the client would not run off without settling their expenses or abandon an unwanted child. As shown by the 1807 advert from the *Caledonian Mercury*, one of her first Edinburgh

[76] *Caledonian Mercury*, 5.9. 1807, 3.
[77] *Newcastle Courant*, 17.4. 1830, 1.
[78] *Caledonian Mercury*, 29.3. 1817, 1.
[79] *Newcastle Courant*, 9.7. 1803, 3.

adverts, respectability was tangible, not a marker of virtue or status, but rather a proof of solvency. Mrs Laidlaw requested that her lodgers 'either bring letters from some person of respectability, or deposit a sum of money for the inlying, and other expenses, then it will not be required to know the parties'.[80] With respectability functioning as a linguistic code for solvency, Mrs Laidlaw's messaging was clear, she was to provide for anyone able to pay, with abundant domestic comforts, additional services and few questions asked. Her long years of practice as well as profits made manifest through her purchases of real estate testify to the success of her private establishment, with her continued presence in the popular press serving as a reminder to her clientele, though becoming less detailed in describing the services offered. Her expansion to care for people in need of nursing or convalescent care as opposed to pregnant women only shows again her ability to adapt to the Edinburgh medical market, but also the capacity of her establishment and staff.

The use of 'respectability' resonates with the ways in which care was offered or denied to the 'deserving' poor. It betrays a shared rhetorical culture of care provision as subject to reputation applied across the social strata, highlighting the nature of care as socially and culturally contingent rather than 'natural' or timeless. Although Mrs Laidlaw by no means catered to the city's poor, instead garnering support of those able to pay themselves out of a potentially precarious situation, the language of her advertising can be placed within a broader narrative of care as only available to the 'deserving'. By situating commodified relations of care and provision for those with access to cash alongside voluntary and charitable provision, I want to highlight the breadth of the moral economy as an organising principle of the care sector. The denial of care, practical for the 'undeserving' poor, and largely rhetorical for the 'unrespectable' paying receiver, can be understood as a form of banishment, a tool of social cohesion and gender conformism. The ubiquitous rhetoric of respectability, notwithstanding the socio-economic status of the intended audience, calls for an enquiry into the marketing of care related services as well as the alternative currencies used in the purchasing of care work across social strata. Whilst not directly linked to the socio-religious discourse that determined access to the expanding welfare system for the poor, the commercial care sector was rooted in the same system of ethics, morality and control, the upholding of which was incremental to social order. Commercialised care was rooted in cultural and socio-economic contexts, challenging the extent of free-market exchange within the care sector. This chapter thus circles back to the value of, and access to care, drawing on the language of advertisements as glimpses of the socio-economic relations they helped facilitate.

[80] *Caledonian Mercury*, 5.9. 1807, 3.

Whilst her adverts habitually closed on her expression of gratitude to the 'Nobility, Gentry, and others who have favoured her with their support', it is unlikely that her clientele counted many members of the landed elites.[81] Rather, as her 1817 advert in the *Mercury* suggested, 'those of respectability, although not in high life' were seeking her treatment. One such client was Isabella Blyth, the unmarried daughter of Swan Blyth, a ship captain resident in Leith. She lodged with Mrs Laidlaw during the period of her lying-in, when her father would habitually visit and dine with the two women. This rather mundane case was only brought to the archive as Swan omitted to settle his debt of £10 to Mrs Laidlaw, only part of the amount charged for Isabella's care.[82] The only named client of the midwife, the daughter of a naval officer who wound up in jail for failing to settle his debt upon Mrs Laidlaw's lawsuit, suggests the midwife's assistance was outwith the reach of those below the middling sorts. The absence of Isabella's child's father and her living with her father also point to the variety of support networks potentially available to solvent young women outwith the traditional nuclear family. When money was available, the repercussions of illegitimacy may not have been felt as deeply.[83]

Many of the midwife's adverts drew attention to the accessibility of Summerhall, being 'only fifteen-minutes walk from Prince's Street, where the mails arrive and depart, but Coaches are waiting to convey passengers to their destinations, and for a trifle will set them down here'.[84] Adverts placed in the *Perthshire Courier* highlighted that 'the Carlisle, Dumfries, Kelso, Dunse, Jedburgh, Hawick, Dalkeith, Lasswade, and Peebles Coaches pass near the house daily'.[85] Or, in the *Cumbernauld Packet*, she suggested that 'many of the Mails from the South daily pass the Back of Mrs. L.'s House through Clerk Street'.[86] Both demonstrating the role of the adverts in making herself known and providing key information for those who may wish to purchase her services, Mrs Laidlaw's travel recommendations testify to the ways through which her clients were expected to arrive. Betraying the geographic variedness of her clientele, they also highlight the accessibility of coach travel to those lacking access to personal means of transport, travelling alone, in anonymity, for a trifle. Although not much is known about the actual women who came to lodge or give birth in Mrs Laidlaw's establishment, the available evidence suggests they were women of means, albeit limited, likely unmarried, often travelling to receive care in

[81] *Ibid.*
[82] NRS CS271/67674, Laidlaw vs. Blyth.
[83] Kate Gibson, *Illegitimacy, Family & Stigma in England, 1660-1834*, (Oxford, 2023).
[84] *Caledonian Mercury*, 12.10. 1820, 1.
[85] *Perthshire Courier*, 17.8. 1815, 1.
[86] *Cumbernauld Pacquet, and Ware's Whitehaven Advertiser*, 12.2. 1828, 1.

their lying-in and hoping to provide for their new-born children at nurse, which would enable them to travel back to where they came from, unencumbered.

None of Mrs Laidlaw's adverts hint at the vending of abortifacients, commonly sold as 'female pills' or 'obstruction pills', though her establishment was likely one where women could turn to terminate a pregnancy. Prior to 1803, no clear legislation prohibiting the performing abortions was in place. In England, the 1624 Infanticide Act pronounced any unmarried woman who wished to conceal childbirth suspect of attempted infanticide; a similar act followed in Scotland in 1690, also equating concealment with infanticide.[87] Given the circumstances, the term concealment used by Mrs Laidlaw was a curious wording. Perhaps in relation to the 1803 Lord Ellenborough's Act, which framed abortion after quickening as a capital offense, the wording of adverts of practitioners became much less explicit. Mrs Laidlaw's later adverts assumed a rather more coded form, with fewer promises of secrecy, and care offered to 'pregnant ladies' as well as 'others in ordinary life, whose situation requires a few weeks or months retirement, with her aid', likely reflecting the increase in policing of services associated with abortion.[88] In spite of the legal attempts to limit the practice, abortions remained widely practiced amongst married as well as single women, as Fissell suggests.[89] The use of herbal remedies such as savin and henbane was well known and practiced as a way of reducing family size and preventing unwanted pregnancies.[90] Pills and potions containing these common abortifacients were advertised and accessible. Mr and Mrs White, a London based surgeon and midwife couple, sold the 'Restorative Salo Pills' at 1L 2s a box, via numerous adverts in the English press for over 30 years.[91] Their 1794 *Northampton Mercury* advert was accompanied by a pamphlet entitled 'Address to the Community, respecting concealed Pregnancy', which offered consolation to 'pregnant Ladies in every Situation of life'. Illegitimate pregnancy was recognisably a miserable condition for the unfortunate mother at the hands of 'uncharitable Censure and Derision of ignorant, base, defamatory Persons' who may judge their situation. The pamphlet suggested that

> The Consolation resulting from this Undertaking [abortion pills] to many of the most reputable and respectable Families in this Kingdom, by securing Peace and

87 The Records of the Parliaments of Scotland to 1707, K.M. Brown et al. (eds.) (St Andrews, 2007-2023), 1690/4/111; Deborah A. Symonds, *Weep Not for Me: Women, Ballads, and Infanticide in Early Modern Scotland*, (University Park, 1997).
88 *Caledonian Mercury*, 12.10. 1820, 1.
89 Fissell, *Long Before Roe* (working title, forthcoming).
90 *Ibid.*
91 *Northampton Mercury*, 17.8.1793, 4; *Hereford Journal*, 7.12.1791, 2; *Bath Chronicle and Weekly Gazette*, 7.1.1808, 4.

> Concord among Relations and Friends, is sufficiently conspicuous to be countenanced by the humane sensible Part of Mankind, Care, Tenderness, Humanity, Honour, and Secrecy having been the Basis of this Concern for many Years.[92]

'Peace and concord' remained on offer by the couple as the result of their treatment in their 1808 advert in the *Bath Chronicle*, whilst promising 'honour and secrecy' as the basis of their establishment in spite of the changing legal climate of the early 1800s.[93] Mrs Laidlaw's omission to advertise abortifacients and contraceptives is curious, especially in her early adverts, perhaps testifying to the more implicit mode of advertising in the Scottish press, where no adverts for 'female' or 'obstruction pills' appear prior to 1800 and remain less common than in England thereafter. The nature of her establishment, however, hints at the likelihood of her assisting in pregnancy termination alongside the services offered in the press.

As reflected by the premises she occupied, Mrs Laidlaw's establishment grew in size over the 50 years of her practice. Such expansion would have been matched by the number of staff she employed, consisting of domestic servants, nurses and wet-nurses. Her network of wet and dry nurses as well as domestic servants was integral to her midwifery practice, revealing the interrelatedness of these various forms of care and bodywork. With the purchase of the Summerhall property, she likely added a groundskeeper or a gardener to her staff, also in charge of the public baths. Her long-term arrangements for her patients and her Clamshell and Summerhall properties containing a kitchen suggest she employed a cook charged with the preparation of food and medicinal remedies. Lastly, her maintenance of several properties at once, running her clinic, a separate shop and a registry office, required her to delegate a considerable amount of her responsibilities, hiring a clerk and a shopkeeper. Running her clinic until the age of 87, she possibly took the role of an overseer or a domestic manager, delegating much of the physical labour involved. Additionally, her mirroring the traditional lodging and board arrangements offered by many female householders once again highlights the rootedness of market based and proto-institutional care provision within the broader space of social reproduction located in the domestic, albeit extra-familial, and commercialised settings.

With an array of domestic staff diversified by distinct responsibilities, her establishment resembles institutional internal management and labour division. Her residing on the premises where she offered her services likewise placed her alongside institutional managers such as matrons in public hospitals. Her skillset thus comprised of

[92] *Northampton Mercury*, 29.3.1794, 4.
[93] *Bath Chronicle and Weekly Gazette*, 7.1.1808, 4.

the practice of midwifery, but also considerable managerial and housekeeping responsibilities. The example of her private establishment echoed the internal workings of the public care sector, with similar staff and administrative composition. With domestic and institutional servants and carers being habitually recruited and employed across the bounds of domestic and institutional spaces, Mrs Laidlaw's staff likewise gained experience in the seemingly distinct occupational trajectories, where they were able to gain better pay in the private sector. The fluidity of the labour market and the bodywork they provided once again emphasises the continuity of care across spaces and in spite of varied monetary value. Once again, the status of the receiver, whether solvent or poor, insider or outsider, deserving or undeserving, respectable or of ill repute, determined the ways in which care was given and at what cost, across the division between the public and private, institutional and domestic, paid and unpaid, or paid by whom.

Whilst any details of payments received from her clients and the wages given to her employees by Mrs Laidlaw are unavailable, her business success alongside the examples of similar providers can shed light on the workings of similar establishments. The second example of a female care entrepreneur this chapter centres is Mrs Alexander, a midwife and childcare provider who ran a similar establishment in Aberdeen.

4.2.2 Mrs Alexander: Marriage, Midwifery and the Life Cycle

> **LODGINGS-MIDWIFERY-NURSES.**
> Mrs. ALEXANDER, MIDWIFE, No. 146 GALLOWGATE, ABERDEEN. Accommodates with Lodgings Ladies whose state of health may require retirement and attention. Mrs A. has considerable experience in the treatment of the complaints peculiar to her sex, having studied under an eminent Physician, and, after having been duly and strictly examined, obtained the certificate of the Medical Society to practise her profession.
> Persons able to describe their case correctly by letter will be furnished with advice.
> Careful Nurses provided for Children.
> Children about two years of age received into the house, where they will be kindly treated, and have their health, education, and morals, strictly attended to. Terms from £13 to £20 per year, according to circumstances.
> Persons honouring Mrs A. with their confidence, may depend on the strictest secrecy being observed; and those wishing to conceal their names, may have their Children received on certain conditions, which may be learned on applying by letter, either direct or otherwise.[94]
>
> **Private Medical Establishment.**

[94] *The Scotsman*, 9.6.1841, 1.

> LODGINGS-MIDWIFERY-NURSES.
> WILLIAM ALEXANDER, SURGEON, 144, Gallowgate, Aberdeen, may be consulted in all cases of a private nature. A safe, speedy, and perfect cure warranted in a few days without Mercury or risk of exposure. Mr A.'s extensive practice has arisen from his greater anxiety to obtain credit for the speedy removal of disease, than from a desire to obtain money from the unfortunate, who are too often deprived of their means without deriving any benefit. There are various kinds of these diseases, each of which requires a method of treatment peculiar to itself; a personal visit or an accurate description in writing is therefore necessary. A certain cure in all cases warranted. PRIVATE LYING-IN INSTITUTION and NURSERY for CHILDREN, under the charge of an experienced Midwife.[95]

Unlike Mrs Laidlaw who ran her business as an individual practitioner and proprietor, Mrs Ann Alexander, née Skene, the second midwife who frequently appeared in the Scottish press, worked in partnership with her husband William. Albeit not as numerous as the adverts placed by her Edinburgh counterpart, Ann Alexander's intervention in the press proves equally rich in evidence, enabling the reconstruction of the establishment she run alongside William. Her first advert appeared in *The Scotsman* in June 1841. Between 1841 and 1844, Mrs Alexander advertised independently from her husband, choosing *The Scotsman* and the London based *Sun* and *Bell's Life in London and Sporting Chronicle*, whilst her adverts from 1846-7 include both practitioners (such as the second example above placed in the *Aberdeen Press and Journal*). Her choice of Edinburgh and London publications reflects her aim to attract clients from out of town, where her promise of discretion would be practicable. William Alexander's attention to afflictions of 'private nature' advertised alongside Ann's midwifery expertise echoes the adverts placed by the London surgeon-midwife duo of Mr & Mrs White mentioned above. Whilst not explicitly offered by the adverts placed by Ann or William, their joint practice likely encompassed abortion and contraception advice, and the treatment of venereal diseases offered through this medium to those who lacked access to informal channels of obtaining such services, or wishing greater secrecy ensured by travelling the distance to avoid being caught up in local gossip or scandal. Contrastingly, adverts appearing in 1848, mostly placed in local Aberdeen press, such as the *Aberdeen Press and Journal*, *Aberdeen Herald*, but also *Perthshire Advertiser*, were by Mr Alexander only, reflecting the couple's separation as well as William's provision for a more local clientele, potentially leaving their joint focus on reproductive health behind. Lacking a degree certificate or membership of a medical society, William was limited to private practice, ineligible to gain renown through institutional practice. His adverts aimed to set him apart from 'travelling quacks' and

[95] *Aberdeen Press and Journal*, 9.12.1846, 1.

vendors of 'useless Quack Medicines', disguising his own lack of fully achieved training or institutional affiliation, though not actually claiming he possessed either.[96]

Unlike her husband, Mrs Alexander presented herself as a trained and certified practitioner, endorsed by the Medical Society (The Royal Medical Society of Edinburgh). Whilst unusual in the context of the Scottish press as one of only two midwives who used the medium to such extent, in spite of the growing number of midwives practicing in Aberdeen, she drew on the existing linguistic tropes utilised by a whole range of practitioners, situating herself within the breadth of medical advertising. Despite Aberdeen's population being less than half of Edinburgh (27,000 in 1801 and 63,000 in 1841), the directories show nearly as many midwives and surgeons advertising via this medium. Whilst the directories are by no means a reliable indication of the real number of practitioners, they include the practitioners catering for the middling sorts, much like Helen Laidlaw and the Alexanders. Poorer inhabitants of both cities would rely on community practitioners and personal connections on the one hand, and the institutions such as the infirmary and the workhouse on the other. The well off would draw on recommendations; private networks and the well earning practitioners catering to them did not need such means of advertising. The directories, as well as newspaper adverts capture those outwith both groups, the middling sorts, professionals, the socially and geographically mobile as well as those wishing to exit their social networks and their modes of surveillance.

Year	1829	1843	1853
Midwives in Directories	24	47	69

Table 4.3 Midwives in Aberdeen Directories
(Scottish Post Office Directory, Aberdeen, 1774, 1784, 1794, 1805, 1820, 1837, 1853)

Year	1829	1843	1853
Surgeons in directories	26	48	146

Table 4.4 Surgeons in Aberdeen Directories
(Scottish Post Office Directory, Aberdeen, 1774, 1784, 1794, 1805, 1820, 1837, 1853)

Ann Skene was born on July 14th 1798 to William and Elspet Skene in Tarland, a small village in Aberdeenshire. She married her husband William Alexander, then resident

[96] *Aberdeen Press and Journal*, 9.2. 1848, 1; *Aberdeen Press and Journal*, 22.9.1847, 4.

in Elgin, in 1826. By the 1830s, the couple lived in Aberdeen, where William made a living as a merchant, and had at least two children, Elizabeth and Margaret, residing with them. William trained as a surgeon, and although he did not finish his studies, he began practicing in the 1840s. Not completing a medical doctorate did not preclude practitioners from working, especially outside of Edinburgh and London. In Aberdeen, the concentration of fully qualified medical men was far lesser and simply having studied medicine would have been sufficient to establish a practice.[97] In 1840, the couple resided in 140 Gallowgate, where William was listed as a surgeon and apothecary and Ann as a midwife in the Post Office Directories. They moved to 146 Gallowgate a year later, where the pair were recorded by the 1841 census, living alongside five children bearing the last name of Alexander aged between 5 and 11, and two young women named Jane Cooper, aged 21, and Mary Wilson, aged 14, likely domestic workers, though this was unspecified in the census. By 1845 the family moved to 144 Gallowgate, where they resided until 1848. By 1849, Ann and the family's children left William and relocated elsewhere. William remained in this residence until 1852, living alongside a female servant Charlotte de Rudeval (a widow aged 24), after which he disappeared from the records, likely due to his death. Ann left Aberdeen and moved back to Tarland, where she was living in 1861 alongside a young boy John Enslie, registered as a boarder in the census. Aged 64, Ann worked as a stocking worker and earned additional income through providing for John. Ann died aged 74 in 1870 in Aboyne, a village near Tarland, recorded as widow of William Alexander, surgeon.

Apart from the Post office directories, no mention of Ann's medical training or profession was made in the census or parish records. The only official record that listed an occupation next to her name was the 1861 census, in which she was recorded as a widow and a household head and thus not subject to coverture. The adverts placed by her and William in the newspapers are thus the only record of the couple's joint business venture in the care sector, a result of the all too common under-recording of married women's occupations.[98] Consequently, nothing is known of Ann's work in midwifery after leaving her husband. Whilst recorded as a stocking worker later in her life, the question remains

[97] Cunynghame, 'The Role of the Edinburgh, Kelso, and Newcastle Dispensaries', 68.
[98] Amy L. Erickson, 'Married women's occupations in eighteenth-century London' Continuity and Change, 23:2 (2008); Eliska Bujokova, 'On the Respectability of this Person Every Thing Depends': Hospital Matrons and Power Relations in the Royal Infirmary of Edinburgh, c. 1817-1820', *Women's History Review*, 32:5 (2023); Catriona M. MacLeod, 'Women, Work and Enterprise in Glasgow, c.1740-1830', PhD Thesis, School of Humanities, The University of Glasgow, Faculty of History, (2015); Peter Earle, 'The Female Labour Market in London in the Late Seventeenth and Early Eighteenth Centuries', *The Economic History Review, New Series*, 42:3 (1989); Maria Ågren, *Making a Living, Making a Difference: Gender and Work in Early Modern European Society* (Oxford, 2017).

whether she continued her midwifery practice in more informal ways that went unrecorded, and if not, why. Unlike Helen Laidlaw who ran her largely profitable business alone and over a period of fifty years, Ann Alexander's working life seems filled with precarity, change and dependence on her husband and business partner. Her adverts reveal the less conventional and largely commodified form of care work, which represented only a small period of her life and career, predominantly spent in the more obscure midwifery practices in a local community, or in different forms of work altogether.

Much like Mrs Laidlaw, Mrs Alexander provided a range of services, including care during and after childbirth, procuring nurses, as well as looking after children for an annual fee. Her promise of discretion echoes Mrs Laidlaw's advertising practices, suggesting the two women ran similar businesses in the two Scottish cities, only a few years apart. Aberdeen, much smaller and more provincial than Edinburgh, was not a destination for medical travel, though its care infrastructure was fast developing, with the infirmary established in 1739, a Lunatic Asylum in 1800 and a poor house in the 1840s. Healthcare provision for the poor was matched by numerous private practitioners, such as the Alexanders, catering to the middling sorts and the better off. Whilst traffic between London and Edinburgh was frequent, Aberdeen may have represented a more obscure location for those unable to afford a sojourn abroad to give birth to an unwanted child, demonstrating the adaptability of the Alexanders to their geography. The sum requested for providing for unwanted children serves as an indicator of the background and status of her clientele, able to pay the fee ranging between £13 and £20, three to four times more than those who sponsored the care of children in the Edinburgh Orphan Hospital discussed in Chapter 5. Crucially, as seen in the below advert placed in the *Bell's Life in London and Sporting Chronicle* around the same time as the one above, the fee for childcare was subject to a London premium, costing between £20 and £30 annually, demonstrating the flexibility of Mrs Alexander's model. The promise of kind treatment, healthy lifestyle, education and moral upbringing was made universally, however. Her focus in the advert on childcare provision as opposed to lying-in care is crucial in pointing towards her potential clientele who travelled to Aberdeen from as far as London for the promise of 'the strictest secrecy being observed' rather than the midwife's skill or professional renown. Her offering external nurses as well as taking in her clients' children in a form of fostering reflects the diverse options at varied prices for those seeking private arrangements as opposed to formal institutions such as the Edinburgh Orphan Hospital, where poverty as well as respectability of the parents were key to the children's admission. Additionally, children placed at nurse might have been taken in by the Alexanders upon being weaned, mirroring the arrangements set up by foundling hospitals and other charitable institutions.

> **LODGINGS-MIDWIFERY-NURSES.-Mrs. ALEXANDER, MIDWIFE**, No. 146, Gallowgate, Aberdeen, accommodates with Lodgings Ladies whose situation may require retirement. Careful Nurses provided for Children. Children about two years of age received into the house, where they may be kindly treated, and have their health, education, and morals, strictly attended to. Terms from £20 to £30 per year. Persons honouring Mrs. A. with their confidence may depend on the strictest secrecy being observed; and those wishing to conceal their names may have their children received on lodging money sufficient to educate and bring them up in a comfortable manner.-Letters addressed as above will meet with attention.[99]

According to the 1841 census, William and Ann cohabited with five children named Elizabeth, Elspet, Margaret, Ann and Robert. Birth certificates only exist for Margaret and Elizabeth, however, with the remaining three not appearing in the records in association with Ann and William. With the knowledge of the couple's private care arrangements and Ann's care for John later in her life, it is possible that the three remaining children were fostered by the family upon the conditions highlighted by the adverts. Especially given the discreet nature of their provision, it would be unlikely that the names of the children's biological parents would have been used. In the absence of additional live-in servants or staff, the establishment run by the Alexanders was not one of scale, and the children of others were likely incorporated into the nuclear family. Taking in orphaned or abandoned children was a common practice of poor families and widows, especially in rural areas, used to augment the household budget and in many cases to provide extra hands for agricultural work. Indeed, upon moving back to her native village, Ann partook in a form of fostering organised by the parish and primarily associated with poor local widows.

As recently shown by Carmen Sarasúa in the context of Spain, this practice has been largely underreported, especially in the context of families as opposed to single women, leading to the large undercounting of the contributions made by married women to household budgets.[100] Whilst no extensive body of quantitative research on the scale of this practice exists in the Scottish context, piecemeal evidence of the payments made by parishes, workhouses and charities to wet and dry nurses indicate that outsourcing childcare through a large network of 'putting-out' nursing arrangements was widespread across the long-eighteenth century. In 1848, Glasgow Parochial board supported 448 children at £5 8s 4d per annum paid to the nurses hired by the parish.[101] In Edinburgh in

[99] *Bell's Life in London and Sporting Chronicle*, 4.7.1841, 1.
[100] Carmen Sarasúa, Pilar Erdozáin, Ricardo Hernández, 'Nursing Babies to Fight Poverty: Wages of Wet Nurses of Spanish Foundling Hospitals in the 18th and 19th Centuries', *Journal of Iberian and Latin American Economic History*, (2023).
[101] 'Glasgow Parochial Board Report' in *Glasgow Herald*, 14.8.1848, 4.

1848, the parochial board paid £3 to relatives providing for children and £6 to wet nurses. This was compared with the expenditure of over £8 for the children's maintenance in the workhouse, on which basis the parochial board argued against institutionalisation of childcare.[102] This was comparable with the expenses per child in the Orphan Hospital, including the institution's running as well as children's upkeep, suggesting that parish nurses' real earning was minimal.

With an emphasis on familialism as the ideal form of childcare, paired with a very loose understanding of the family, independent from legal as well as blood ties, various forms of fostering were widespread across Scotland, though much research is needed to map out its distinct forms. The case of the Alexanders is interesting in situating the practice largely associated with the economies of makeshift participated in by the poor within the middle class household of two medical practitioners. Although an isolated case, this example proves useful in extending the practice of paid foster and delegated parenting across the social scale. Whilst taking in children of less well-to-do parents was common amongst Scottish elites, the practice amongst the middling sorts is less documented, especially when the arrangements in question involved a money exchange.[103] It highlights the accessibility of alternative childcare arrangements to the better off without carrying the stigma of child abandonment. Whilst those able to finance a 'dignified' form of delegated childcare were freed from unwanted parenthood, the same was not the case for poor mothers of illegitimate children censured as 'bastard-bearers', as suggested by Patricia Crawford.[104] As shown in the work of Jennifer Johnson-Hanks exploring the anthropology of the life cycle, motherhood can be viewed as socially contingent as opposed to gestational, a role socially and culturally assumed after the physical act of conceiving and giving birth, as opposed to realised through the act itself.[105] Examples of the variedness of care arrangements for unwanted children highlight the element of choice available to mothers with access to cash compared with the limited options faced by poor women. They challenge the growing sentimentalisation of motherhood, invoked at convenience by the better off as a tool of cultural self-fashioning and the construction of feminine virtue, and abandoned when no longer applicable, such as in cases of pregnancy outside of wedlock.[106]

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[102] *The Scotsman*, 11.9. 1844, 4.
[103] Janay Nugent, ''Your Louing Childe and Foster': The Fostering of Archie Campbell of Argyll, 1633-39', in Janay Nugent, and Elizabeth Ewan, (eds.), *Children and Youth in Premodern Scotland* (London, 2015), see also current research undertaken by Kate Gibson, 'Looked-after Children: Fostering and Adoption in Britain, 1700-1839' (University of Manchester, Leverhulme ECF).
[104] Crawford, *Parents of Poor Children*, 30.
[105] Jennifer Johnson-Hanks, 'On the Limits of Life Stages in Ethnography: Toward a Theory of Vital Conjunctures', *American Anthropologist*, 104:3 (2002).
[106] Gibson, *Illegitimacy.*

Whilst better-off women could postpone social motherhood or avoid it entirely, for poor mothers, the realities of gestational and social motherhood were closely intertwined. Dispersed or delegated childcare was commonplace and sanctioned by parishes that facilitated nursing arrangements allowing poor women to earn a living. The removal of childcare responsibilities *altogether* was, however, rarely available outside of abandonment, read as a 'denial of maternity', carrying a stigma and infanticidal connotations.[107] As Crawford suggest, 'nurturing infants was a mother's duty, so single mothers who failed to care for their infants were condemned as unmaternal and unwomanly'.[108] As shown by the range of options for well-to-do unwed mothers, the consequences of an illegitimate pregnancy might not have been so grave when money was available.

Whilst Mrs Alexander's familial, professional and residential circumstances have changed, she participated in a form of foster care throughout her life-cycle, with the practice providing her with a consistent source of income, likely enhanced by a sense of companionship and care found in cohabitation in her older age. When placed in the context of the vast sector of delegated childcare explored in this thesis, the range of remuneration received by families for taking in foster children determined by the status as well as location of both biological and foster parents provides additional evidence to the relative value of care. In spite of receiving somewhere between £13 and £30 annually for the care of a single child, the fostering practice of the Alexanders resembled that of the carers employed by the parish, paid significantly less. The monetary value of care was once again determined by who was doing the caring and for whom, with the physical labours of care remaining constant. Reframed as a lucrative entrepreneurial pursuit as opposed to being the last resort of poor families in areas where few job prospects existed for married women, the Alexanders' commodification of fostering once again challenges the depiction of care as low paid and low status. Additionally, it contributes an important example of paid extra-familial care taking place within the domestic setting, posing challenges to the understanding of the family, household and parenting in early Victorian Scotland.

4.3 Conclusion

This chapter has focused on the market axis of the care diamond, bringing together a range of workers employed in medical, nursing and convalescent care as well as various forms of

[107] Crawford, *Parents of Poor Children,* ch. 1; Keith Wrightson, 'Infanticide in Earlier Seventeenth-Century England', *Local Population Studies*, 15 (1975), 16.
[108] Crawford, *Parents of Poor Children,* 45.

bodywork and the work of social reproduction. Through examining these different forms of care alongside one another, the overlap between market-based and domestic forms of care is once again highlighted. Existing outwith established networks of trust; newspaper advertising functioned as an instrument of the commercialised care sector inclusive of the work of domestic service and provision of bed and board. The range of practices offered through this medium, demonstrate the continuities in care work across a variety of spaces habitually perceived as separate, ranging medical institutions, private care establishments and households. Focusing on labour when writing the history of care has been a conscious choice made to highlight the nature of care as primarily an economic factor, although existing in overlap with socio-cultural structures and affective relations. Through focusing on the care labour market as a whole, the continuity between the work itself and those who performed it becomes apparent. Alongside the focus on labour relations, this chapter drew on gender as a category of analysis, contradicting the depiction of care as a female domain, whilst thinking about the gendered bodies of carers and the embodiedness of care work.

The remainder of the chapter focused on Mrs Laidlaw and Mrs Alexander, demonstrating the opportunities for entrepreneurship within the care sector, here facilitated through the anonymity afforded by the medium of advertisements, used to facilitate marketing to a clientele beyond local networks of acquaintance, trust and often exempt from mechanisms of social control. The case of Mrs Laidlaw provides insights into the career opportunities for female practitioners within the care sector. The nature of her establishment highlights the growing preference for proto-institutional care and her ability to employ a model of economy of scale onto her care establishment through the employment of numerous staff, diversification of services and building of a vast network of external practitioners. Unlike Mrs Laidlaw who worked as a midwife for over fifty years, Mrs Alexander engaged in various employments throughout her life cycle. As a married woman, her care work was conducted in conjunction with her husband, also a practitioner, and intersected with and shaped the family's domestic life. The Alexanders' role as foster parents stemmed from Mrs Alexander's work in maternal and neonatal health and may have begun as an expansion of the range of her services. The family's household thus became the locus of care for the children of others, organised as a paid practice, though located in the domestic familial space. Residing long-term with the Alexanders, the distinctions between foster children and the family's biological ones likely thinned, in spite of the family receiving payment for their upkeep, again highlighting the reality of paid relationships of care in the domestic space. In spite of resembling closely the fostering and nursing arrangements practiced by poor families, the fee Alexanders received surpassed greatly that paid by parishes to local wet and dry nurses. Closing on the story of the

Alexanders, this chapter exemplified the contingent value of care, dependent of who was doing the caring and for whom. The myriad forms of caring relations exposed by the newspapers primarily point towards the caring relations organised through a form of market exchange, at the same time, however, they shed light on the arrangements that underpinned them, in the institutional space as well as the domestic, and the varied spaces somewhere in between.

5 A 'Pretty Family' in 'that Little Republic': Cohabitation, Staff Relations and the Role of Labour in the Edinburgh Orphan Hospital and Workhouse c 1727 c 1840[1]

> To every hour there is assigned some employment, and not a child but has some post or place, from which, it is their greatest correction to be degraded, though the meanest office in that little republic.[2]

This chapter focuses on a single institution located in Edinburgh, set up to take in and provide for 'orphaned and fatherless' children of those deemed 'deserving poor' from the city and further afield. Whilst similar institutions for orphaned or needy children of the better off already existed in Edinburgh, the Orphan Hospital and Workhouse was aimed at those who failed to qualify for admission on the basis of parental status, affiliation and freedoms. In the Edinburgh context, the Orphan Hospital was the only coeducational institution, and similarly, the staff employed by the school consisted of resident men and women, which was unusual in comparable establishments. Whilst care institutions generally aspired to provide children with a supplementary family, the single-sex composition of the majority of orphanages and boarding schools resulted in the adoption of different models of institutional domesticity not directly intended to mirror the two-parent family model. Habitually, boys' schools were headed by a master and girls' by a mistress, both responsible for overseeing their respective charges, providing moral and spiritual guidance, catechism and practical instruction. Within the strictly gendered spaces of single-sex schools, the roles of masters and mistresses were largely comparable. By contrast, the co-educational nature of the Orphan Hospital required a master and mistress working together in a model that mirrored the ideal of the family-household, complete with apprentices and servants. In line with early eighteenth-century reformism, the hospital was envisioned as a supplementary 'home' as well as a tool of improvement, for those children who lost their families, or whose kin sought to capture care resources for their children. The master and mistress, both required to be childless and unmarried, 'having acquired somewhat like a parental affection for indigent youth', were expected to dedicate 'their whole attention, night and day, […] to make them [the children] virtuous, healthy and happy', as suggested by Thomas Tod (treasurer between 1781 and 1796).[3] Their 'parental' roles were, however, symbolic, normative and strictly gendered as opposed to rooted in experience of parenting and childcare. The emphasis on virtue and health stemmed from

[1] Thomas Tod, *An Account of the Rise, Progress, Present State and Intended Enlargements of the Orphan Hospital. To which is added, Poetical Meditations on Various Subjects* (Edinburgh, 1785), 4.
[2] *Ibid*, 4.
[3] *Ibid*, 4.

the aspiration to provide for the body and soul, following the curriculum of the Society in Scotland for Propagating Christian Knowledge (SSPCK, established 1710), a major supporter of the orphanage. The ideal of children's happiness was seen by the managers as resulting from a sense of belonging, social order, but also the tender care received from the hospital staff, who were commended for their 'deep and motherly interest in the Orphan children' or habitually described as 'father, counsellor and companion to the children', drawing on existing gendered imaginings of familial structures.[4]

This chapter explores the hospital's patterns of cohabitation, and forms of work, within a framework of a household-family model of institutional formation I conceptualise for this study. In line with Cavallo and Evangelisti's study of domesticity within institutional spaces, I argue against the binary opposition between the 'natural' family and the institution, focusing instead on the interweaving of varied residential and welfare patterns practiced in the long eighteenth century. As the two authors suggest, 'if the notion of institution is associated with the transmission of models of behaviour the family is undoubtedly the first and main institution'.[5] Exploring the institutional space through the lens of the household-family, I argue, can illuminate its conceptual as well as practical organisation in parallel with imagined familial structures and the cultural norms that surround it. The incorporation of familial norms and the identification of governors and governesses with parental figures was not unusual, as shown by Jane Hamlett et al., with patriarchal hierarchies employed as organising principles of many institutional structures.[6] Less frequently were institutions modelled upon the two-parent ideal, however. As suggested by Naomi Tadmor, the use of the term 'family' had much broader meanings than simply referring to a nuclear unit of parents and children across the period studied.[7] As understood here, 'family' delineates cohabitation, distribution of resources and labour, and shared welfare strategies, rather than lines of blood or marriage across residential institutions of varying kinds. The ideal of the two-parent familial model employed specifically by the Orphan Hospital was thus invoked in the distribution of responsibilities,

[4] NRS GD417/6, Nov 1844, Nov 1807; Ariadne Schmidt, 'Managing a Large Household: The Gender Division of Work in Orphanages in Dutch Towns in the Early Modern Period, 1580-1800', *History of the Family*, 13 (2008); Claudia Soares, *A Home from home?: Children and Social care in Victorian and Edwardian Britain, 1870-1920* (Oxford, 2023).

[5] Sandra Cavallo, Silvia Evangelisti, *Domestic institutional interiors in early modern Europe* (Farnham, Surrey, 2009), 15.

[6] Jane Hamlett, *At home in the institution: material life in asylums, lodging houses and schools in Victorian and Edwardian England* (Basingstoke, 2015); Soares, *A Home from home?*.

[7] Naomi Tadmor, *Family and Friends in Eighteenth-Century England: Household, Kinship, and Patronage* (Cambridge: Cambridge University Press, 2001); Naomi Tadmor, 'The Concept of the Household-Family in Eighteenth-Century England', *Past and Present*, 151 (1996).

work, and space in the institution as a structural tool, whilst providing a basis for projected affective relations between the staff and the resident children.

The rich institutional archive of the Edinburgh Orphan Hospital later known as the Dean Orphanage allows glimpses of the lives of resident staff, their working conditions and occasionally their career trajectories that reveal the vastness and connectedness of the institutional care sector. This chapter thus primarily focuses on the relations and experiences of labour and co-habitation of staff and children as well as their 'families and friends' within the household-family model. It explores the relationship between formal rules and requirements relating to the staffing and the lived experiences of work in the hospital. It questions the ways in which the employees' own families were integrated into the institutional household, and how residential decisions were made by employees and the management. Secondly, it examines the ways in which familial and institutional forms of care intertwined, with families drawing on institutions to temporarily relieve their financial precarity, as opposed to such institutions being seen as exclusively top-down instruments of power and reform directed at the poor and their children.

Previous work by Tim Hitchcock, Samantha Williams and Jeremy Boulton focuses on the incorporation of institutional care into pauper survival strategies in London during the long eighteenth century.[8] The evidence gleaned from the institutional archive of the Orphan Hospital supports these findings, highlighting the commonalities in the lived experiences of urban poor across geographies. The entanglement of familial and institutional structures of both resident children as well as employees is key to our understanding of care as a composite practice that was distributed between multiple actors with a wide array of shared as well as contrasting needs and aims. By highlighting the transient and supplementary nature of care arrangements set up in pragmatic ways in response to availability and need, I aim to stress the rootedness of care institutions in the broader economy of welfare. By pointing out the complex residential and familial arrangements of both children and staff, I argue against the Foucauldian narrative of binary relations between institutional staff and children depicted as those with power and the

[8] Tim Hitchcock, 'Unfawfully Begotten on her Body': Illegitimacy and the Parish Poor in St Luke's Chelsea' in Tim Hitchcock, Petr King, Pamela Sharpe, *Chronicling Poverty: The Voices and Strategies of the English poor, 1640-1800* (London, 1997); Samantha Williams, *Unmarried Motherhood in the Metropolis, 1700-1850: Pregnancy, the Poor Law and Provision* (Cambridge, 2018); Jeremy Boulton, 'It is Extreme Necessity that Makes Me Do this': Some 'Survival Strategies' of Pauper Households in London's West End during the Early Eighteenth Century', *International Review of Social History* 45 (2000); Jeremy Boulton, 'Welfare Systems and the Parish Nurse in Early Modern London, 1650-1725', *Family and Community History*, 10 (2007).

powerless.[9] As shown by Hitchcock, the reality of institutional admissions did not always reflect the rhetoric of necessary respectability of relief claimants and the condemnation of those deemed to lack virtue. In addition, the very purpose of institutional care to function as a tool of social cohesion, supporting existing social structures and preventing the many social ills of pauperisation feared by the middling sorts, meant that they were often less discriminatory than they might at first appear.[10] Whilst not to be seen as harmonious havens for the dispossessed, voluntary institutions were an indispensable part of the economy of makeshift that enabled families to temporarily ease off the pressures of looking after one another in times of hardship. Similar strategies were used by those employed by the Hospital, as well as those admitted as objects of its charity. Many people finding employment as institutional servants, nurses, kitchen staff and warders sought such work for the residential arrangements it offered as much as a way of gaining income. Many of the children admitted came from families of servants, and thus the hospital's resident children and staff shared similar histories of poverty, precarious living and pluriactive survival strategies. Additionally, employees as well as children followed a strict regimen and were unlikely to enjoy free time or movement, much like servants in private households. Whilst masters and mistresses were more fortunate in their circumstances as housekeepers, teachers and ministers, this did not exclude them from the experience of poverty and destitution resulting from loss of employment or a spouse. This is not to suggest a life of harmonious equality between members of staff or between staff and children and their families, but rather to sketch out a model that appreciates the similarities between those who came to reside in voluntary institutions through varied avenues that formed an indispensable part of cohabitation in the eighteenth century urban landscape.

The orphanage is undoubtedly part of the broader story of the expansion of the Scottish (and British) state, linked to the emerging concept of welfare as a political question, which is further explored in Chapter 6. At the same time however, it cannot be divorced from the histories of voluntarism and charitable provision that preceded the long-eighteenth-century expansion of state-sanctioned welfare. As such, the question of power and control exerted over the lower classes remains integral to the subject debated here, seen from the point of view of the expanding state as well as the more dispersed 'elites'. Similarly, however, institutions such as this one remain rooted in the histories of familial

[9] Michel Foucault, *Discipline and Punish: the Birth of the Prison* (Harmondsworth, 1977); Michel Foucault, *The History of Sexuality* (New York, 1985); Michel Foucault, *The Archaeology of Knowledge* (New York, 1972); Erving Goffman, *Asylums* (New York, 1961); Kathleen Jones, A. J. Fowles, 'Total Institutions' in J. Johnson, C. DeSouza, *Understanding Health and Social Care: An Introductory Reader* (Sage, 2008).
[10] Hitchcock, 'Unfawfully Begotten on Her Body'.

welfare strategy and the makeshift economy that marks the lived reality of poverty in any given period or geography. By straddling these often demarcated histories, I use the Orphan Hospital to shed light on the residential and labour relations in an institution of care whilst posing questions about the nature of family, care work, space and the temporality of welfare. By turning away from the power exerted through the institution as a top-down tool, I hope to explore the complexity of institutional lives, labour relations and their gendering.

Naomi Tadmor's 1996 article on the concept of the household-family provides a tool for family historians to establish an expanded notion of family beyond the nuclear.[11] She views the household-family as composed of relations of residence, economic co-dependence as well as authority, whilst allowing for the complexities of life-cycle, temporality and affect in the context of co-residential relations.[12] Loosely drawing on the histories of institutional domesticities by historians such as Jane Hamlet, Lesley Hoskins and Rebecca Preston, I aim to expand Tadmor's model to encompass residential institutions providing care. This allows me to survey both the intentional deployment of the familial model by the institution's management, but also pose questions about the care work that constitutes the backbone of these establishments' running.

Situating the household-family model within narratives of care and welfare optimisation, Peregrine Horden describes a model of interweaving familial and extra-familial relations that include institutions of care.[13] His model is deployed here to survey the familial and residential experiences of the hospital's staff and the multifarious ways in which institutional employees incorporated their biological families into the institutional ones through patterns of residency, provision and association. Additionally, this chapter examines the ways in which the familial and paternalistic rhetoric that predominated in the hospital's ethos impacted the working lives of the hospital's staff, both as a way of exerting pressure and lending itself to negotiations. Furthermore, accessing familial ideals through their institutional enactment serves as a way of revealing contemporary understandings of the family as a social unit and a care provider, amplifying the providing, disciplinary role of the family in resource-pooling and welfare optimisation. Instead of drawing out the opposition between the affective and the material aspect of eighteenth-century familial relations, I aim to amplify their connectedness, in both familial and

[11] Tadmor, *Family and Friends*; Tadmor, 'The Concept of the Household-Family', Hamlett, *At Home in the Institution.*
[12] Tadmor, *Family and Friends*; Tadmor, 'The Concept of the Household-Family'.
[13] Peregrine Horden, 'Household Care and Informal Networks: Comparisons and Continuities from Antiquity to the Present', in P. Horden, and R. Smith, *The Locus of Care: Families, communities, institutions, and the provision of welfare since antiquity* (London, 1997).

institutional contexts. The institutional space is thus conceptualised as a locus of cohabitation and provision, subsistence production and services, and in a limited capacity also for-profit production. Closely resembling the economic model followed by households as units of production, reproduction as well as consumption, the institutional family can thus be seen as a microeconomic unit. Characterising the institution in these terms lends itself rather well to expanding the household-family model beyond formation and formal structure to thinking about its everyday workings.

Thomas Tod's description of the institution's structure as a 'little republic' resonates with Karen Harvey's study of gender in the domestic setting, suggesting the need to depart from the feminised idea of the 'home' towards a broader notion of the 'house', to accommodate domestic masculinities.[14] Harvey's emphasis on the permeable nature of the domestic both refutes the private/public, feminine/masculine division of eighteenth century *spheres* of life, and invites a greater focus on the physicality of the inhabited space. Her highlighting of the conflation of the 'public' and 'private' is especially significant in the present context of institutional households. Lastly, her focus on masculinity within the domestic setting is useful here in informing the treatment of male staff and managers and their roles in the institution. It provides a valuable tool for the study of male care work and its depiction through the imagery of 'tender masculinity' that appears permissible in relation to children and charitable provision more broadly.[15]

This chapter thus builds on the discussion of the care sector and private care entrepreneurship presented in Chapter 4, providing a case study of a public residential institution of social care that emerged from the 'improvement' ideology. Strongly rooted in sentiments of Christian charity, civic philanthropy and new forms of patriotism and notions of economic progress, the Orphan Hospital represents a key example of early eighteenth-century Scottish reformism. I place care work in its broadest sense at the centre of the debate around provision, welfare and institutional space, understood as a space of co-residence as well as involving complex affective relations. The discussion commences by taking a close look at the Edinburgh institution from its inception in 1727 up until the 1840s, its composition, structuring, and staff relations in light of the household-family model. It then examines the role of labour in the hospital's running and the upbringing of the resident children and the division of labour between staff and children. It explores staff relations and patterns of labour to interrogate forms of care work when situated within a contractual institutional context. Lastly, it interrogates the perceived dichotomy between

[14] Karen Harvey, *The Little Republic: Masculinity and Domestic Authority in Eighteenth-Century Britain* (Oxford, 2012), 1-23.
[15] *Ibid*, 1-23.

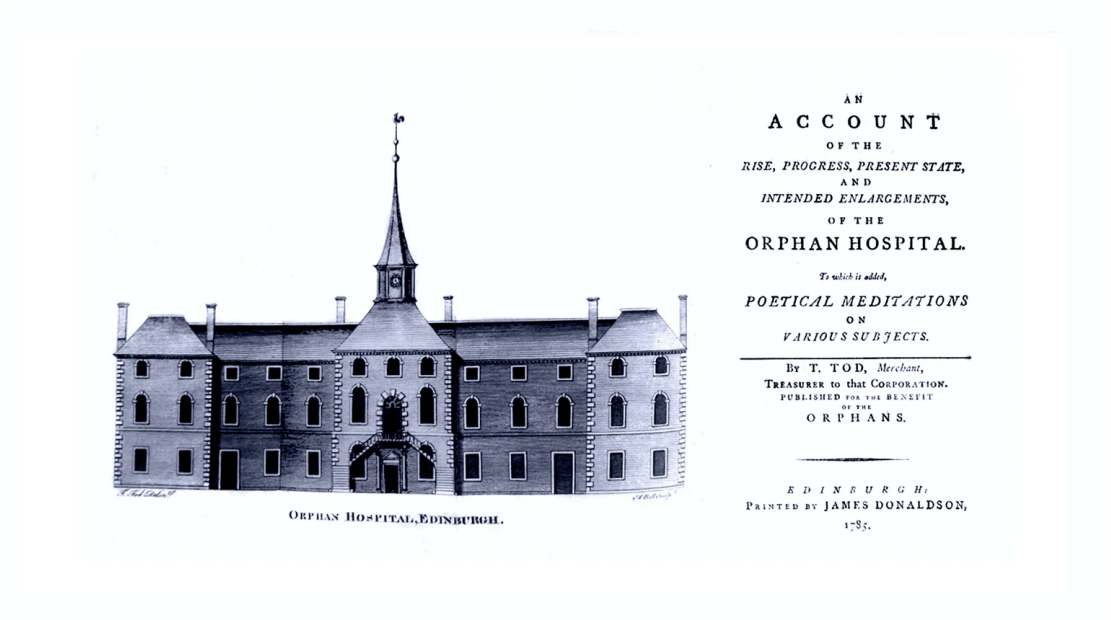
familial and institutional care, instead highlighting their entanglement through the formation of institutional structures, but also in their strategic use by individuals, families and communities in times of hardship.

5.1 'The best-regulated orphan-hospital': The Establishment and Organisation of the Edinburgh Orphan Hospital[16]

The establishment of the Orphan Hospital was first proposed in 1727 by Andrew Gairdner, an Edinburgh textile merchant and burgess. The hospital represents one of the earlier social projects in the city rooted in the notions of 'religion and reason' that shaped Scottish reformism of the period. The origins of the hospital can be largely credited to Gaidrner, who also assumed the role of its first treasurer. Having been the treasurer of the Trinity Hospital, a refuge for elderly and penurious burgesses and one of the few Edinburgh institutions founded before the mid-seventeenth century, Gairdner was involved in the milieu of institutionalised philanthropy long before his interest in child provision. He first published a plea for the establishment of a general orphan hospital in 1727 as part of his treatise on the necessity of improving the Trinity Hospital.[17] His vision of a general orphan hospital followed the recent establishment of a number of institutions with restricted admissions, the George Heriot's Hospital for sons of Edinburgh's burgesses and freemen, Watson's Hospital for the sons of Edinburgh merchants and especially those members of the *Company of Merchants of the City of Edinburgh*, and the Trades' Maiden and Merchant's Maiden Hospitals for daughters of the city's tradesmen and merchants. Gairdner envisioned a universal, co-educational school for children of 'respectable classes' of artisans, tradespeople and servants from across Scotland fallen into misfortune, thus allowing for a rather broad admissions policy in the early decades.[18] As still maintained by the managers in 1833, the Orphan Hospital was not 'an Institution for the children of those who have possessed any certain status, or acquired privileges in connection with some corporation or particular branch of the community, in virtue of which alone an admission to its benefits may be secured'.[19] Contrarily, 'the circumstances of the severest destitution

[16] Henry Home, Lord Kames, *Sketches of the History of Man*, ed. by James A. Harris (Indianapolis, 2006), Vol III, Sketche X, 523-524.
[17] Andrew Gairdner, *An Historical Account of the Old Peoples Hospital, Commonly called, The Trinity Hospital, in Edinburgh; with Arguments and Motives pleading for Assistance to pay off the present expensive Reparations, and to raise a Fund for maintaining many more People* (1727, Edinburgh).
[18] *Regulations of George Heriot's Hospital* (Edinburgh, 1795); *The Rules and Regulations of George Watson's Hospital* (Edinburgh, 1724); NLS 2.628.1.
[19] NRS GD417/36 Historical Account of the Orphan Hospital 1833, 29.

form the only preferable claim to its benefits'.[20] The orphanage thus remained an institution for the less privileged, though its admissions policy increasingly excluded the most destitute, who were to be sent to the city's Charitable Workhouse established in 1743.


ORPHAN HOSPITAL, EDINBURGH.

AN
ACCOUNT
OF THE
RISE, PROGRESS, PRESENT STATE,
AND
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ORPHAN HOSPITAL.
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ON
VARIOUS SUBJECTS.
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TREASURER to that CORPORATION.
PUBLISHED FOR THE BENEFIT
OF THE
ORPHANS.
EDINBURGH:
PRINTED BY JAMES DONALDSON,
1785.

Fig. 5.1 Edinburgh Orphan Hospital, 1789

Gairdner's project fast gained support from the *Society of Improvers In the Knowledge of Agriculture in Scotland* and the *Board of Trustees for Fisheries and Manufactures*, both linked by characteristically uniform membership and involvement in numerous charitable institutions such as the Edinburgh Royal Infirmary. Their support signalled the hospital's rootedness within the project of national improvement as opposed to simply reflecting a centralising trend in social provision. A committee of the Society of Improvers was set up to assess the profitability of the venture, concluding 'that it would be of great advantage to the Country, because the Orphans might be employed in spinning, and other useful Parts of the Linen and Woollen Manufactures'.[21] Additionally, the principal patron of the hospital became the SSPCK, who provided considerable support in superintending the hospital's construction in 1733, renting a house in Bailie Fife's Close and later furnishing textbooks and paying the master. The SSPCK's involvement remained a central influence on the hospital's running, staffing and the education provided to

[20] *Ibid.*, 29.
[21] Robert Maxwell, *Select Transations of the Honourable The Society of Improvers In the Knowledge of Agriculture in Scotland. Directing the Husbandry of the different Soils for the most profitable Purposes, and containing other Directions, Receipts and Descriptions. Together with an Account of the Society's Endeavours to promote our Manufactures*. (Edinburgh, 1743), 443.

resident children, and many masters and male teachers employed at the hospital had begun their careers as teachers to the SSPCK across Scotland.[22]

In addition to its evangelical foundations, Gairdner's writing as well as presentations to the *Society of Improvers* betrays the hospital's strong roots in the national improvement project through foregrounding the children's education in textile production, extending the individual benefits the children received to the promotion of industry in and around the country.[23] Whilst the majority of the children received came from Edinburgh and its close surroundings, the hospital was envisioned as a national institution and admissions were not conditioned by rules pertaining to the settlement of children or their families. The rationale for the promotion of both individual and national interests was clearly introduced in the campaigns preceding the hospital's establishment motivated by populationist economic policy as expressed in Gairdner's presentation to the Society:

> That the Welfare and Prosperity of all Nations depends much upon the Natives being virtuously educated, and industriously employed in the manufacturing the Produce of their own Country; and that yet it is observed, that great Numbers of poor Orphans, who have none to take care of them, are neglected in their Education, and put to no Business of any kind, whereby they become a Burden to the Country, and entirely useless to the Commonwealth.[24]

Following the establishment of similar institutions in England, Holland, Germany and France, the proposal was directly linked to the theoretical and practical dimensions of European Enlightenment thought and its emphasis on population retention and education as highlighted by Otto Ulbricht in the German context.[25] It is maintained here that Scottish reformism and its practical manifestations were directly linked to the broader expansion of centralised provision and the proto-welfare state across Europe led by the mercantilist belief in population driven economic growth as emphasised earlier in this thesis.

Whilst care regimes were shaped by geographies, cultures, familial patterns as well as policies, my emphasis here is on the relationship between various care providers as primarily determined by economic structures. In Gairdner's plea, childcare is depicted as a collective responsibility rather than a strictly familial one, and whilst families were the

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[22] Andrew Gairdner, *An Historical Account of the Old Peoples Hospital;* Thomas Tod, *An Account of the Rise, Progress, Present State and Intended Enlargements of the Orphan Hospital. To which is added, Poetical Meditations on Various Subjects* (Edinburgh, 1785); NRS GD417/35 Historical account of the Orphan Hospital 1777, Statutes of the corporation 1776; NRS GD417/36.
[23] Maxwell, *Select Transactions,* 443-56.
[24] Maxwell, *Select Transactions,* 445.
[25] Maxwell, *Select Transactions,* 450; Otto Ulbricht, 'The Debate about Foundling Hospitals in Enlightenment Germany: Infanticide, Illegitimacy, and Infant Mortality Rates', *Central European History*, 18, 3 (1985).

imagined locus of most caring relations, the overseeing of this work of social reproduction remained a collective concern. Tied directly to national prosperity, populationist thinking continued to be the connecting principle between traditional familialism and institutionalised provision until the early-nineteenth century. Institutions such as the Orphan Hospital were entrenched in the broad care infrastructures as mechanisms that would uphold familial structures or provide temporary relief to families experiencing hardship. They were rooted in the communities within which they operated, incorporating links of patronage within their very fabric. On the other hand, however, with the expanding emphasis on formal schooling, these institutions lay the foundations for, or became transformed into boarding and day schools for the middling sorts by the mid-nineteenth century, as in the case of the Mary Erskine schools for girls and Heriot's and Watson's schools for boys as well as the Orphan Hospital. By the 1890s, the Orphan Hospital was an established day school as well as a boarding house that accepted paying scholars alongside orphaned children, expanding the renown as well as revenue of the institution.[26] As discussed in Chapter 2, the mid eighteenth-century legalism gave way to increased centralisation and universalization, moving the locus of care (and in this context education) into the public realm. The Orphan Hospital discussed here offers evidence of this reframing of institutional care from being something of an exception for unfortunates to becoming a desirable source of education and vocational training. Remarkably, however, its internal structure and everyday running remained largely consistent from its foundation in 1727 until the mid-nineteenth century.

Given the limited capacity of the initial rented premises of the orphanage to house only 30 children, the founders envisioned a new building to reflect the ambition of the members of the incorporation.[27] The foundation stone of the new orphanage was laid in 1734, and the building, funded from local collections and donations in cash, kind and gratuitous labour, was ready for the reception of the first children in 1735, albeit with only one section complete. The building was modelled upon St Thomas' Hospital in London and followed the plans of the Edinburgh infirmary's creator William Adam, renowned for his work on institutional designs.[28] The original building of the orphanage from 1730s located in Dingwall Park formerly belonging to the Trinity Hospital, described as 'plain, clean, healthy and convenient'. Initially, the hospital accommodated up to 80 children, expanding to 130 in the 1780s. In 1742, the hospital received a Royal Charter establishing

[26] NRS GD417/37 Historical account of the Orphan Hospital 1894.
[27] Jane Hamlett, Lesley Hoskins, Rebecca Preston *Residential institutions in Britain, 1725-1970: Inmates and environments* (London: Pickering & Chatto, 2013).
[28] NRS GD417/36.

a Corporation and giving the managers the legal rights to independently run the charity. The hospital statutes were drafted the following year and stayed more or less in effect throughout the eighteenth century.[29]

The hospital's income in the early years constituted of donations, church collections and private bequests, which were used for the maintenance of children, staff and the premises. A major challenge to the revenue was posed by the establishment of the Charity Workhouse in 1743, which became newly responsible for the maintenance of the poor of the city, and thus swallowed up a large portion of the revenue otherwise directed to the Orphan Hospital, again reducing the number of admitted children to 30. The incorporation thus began to rely on external investment in property and financial markets, whilst organising a series of well-attended sermons that supplemented the dwindling revenue from public collections. Whilst the hospital had the word *workhouse* in its name until the late eighteenth century, it clearly distinguished itself from the city's new Charitable Workhouse. Whilst the Workhouse was set up to house the most destitute and increasingly became an instrument of deterrence for relief claimants, the hospital's self-fashioning remained faithful to Gairdner's vision of familial care, educational provision, and a safety net for the deserving poor.[30] After the erection of a chapel adjacent to the hospital by Lady Glenorchy in 1772, a stream of reliable donations was established, which the hospital continued to use for its running. Additionally, large private bequests contributed to the funds the Incorporation was able to invest, enabling the hospital to become largely independent from city and church collections and donations. With the active involvement of the treasurer Tod, the hospital's admissions policy increasingly emphasised its orientation towards the respectable. Tod believed that 'the Children of common Beggars or of very low or mean parents should not be admitted', 'such children are very unfit companions for those who are descended from respectable parents, having early imbibed the mean vices of lying, imprudence and falsehood, which seldom any education can correct or obliterate'.[31] According to Tod, the hospital was to serve those formerly in a

> Respectable situation as Masters Farmers or those of a more superior rank thro' the whole British Empire, but have no exclusive title to any other charitable Institution, and tho' by misfortunes they are fallen down to be as indigent as those who are

[29] NRS GD417/34 Statutes of the Corporation 1743, 76; NRS GD417/36.
[30] NRS GD417/3, Aug 1789.
[31] NRS GD417/3, Aug 1789.

> admitted into the poorhouse, yet merit to have their offspring brought up in a more respectable footing and to associate with their once equals in Station of Life.[32]

Final expansions took place in 1812 with the erection of a large wash-house, laundry, sick rooms and a dwelling house for the master. However, with the rapid construction of the New Town and the North Bridge directly above the hospital, the managers began to contemplate the hospital's removal to a quieter setting. With the growing incidence of disease and greater mortality, the hospital was finally removed to the nearby village of Dean in 1833, where a new building that could accommodate up to 200 children was constructed. The new edifice was supplied with sufficient gas and water on all its three floors with the addition of heating channels leading from the stove room to regulate the heat in the building throughout the year. Similarly, considerable separation was made between the sick ward and the rest of the building to allow for stricter quarantining of those suffering from contagious disease, reflecting the growing emphasis on the medical and hygienic properties of residential space. The hospital was subsequently renamed as Dean Orphanage, bearing the name of its new location. The building designed by the prominent architect Thomas Hamilton reflected the growing renown of the institution as well as the 'commanding situation which they had obtained' in the Dean village.[33] Whilst avoiding anything too 'showy or ambitious', the construction was not to be anything 'resembling an ordinary workhouse or penitentiary, or any thing even that was mean in its appearance, or out of keeping with its proximity to the metropolis and with the surrounding objects, or in violation of the improved taste of the times'.[34] Exerting a 'certain moral influence' as well as 'a corresponding cheerfulness of mind', the final construction was achieved at the staggering sum of £11.849, demonstrating the institution's expansion since its humble beginnings a century prior.[35]

5.2 Management, Oeconomy, and the Household-family

Household composition and management were key aspects of how the hospital was imagined. Receiving a royal patent in 1742, a Corporation was established of the original contributors who thus gained executive powers. According to the Corporation rules, every contributor to the charity became a member and was entitled to attend meetings, partake in executive decisions regarding the charity and join committees whose responsibility it was

[32] *Ibid*.
[33] NRS GD417/36, 26.
[34] *Ibid*, 26.
[35] *Ibid*, 27.

to oversee various affairs of the house and its economy. The Corporation met quarterly, presided over by the managerial committee of 15 members of the Corporation sworn in at each meeting. The managerial committee met monthly and the committee for admissions of children met annually, in May. In August, the voluntary officers of Treasurer, Accountant, Clerk, Controller and the fifteen managers were elected or confirmed. The managers constituted three committees, one overseeing the external oeconomy of the establishment, the second presiding over the election of paid employees and the whole internal economy, including the children's regimens and diets. They were directly involved in supervising the children's wellbeing. A third committee was set up to oversee the workshop and manufactory, including the servants, apprentices and children employed in it and the inventory of goods. The managers were responsible for the capital stock of the Corporation, which they were to increase through lending and investment. Whilst the regular expenditure of the hospital was run from donations and presentations, the capital stock was used to finance the estate and future expansions of the establishment.

This organisational model was derived from imagining the hospital as a permanent household, implying personal and affective relations rather than short term care arrangements, as was the case in institutions offering short term medical assistance discussed in Chapter 6. The household-family model was followed as a substitute for familial support networks whilst promising reformatory potential, but also as a structural model for the staff to uphold. According to the first set of rules and regulations, the officers, or internal staff of the hospital consisted of the master, mistress, schoolmaster and servants appointed by a committee of managers. Additionally, the voluntary treasurer stood equal with the managers and was the most involved in the institution's everyday running, revenue, purchases and staff relations. As evident with Gairdner and Tod, some treasurers chose more involvement with the running of the hospital, though others generally took a more distant approach, limiting their engagement to fiscal matters. Whilst mostly engaging with the revenue management, some treasurers such as Tod saw their role as spanning the managerial as well as everyday overseeing of the institution. A voluntary accountant and controller were also appointed alongside a salaried clerk in charge of casting minutes and other administrative tasks.

Domestic affairs were generally managed by the master and mistress in close collaboration. Across time, this parent-like duo consisted of conjugal partners as well as total strangers, whilst their professional roles of the *pater* and *mater familias* remained all encompassing. The master, or later governor of the house, was expected to be a 'man of good repute, exemplary for piety, gravity, temper and prudence and free from the burden

of Children'.[36] His responsibilities primarily comprised pastoral support, oversight and the management of sermons, and the religious instruction of children and servants. He was to oversee the children's education, behaviour and appearance and discuss the dietary plans with the mistress. He was expected to discipline the boys and male staff. He was assisted by the schoolmaster, who was responsible for the children's education and also expected to be unmarried and childless, a man of piety and an experienced teacher.[37] The master was in charge of the male servant who maintained the gardens and assisted with housework, including kitchen tasks, aiding the women servants. By 1823, reflecting the hospital's expansion, the male servant was replaced by the warder more directly in charge of the boys' wing and an assistant to the master, and a gardener responsible for the grounds of the hospital.[38]

The role of the master was pastoral rather than administrative. By contrast, the role of the mistress or housekeeper, which existed across many establishments of varying natures, was mostly managerial. The involvement of the SSPCK in selecting the master largely shaped the emphasis on pastoral support and religious instruction. The weight placed on the fatherly comportment of the master, his kindness, justice and benevolence, however, took the role beyond spiritual guidance. The master of the orphan hospital was akin to the pater familias detailed in John Tosh's study of domestic masculinity.[39] His relationship with *his* institutional 'family' as his dependants is clearly discernible from the parameters of the role as well as its complex blending with the realities of the job. The master's respectability and virtue lay in his character, justice, piety and benevolence that characterised the role of tender fatherhood in emerging discourses on the middle class family. Harvey and Zucca Micheletto challenged the notion of normative ideals of masculinity as determining its lived experiences. However, the shaping of occupational roles through gendered norms was a distinct process, I argue, in which gendered ideals translated directly into occupational fashioning.[40] The variedness of the role's parameters depending on its location in single-sex or coeducational, lower or upper class institutions complicates the picture further, making the question of occupational realities of

[36] NRS GD417/1, 361.
[37] NRS GD417/1, 366.
[38] NRS GD417/5.
[39] John Tosh, 'What Should Historians Do with Masculinity? Reflections on Nineteenth-Century Britain', *History Workshop*, 38 (1994); John Tosh, Masculinities in an Industrializing society: Britain, 1800-1914, *Journal of British Studies*, 44:2 (2005); John Tosh, *Manliness and Masculinities in Nineteenth-Century Britain; Essays on Gender, Family and Empire* (Edinburgh, 2005.
[40] Harvey, *The Little Republic;* Beatrice Zucca Micheletto, 'Husbands, Masculinity, Male Work and Household Economy in Eighteenth-Century Italy: The Case of Turin', *Gender & History*, 27 (2015), 752-72; Hamlett, Hoskins, Preston, *Residential institutions in Britain.*

institutional carers rather interesting. The Orphan Hospital's statutes placed an emphasis on the joint management of the master and mistress, who were both responsible for their respective domains. This was not the case in single-sex residential institutions headed by either a master or a mistress. To draw an example, the master of the Watson's Hospital was responsible for casting household accounts and keeping inventories, generally a matron's job across infirmaries and hospitals, on top of his pastoral, educational and managerial role.[41] Whilst the Orphan Hospital often employed a married couple to fill the position of master and mistress, the statutes of Watson's establishment suggested a termination of the master's contract upon marriage. The Orphan Hospital's approach to the marital clause was more flexible, often prioritising married couples as employees in their formation of institutional household-family composition. Moreover, masters' or mistresses' daughters were often engaged as assistants, resulting in the direct incorporation of their nuclear families into the institutional household.

In addition to the master, a schoolmaster and a master weaver were employed to teach the children writing, reading and counting and textile trades. Whilst the master weaver was employed externally without residing in the house, the schoolmaster or male teacher was expected to live in the hospital and take part in the children's education beyond the classroom, whilst serving as an assistant to the master, being further incorporated into the household family.

The mistress, much like the master, was to be 'a person free from the burden of children, of unblemished character, one of piety, virtue and experience in the Oeconomy and frugal management of a family'.[42] She was to keep inventories, run dietary management, order provisions and keep charge of 'all the utensils in the kitchen, bakehouse and brewhouse'.[43] She was to maintain cleanliness and order and manage the girls' work in helping the servants with cleaning and maintaining the house. Additionally,

> She is to have the direction of all the girls and women servants in the hospital and she is carefully to attend the carriage and behavior of the girls and women servants in the ffamily and that they behave themselves decently and to recommend to them secret devotion […] She is to have Authority over the Girls, and when any of them are guilty of ffaults or idleness, she is to reprove and correct them, and when any of them do not amend, prove stubborn or are guilty of gros faults, she is to Represent it to the Committee of Managers, who may thereupon order further punishment or Expulsion.[44]

[41] *The Rules and Regulations of George Watson's Hospital* (Edinburgh, 1724).
[42] NRS GD417/1, 365.
[43] *Ibid*., 365.
[44] *Ibid*., 365.

Like the master and schoolmaster, the mistress was to reside and take her meals in the house, alongside the two men. The mistress and master held positions of authority in parallel, in which her domain encompassed the majority of maintenance, provisions and household chores, whilst the master was primarily responsible for spiritual guidance and pastoral support. However, in relation to the female children the mistress was also expected to exert moral and religious influence alongside training the girls in domestic chores in preparation for their future engagement in domestic service. The two roles were imagined in complementary terms, along the lines of normative ideals of gendered household distribution of tasks and domains. The practice of employing married couples contrary to the statutes in the two adjoining roles further reinforced the familial imagining of the hospital's management repeatedly invoked by the records pertaining to provisioning for the hospital's inhabitants on the one hand, and their labour responsibilities on the other.

The familial model employed at the Orphan Hospital is further emphasised when compared with the rather different role of the mistress of the Merchant's Maiden Hospital. According to the statutes, her 'Principal Care shall be, to see that the Children and Servants be brought up in the Fear of Almighty GOD'.[45] She was to catechise the inhabitants thrice weekly, pray with the children three times a day and 'as oft read, or cause some of the Children read a Portion of holy Scripture distinctly'.[46] She was to be a person of 'so much Discretion, as to be fit to govern and direct all that live within the said Hospital, and of that Care and Prudence, as to be fit to take an Account of the same'.[47] Combining the roles of the master and mistress in the Orphan Hospital, the mistress or governess was the principal authority in the Merchant's Maiden. The language of natural affection and familial care was less prominent when compared to the Orphan Hospital, and the staff hierarchy in the Merchant's Maiden was more explicitly rooted in skill, experience and age, with the mistress expected to be over the age of 40 and her direct subordinate, the schoolmistresses, over the age of 25. In the Orphan Hospital, the guiding principle of staff organisation was the complementarity of clearly demarcated and gendered roles of the master, mistress, subordinate employees and children, mirroring the familial organisation of responsibility, influence and labour.

[45] NLS 2.628.1, *The Rules and Constitutions For Governing and Managing the Maiden Hospital, Founded by the Company of Merchants, and Mary Erskine, in Anno 1695*,18-19.
[46] *Ibid.*, 18-19.
[47] *Ibid.*, 19.

5.2.1 Selecting the Master and Mistress of the House

Contrary to its clear imagining, the ideal institutional family envisioned by the management was not easily obtainable, given the expectations placed on office holders and the level of pay that did not much exceed the salary of an SSPCK teacher, following the SSPCK's guidelines to only provide a basic salary in an institution of charitable provision. The high turnover of masters and mistresses demonstrates the level of fluctuation in institutional employment and the ways in which rules and regulations were bent to accommodate the hospital's staffing needs. Archival records that document the hiring of masters and mistresses reveal a lot about the candidates' personal, professional and familial lives, demonstrating the complex ways in which biological and institutional families intertwined and coexisted within welfare networks.

When the first master George Brown was engaged in 1734, his wife Mrs Brown was hired as the mistress, and the family's servant was employed as a servant to the orphanage, alongside a second servant chosen by the new mistress. The pair resided in the hospital alongside at least one of their multiple children, Christian. Additionally, David Brown, the master's brother, was hired as the master weaver at the rate of £15 and, by 1735, £20 p.a. without any residency requirement. Five years later, mistress Brown handed in her resignation, complaining of the heavy workload, given that her assistant was let go in an effort to save costs. Additionally, she felt unable to care for her own children due to her employment in the hospital. As her resignation coincided with the master's illness, it was discouraged by the managers until his recovery. In the meantime Mrs Brown was expected to cover her husband's duties. When the master recovered, he requested the managers reconsider his wife's resignation, which was accepted and Isobel Paterson was hired as the new mistress in July 1740. George Brown and Christian remained in the hospital in spite of Mrs Brown's departure most likely to a separate household with the remaining children. In November, master Brown also resigned to take up a position as a preacher for the reformed church in England, receiving a favourable character from the managers.[48]

Upon Mrs Brown's resignation, the managers agreed that a married woman with children should not be engaged as mistress in the future. This was, however, never properly followed, given the difficulty of obtaining suitable candidates that matched the range of formal criteria set by the hospital.[49] Likewise, married masters with children continued to be engaged. Much like the case of the Browns, many office holders employed

[48] NRS GD417/1, NRS GD417/15.
[49] NRS GD417/1, NRS GD417/15.

by the hospital had families or dependants, who often came to reside and work in the hospital, blending into the spatial and organisational framework of the institutional family. The evidence of such complex residential patterns suggests alternative ways in which working men and women combined their personal and professional lives according to necessity and the availability of work opportunities. Additionally, it challenges the clear demarcation between institutional and familial spaces by bringing examples of their complex overlapping. It also offers numerous examples of nuclear families functioning as flexible units that could be incorporated into broader welfare strategies and networks as opposed to functioning as fixed self-sufficient units of provision, production and cohabitation.

Attempts to incorporate masters' families into their professional lives were made by managers as well as the candidates themselves in repeat attempts to find a suitable candidate for the post. In 1804 Mr Gilbert MacDonald, formerly a teacher, was selected for the post at the salary of £25 p.a., the standard rate paid by the SSPCK. The managers expected his wife to take up the position of mistress, who was also wanted, at £20 p.a., which was comparable to the salary received by the matron of the Royal Infirmary, though without the regular benefits paid by the bigger establishment. The MacDonalds had three children and their eldest daughter, a trained mantua maker, was to take up the position of the female teacher at £10 p.a., whilst their younger children aged 8 and 9 were to be taken in, educated and later apprenticed at the hospital's expense. By blending the nuclear and institutional families into a co-residential and occupational arrangement, the managers had hoped to ensure longevity of management, unencumbered by external alliances and responsibilities. In spite of the added value of the salaries of the wife and daughter, the master's salary was rather low in exchange for the institutional demands made by the hospital. Whilst the salaries received by teachers and ministers did not much exceed the rate of pay received by the master, they afforded a greater level of freedom and privacy, whilst also not requiring familial separation. At the same time, having to secure board and lodging would have significantly diminished the teachers' income. In spite of the accommodations made by the managers, Mr MacDonald declined the offer. The managers continued to struggle to fill the position with a number of candidates being sworn in and resigning only a few months later.

In October 1808, Mr Aitken, an SSPCK teacher from Cannongate was offered the position followed by a period of negotiations surrounding his ability to fulfil his duties alongside his familial responsibilities. Whilst the managers expressed their wish to find an unmarried man, Mr Aitken's experience was considered unparalleled amongst other candidates and so provisions for his family had to be made, with the managers attempting a

new strategy of proposing the family separate in order to secure the master's ability to fulfil his professional role. The records suggest the managers' reluctance to bring in the family and so a separate house was provided with an addition to Mr Aitken's salary of £50 p.a. representing a family wage and roughly equalling the joint income of the McDonalds a few years prior. The contract entitled the master to take leave on Sunday evenings to stay with his family and return to the hospital on Monday, which was thought to ensure his maximum attention to the hospital. Whilst his wife and daughter were provided for in a separate house, his son was taken in to be educated at the hospital. Mr Aitken accepted the role, but resigned only a year later, presumably to take up a more lucrative position elsewhere, leading to the managers offering an additional increase to the next candidate.

When a new master Mr John MacDonald was elected in 1810, he was allocated £80 p.a. with the addition of £15 as a living allowance, a sum assumed to cover the expense of his family moving to Edinburgh and maintenance in a separate house. The salary increase was again thought to include a family or breadwinner wage to provide more competitive conditions for the role that was so difficult to fill. Equal to the salary of the Royal Infirmary apothecary, this increase defied the SSPCK's intention to keep the master's pay low. The pay received by future masters was reduced to £60 for masters without dependents, highlighting the family wage strategy employed. Reflecting the changes in institutions aiming to reconcile their formal requirements and the practical realities of an increasingly expanding market of institutional care and education, the family wage was an interesting development. Whilst in contradiction with the rules that required the master to be unmarried, it practically incorporated his family into the institution's ecosystem, either physically or through pay. The managers' discussions of candidates for the role suggest it was a struggle to find a qualified person who also fitted the extensive devotional and familial qualifiers prescribed by the institution and the SSPCK.

These examples demonstrate the ways in which the managers increasingly overlooked the marital clause, leading to the creation of complex residential and familial arrangements. When Mr MacDonald's wife died only a few years later, the managers suggested that this warranted a salary decrease. This was never realised, and instead they paid the master £20 for the expense incurred by providing for his wife in sickness. The family's children were not mentioned, and it is unclear whether they came to reside in the hospital after their mother's death or were placed with a paid carer. No such arrangement was reflected in the master's salary, however, as Mr MacDonald did not stay in the role for long. Six months later, he wrote to the managers that he had experienced a change of heart in his faith and could not be convinced to attend sermons and a new candidate had to be

sought yet again. Future masters were likewise offered a family maintenance sum, to furnish them with separate accommodation.

The varied strategies of incorporating the masters' families by offering them employment, education and residence in the hospital on the one hand, or providing them with separate accommodation and a higher family wage on the other demonstrates the difficulty in finding a suitable candidate for the role at the level of pay prescribed by the SSPCK in an increasingly competitive market. It reflects the growing preference for a professional rather than marital duo of the master and mistress, resulting in the managers' increased expense and efforts to remove the masters' dependants from the premises. It also, however, shows just how common trade-offs between professional and familial lives were for individuals employed in institutional provision. By shedding light on the residential arrangements of the hospital's managerial staff, questions arise around the meanings of the family and its composition, but also the relationship between the work, family and residence in the context of institutional care.

For the staff members, including the lowest ranking, a post at an institution like the orphanage not only meant stable employment and pay, but also decent accommodation and a regular diet. Given the close oversight of the hospital's purchases and provisions by the contributors, the produce consumed by the children and employees was subject to quality control and whilst not particularly indulgent, the diet was nutritious, regular and plentiful. In the early years, diet consisted of broth, meat, eggs, bread and butter and cheese, with oatmeal for breakfast and dinner. Servants were generally allowed a mutchkin of ale a day and children received half a mutchkin.[50] The beer and bread were initially prepared in the house and meat, meal, eggs, cheese and butter alternated according to availability and price.[51] By the 1750s bread and beer were more frequently outsourced.[52] The diet varied according to season with more fresh produce in the warmer months. In the 1780s a kitchen garden was established to provide more fresh produce with the growing emphasis on healthy diet. Provisions per child were estimated to not exceed £5 10s 3d given the considerable household production.[53] The provisions for all staff were included in this amount, with the hospital's employees receiving the same diet, and older boys and servants receiving larger quantities than younger children.[54] This amount increased along with rising prices to £6 17s 6d by 1800s. To aid strict economy, other grains such as rice or

[50] One mutchkin equals ¾ of a pint.
[51] NRS GD417/17.
[52] NRS GD417/2, 1750s.
[53] NRS GD417/2, 1782.
[54] NRS GD417/2, 1782, NRS GD417/17.

barley were introduced throughout the period according to fluctuating availability and cost.[55]

For single women engaged as matrons, teachers or servants, the hospital offered greater job security than the majority of employment opportunities available. Additionally, for women with dependents who were able to carry out some handiwork or otherwise be of assistance, the hospital was able to offer employment and accommodation, which did not require familial separation by providing places for their children. Mrs Mickle, engaged as matron in 1799 at £20 p.a. with board and washing, was joined in the hospital by her disabled 17-year-old daughter who helped teach the girls to sew and mend clothes. Mrs Mickle was recommended by Mrs Mountford, the matron of the Merchant's Maiden, and Mr Pitcairn, a committee member, who had been supporting the family for ten years since Mrs Mickle's husband's death, and considered Mrs Mickle a 'virtuous and worthy woman, who would be a treasure to the hospital'.[56] Her daughter who was 'not able to separate' from her mother did not receive an additional salary, though remained living in the hospital and receiving regular diet for the duration of her mother's engagement. Both women were thought to 'have the interest of the children at heart' and stayed in the position for six years.[57] Mrs Mickle was able to continue living with her daughter, who was unfit for work in domestic service, the most common employment for lower class young women. The managers believed the matron to possess professional integrity, but eventually judged that she lacked 'necessary activity and exertion to discharge her function', and the two women were dismissed in 1805.[58] They received £20 alongside the rest of their yearly pay, however, demonstrating the hospital's recognition of responsibility towards its employees. Mrs McLean and her niece, Miss Malcolm, were hired instead at £20 and £7 p.a. to act as mistress and assistant teacher. Miss Malcolm was favoured by the managers and her salary was increased to £10 p.a. only a few months later. Both women stayed in post until Mrs McLean's death in January 1824, when Miss Malcolm decided to leave, citing her low wages as the reason for her resignation. Her salary of £10 was lower than a man servant's pay at the Royal Infirmary (£12 3s) or a spinning mistress's salary, though without board, in the burgh of Inverness (£15).[59] Miss Malcolm was likely able to find a better paid post with her experience gained at the hospital in administrative and housekeeping tasks as well as work in spinning and textiles production, though she remained in the post until her

[55] NRS GD417/3, 1800.
[56] NRS GD417/3, May 1799.
[57] NRS GD417/3, 1800.
[58] NRS GD417/3, March 1805.
[59] Many thanks to Juliette Desportes for providing the evidence on female spinners' earnings, Lothian Archive, LHB1/1/9, 1824.

aunt's death, demonstrating the non-monetary benefits of the post, including working alongside her aunt whom she assisted in the role of matron, which also provided the two women with a kin-based residential arrangement within the context of the institution. Her case thus demonstrates the mechanisms of social mobility allowed to women working across the emerging institutional sector, gaining skills and favourable references that functioned as a currency in the expanding job market. The managers' regard for the two women was expressed by their grant of an annual life rent of £10 to Miss Malcolm, demonstrating the long-term ties between the institution and its long-serving members of staff.[60]

The managerial structure of the Orphan Hospital reflects its top-down imagining along the familial model used as an organisational framework. Whilst in many ways restrictive, employment in residential institutions could have been a lucrative option, providing greater stability than often afforded in the private sector.[61] Staff members were able to draw on networks of support provided by the hospital as well as build their professional credentials, which would lead to better employment prospects in the future. With many staff members bringing their families to reside in the hospital, their familial and occupational lives converged, with the domestic and institutional aspects of the establishment largely overlapping.

5.2.2 Keeping 'all the house and everything in it clean': Servant Staff and Domestic Labour[62]

In the hospital's earlier years, the male teacher was the only formally employed resident member of staff responsible for instructing the children whilst serving as an assistant to the master. Whilst the mistress often employed, albeit informally, a female relative as her assistant, she remained the main figure in charge of all female residents and her workload was thus much greater than that of the master. In 1823, the role of the schoolmistress was introduced to aid the mistress's workload. She was to oversee 'the habits, personal cleanliness and manner of the School Girls and to teach them sewing, spinning, knitting, the making of their own clothes and the keeping of these and the Boy's clothes in good repair'.[63] She was to ensure they rose on time and behaved properly, so that the housekeeper could dedicate her full attention to the affairs of the house.[64] Additionally, in

[60] NRS GD417/5, 1824.
[61] Goffman, *Asylums*, xiii.
[62] NRS GD417/1, 368.
[63] NRS GD417/5, 200-1.
[64] *Ibid*.

the 1820s, the girls' education became increasingly focused on domestic tasks and preparing them for service and subsequently marriage. Training that formed the 'house department' of the girls' education fell under the mistress's domain, with the schoolmistress mostly responsible for teaching the girls textile trades. In spite of the division of the workload, both roles remained all-encompassing, which led to complaints by some staff members. Margaret Matheson, the female teacher between 1848-9, for example, complained to the managers that the workload was 'oppressive, and wearing out to the Teacher, [and] it does not conduce to the good of the Children, as it is impossible that the Teacher's mind can be in the fresh and lively state that is essentially necessary, during the whole of such a long day'.[65] Consequently, she resigned from her post after only three months after her engagement, citing the 'extremely long hours of duty; which are, I may say, from five o'clock in the morning, when I require to be up, till half past nine at night, when I get quit of the children, being a day of about 16 ½ hours long, with intervals of only a few minutes for meals'.[66] Miss Matheson complained that such working hours were 'much too long for any ordinary constitution of either mind or body' and generally unfavourable.[67] A committee was appointed to discuss possible changes to her duties and entice her to withdraw her resignation, as the mistress, Miss Laing, was pleased with her work. Miss Matheson negotiated extended times for breakfast and dinner of twenty and thirty minutes respectively and requested a pledge that these would be without interruption, besides an hour each day entirely to herself, whenever convenient to the 'family'. She was also promised leave to visit her 'friends out of the Hospital once a fortnight from two o'clock till seven' as well as moving her morning start on Sunday from six to seven o'clock.[68] In spite of the concessions made by the managers and the matron, willing to step in for the teacher in her absence, Miss Matheson resigned in December 1848 to take up a position elsewhere.

Miss Matheson was able to negotiate with her employers, who habitually made concessions to avoid the trouble of having to find a new member of staff for the arduous and underpaid public offices in the hospital. With the expansion of institutional provision, experienced members of staff like Miss Matheson were able to gain bargaining power in their workplace. Those who stayed employed in the hospital for a prolonged period of time were rewarded with regular payments and occasionally the promise of a lifelong pension, like the schoolmistress Miss Malcolm, or the master between 1759 and 1802, William

[65] NRS GD417/6, 363.
[66] *Ibid*, original emphasis.
[67] *Ibid*.
[68] *Ibid*.

Peebles. The master and mistress were in receipt of 'gratuities' that ranged from £1 to £15 p.a. Whilst conceptualised as staff benefits, they came to function as a way of supplementing the otherwise generally low salaries received by the officers. Sometimes servants also received support from the institution. When William Bell, the man servant to the establishment died in 1740, his daughter was admitted to the hospital, thus relieving her mother's caring responsibilities in a time of hardship.[69] Such provisions were not unusual across institutions such as the orphanage, which recognised a duty of care towards their employees as well as the children. Once again, such instances highlight the entanglement between institutions, communities, families and individuals that can be viewed as shaping the mixed economy of welfare as opposed to functioning as bodies clearly demarcated into categories of public and private, institutional and domestic. Much like in the context of the household-family, it was necessity mixed with cash and in-kind payments that provided the underlining structure of the relations between the hospital, its staff, admitted children and their families. The complex ties of reciprocal obligation, provision, relations of labour and cohabitation as well as subsistence production and consumption thus closely echo the composition of the household-family.

The majority of housework, care work and kitchen work was carried out by female servants with the help of resident children, especially the girls. 'Women servants of good report, unmarried and having no children' were engaged by the matron, and were expected to

> Make ready the victuals, wash and dress all the linen in the Hospital, make all the Beds therein, attend such of the children as shall be sick, and see that all the children be kept clean, they shall sweep and keep all the house and everything in it clean, and assist in brewing and baking.[70]

Initially, only two servants were employed rising to four in 1738. By 1800 an additional servant was hired to work in the sick house in response to a spreading skin condition amongst the children. By 1823, a designated nurse was appointed to the role, though she was expected to aid the servants when necessary rather than her role being strictly confined to the sick room. Additionally, older children were expected to aid their younger counterparts in matters of hygiene, dressing, tidying and generally attending to their needs, echoing dynamics between siblings. Whilst generally employed in various tasks around the house, servants of the orphanage were able to express preference and at times negotiate with the management in order to alleviate their workloads. In 1737, Marion Livingstone, a

[69] NRS GD417/1, 1740.
[70] NRS GD417/1, 368.

woman servant, petitioned the managers claiming she would not be employed in 'washing the children and dressing victuals', and would only perform her usual tasks of cleaning and keeping the premises in order.[71] In response, one additional servant was hired by the mistress to aid the two current employees in their workload.[72] Whilst the lines between care work, kitchen tasks and general maintenance appear blurred for the most part, glimpses of the work relations actually in place raise the question of how institutional workers saw the relationship between cleaning, washing, food preparation and childcare, that formally all fell under the myriad duties of domestic servants. Whilst clearer occupational demarcation is visible in the period post 1800, episodes such as Marion Livingstone's petition hint at more complex relations organised around the notions of respectability and agreeableness of certain types of work and the ways in which employees bargained to avoid the types of work they saw as unpalatable.

As shown in more detail below, the domestic workload was shared between the servants and children, which was not commonplace in institutions intended for children of higher status, and reflected the lower status of the children admitted into the orphanage as well as their preparation for the future work. In the Watson's Hospital, domestic servants were the only female members of staff and thus directly answered to the master and treasurer. The servants were expected to be unmarried and childless women over the age of forty. One of them was habitually selected by the master as head-servant, though 'if there is no *principal Woman-Servant*, then a particular Number of *Boys* are to be in the Charge of every *Woman*.[73] The clear demarcation between the boys, or scholars (as they were occasionally referred to in the Watson's) and the female servants juxtaposes the lack of a hierarchy in the Orphan Hospital, where children and servants were to be employed in similar tasks. With the Orphan Hospital accepting children of servants and labourers, the children were brought up to work as domestics, artisans and tradespeople. The Watson's, on the other hand, reflected the higher status of the resident boys determining their status above the service staff in the institution. Labour division and patterns of mastery and oversight across care institutions reveal ties of status and gender with notions of belonging to certain social strata in spite of receiving institutional provision. Echoing Carolyn Steedman's work on the complex hierarchies within servant/children relations, the varied institutional arrangements stress the parallels between familial and institutional

[71] NRS GD417/15, 73.
[72] *Ibid*.
[73] *The rules and regulations of George Watson's Hospital.*

cohabitation and labour composition. Similarly, they echo the importance of status and class to institutional fashioning.[74]

5.3 'Reaping the benefits of labour': Children's Admissions and Labour Relations[75]

The children's time was subject to a strict regimen that reflected the institutional ethos of hard work, industriousness and gratitude. According to the original statutes the hospital was to accommodate both female and male children selected from petitions submitted to the committee of managers annually in February, with the possibility of filling any vacancies in August if any children left during this time. Each child's patron was to pay £5 annually and the children were required to have adequate clothing upon entering, though this was later replaced with uniforms made by the children themselves during their education in textile production and finishing trades.[76] In the 1730s, up to 30 children between 6 and 12 were to be chosen and were expected to stay in the hospital until the age of 21, unless a suitable situation was found earlier. This exceptionally high age was brought down only a decade later with an explicit rule not to keep girls past the age of 15 and to procure apprenticeships for boys generally between the ages of 14 and 16. By the 1770s, children between the ages of 7 and 11 were accepted and the hospital required a proof of age upon admission. All children were to undergo a medical check before entering and were only taken in when found healthy and resilient, which was to prevent contagion and additional expense to the hospital, but also to enhance the hospital's output in textile production. When children contracted an infectious disease, they were quarantined outside of the house, and in incidents of long-term convalescence, they could be sent to their relations who received payments from the hospital for providing care. The hospital did not have the staff capacity to provide round-the-clock care and familial networks were thus re-employed. In January 1819, Mrs Peters received 3s 6d to look after her son, who was 'in a very delicate state of health' after a long sickness.[77] Similarly, Mrs Cranstoun, in July 1828 received 3s a week for supporting her child who was nursed in the country before being admitted back at the hospital.[78] Throughout the years, the age requirements fluctuated with older children given preference upon the grounds of their greater stability and adaptability. Similarly, admission fees fluctuated between £3 and £5. Large donors to the hospital bequeathing initially £100 and by 1800s £200 or more were granted a perpetual and

[74] Steedman, Carolyn, *Labours lost? Domestic service and the making of modern England* (Cambridge, 2009).
[75] NRS GD417/18, March 1749.
[76] NRS GD417/1.
[77] NRS GD417/5, 45.
[78] *Ibid*, 259.

hereditary right to recommend between one and three children annually, rooting the hospital in traditional networks of patronage. One such notable example was the Earl of Hopetoun, also a key supporter of the Edinburgh Royal.

Admitted children received instruction in reading, writing, arithmetic and catechism alongside practical education in textiles and domestic chores. Their daily regimen was one of the principal subjects debated by the managers over the years, reflecting the attention paid to installing a sense of hard work and preventing idleness in the future as well as maximising productivity. Especially during Tod's treasury, the day was demarcated into blocks of instruction, work and prayer with a two-hour period of free time after lunch, which was later reduced to allow additional time for instruction.[79] In the 1830s and 40s, the managers discussed the subject of the children's regimen in much detail, showing the gendered and seasonal nature of the children's tasks. Much attention was paid to communal prayers, which were performed in the morning as well as private devotions. Whilst boys were encouraged to spend more time in private prayers and catechism, girls were generally employed in sewing and handiwork at all spare moments throughout the day. Similarly, whilst all children had dedicated playtime, this was extended for the boys, with the girls again employed in sewing. A strict regimen was recommended as a way of 'regulating the internal economy' and keeping order.[80] Gradually, regulating the children's education became a greater priority and by 1840s, more time was dedicated to lessons in spelling, reading, writing, arithmetic, but also geography and singing and physical exercise for both boys and girls, with the gendered divergence appearing in the vocational rather than academic training.[81]

As part of the initial textile project, the institution secured the lease of workshops located in Paul's Works, where children were instructed in spinning, weaving and textile production, though this scheme only lasted a few years due to complications and its general unprofitability. Paul's Works fulfilled a similar role from at least the early-sixteenth century, housing 'sturdy beggars' and orphans. In 1619, it was repurposed as a charitable textile workshop intended for 'native commodities unwrocht…be the working of the quhilk commodities…ydle people micht be sett on work and sustenit'.[82] Throughout the seventeenth century, the workshop was run for the purpose of putting the poor to work under different authorities, though it failed to result in profit and was heavily subsidised by collections. Andrew Gairdner was responsible for incorporating the workshop with his

[79] NRS GD417/3, 1800.
[80] NRS GD417/193, Report on Children's Education, 1837.
[81] NRS GD417/193, Report on Children's Education, 1844.
[82] Marguerite Wood, 'St. Paul's Work' in *The Book of the Edinburgh Old Club*, 17. Vol. (Edinburgh, 1930).

Orphan Hospital from in 1733. Textile production for subsistence, however, remained a staple of the orphanage throughout the long eighteenth century. During the initial venture, between November 1733 and November 1734, the 30 resident children spun 89 stone and 11lb of yarn, or about 24lb a week between.[83] This compared with the average spinning of between 1 and 3lb per week by an experienced spinner.[84] Importantly, most of the wool spun was used within the workshop to produce broadcloth used for making work clothes for boys, aprons and petticoats for girls and bedding for the hospital's use. Linen cloth was also produced and made into shirts and shifts. The children also produced woollen stockings. Of the 1,080 yards of broadcloth woven within the first year, only 196 yards was sold, rendering the profits of the workshop by no means adequate to covering the cost of the master weaver and the general running of the workshop. On the other hand, the remaining 884 yards of cloth were used to make clothing for the children, including at least 150 shirts, 30 blankets and 127 pairs of stockings.[85] Whilst a short-lived venture, the incorporation of the orphanage into textile production shows the institution's rootedness in the 'improvement' project. As I have argued elsewhere, such initiatives were not unique to the hospital or the Edinburgh context, but instead were symptomatic of tenets of the Scottish 'improvement'.[86] As suggested by Gairdner, the institution was to be of 'great advantage to the Country, because the Orphans might be employed in spinning, and other useful Parts of the Linen and Woollen Manufactures, that 4d. rightly employed towards their Support, if under good management, would go a greater Length than 16d. employed in Charity', stressing both the productive potential of the hospital and the long term effects of education and vocational training on the children.[87] With the abandonment of surplus production for sale, the workshop remained in operation for subsistence production in the following years. Additionally, the hospital continued to outsource spinning by distributing wool for spinning to outworkers even after the children no longer took part in for-profit spinning. Whilst the hospital's revenue continued to grow considerably, the emphasis on self-sufficiency, at least in relation to textiles, remained strong until the late nineteenth century, when the hospital turned its focus to educational provision, including as a day school for paying pupils.[88] Once again, the emphasis on self-sufficiency and subsistence

[83] NRS GD417/33, Historical account of the Orphan Hospital, 1734; NRS GD417/262 Records of Orphan Hospital manufactory and Paul's Work. Spinning book, 1734-7.
[84] Many thanks to Juliette Desportes for providing the evidence on female spinners' earnings.
[85] This is calculated at just under 2 yards of cloth for a shirt and just over 3 yards for a blanket. Counts of cloth available: NRS GD417/33, Historical account of the Orphan Hospital, 1734.
[86] Eliska Bujokova, Juliette Desportes, 'Poor Relief as 'Improvement': Moral and Spatial Economies of Care in Scotland, c. 1720s-1790s', *Continuity and Change,* 38:2 (2023).
[87] Maxwell, *Select Transations*, 443.
[88] NRS GD417/37.

production mirrors the household economy as practiced by household-families. Making clothes in the hospital was initially adopted due to cost-efficiency. Whilst a tailor continued to be employed to aid with textile production and mending clothes, most articles of children's clothing were outsourced by the 1820s at which point more time was dedicated to training the girls in domestic chores and to learning for both girls and boys.[89] With the general decline of the linen industry in Scotland in the 1820s, the orphanage's emphasis on the children's employability led to a large part of the textiles training being abandoned.[90]

Children's labour as much as instruction and provision remained an integral element of the institution's role, with its long term reformatory potential being highlighted over its role as a provider for the dispossessed. In spite of the similarities between the institutions' regimes and emphases on labour, the hospital never associated with the city's Charity Workhouse. Rather than deterrence from dependency on relief, which was the objective of the workhouse, the role of the Orphan Hospital was preventative and reformatory. The reformatory potential had its limitations, only extending to those not yet marked by poverty, however.[91] The emphasis on practical instruction as well as material self-sufficiency formed a large part of the justification made to the hospital's funders, especially in the first 30 years, but also fulfilled a practical role. The institutional household as the locus of labour and subsistence production thus resonates with eighteenth-century household composition more broadly with its comprising of blood-family, paid help, apprentices and lodgers who collectively contributed to a shared welfare optimisation strategy. Such households, whilst hierarchized, were organised along the lines of age and gender rather than an opposition between family members and cohabitants. Especially when married couples were hired as joint masters and mistresses, the blending of biological/legal families with institutional ones becomes apparent.

Bringing up children to find work as servants and journeymen, preventing idleness and fostering labour discipline and relieving their families in times of hardship remained key throughout the period. It resembled the ways in which 'natural' families brought up children with their future contributions to their collective familial welfare in mind. In January 1840, Mr Tawse, one of the hospital visitors from the incorporation reported on the employment of children in the sick room in 'working stockings and doing so cleverly

[89] NRS GD417/5, 360.
[90] See for example: Christopher A. Whatley, *The Industrial Revolution in Scotland* (Cambridge, 1997); *The Oxford Handbook;* Anthony Cooke, 'The Scottish Cotton Masters, 1780–1914', *Textile History*, 40:1, (2009); Stuart M. Nisbet, 'The Making of Scotland's First Industrial Region: The Early Cotton Industry in Renfrewshire', *Journal of Scottish Historical Studies*, 29:1 (2009).
[91] NRS GD417/3, Aug 1789.

and well'.[92] One of the boys who was confined with a knee injury was commended for 'employing himself working stockings' of which 'he has already made 16 pairs'.[93] Handiwork and making stockings was a common pursuit in workhouses and infirmaries, with such institutions participating in the large network of putting out industries whilst using labour as a remedy for idleness.

Most housework and maintenance was divided between female servants and resident children, especially older girls. The mistress appointed 'two or more of the girls by turns to attend her to mercate, and carry home the meal and in dressing the victuals'.[94] Additionally, the girls were to be 'aiding and assisting to the servants in washing and cleaning the linen, in sweeping washing and cleaning the house and in baking and brewing'.[95] The division of labour reflected the emphasis on efficiency and economy, with the number of servants being determined by the number of children and their ability to carry out household labour. In 1739, the mistress required an additional female servant to aid the existing three in 'washing and dressing the Cloaths of the Hospital, making ready the victuals, brewing, cleansing the house, making the beds and combing the children's heads', exacerbated by the 'biggest of the Girls going out to service [which] will render their work heavier'.[96] In the end, a man-servant was hired to 'dress the yards and dress the victuals', allowing the female servants more time to spin.

The blurry division of maintenance and subsistence work between servants and resident children reflects the complexities of institutional cohabitation. The strong resemblance with a household-family is not incidental, with the idea of all cohabitants contributing to the maintenance and subsistence of the shared household being present across familial as well as institutional spaces. Additionally, the participation of children and servants in the spinning venture shows the place of for-profit production in addition to subsistence production that remained integral to household management throughout the period. Moreover, it shows the broad conceptualisation of labour in the hospital in opposition to leisure, not defined by the generation of profit. This serves as a reminder of the secondary nature of cash payments in the contemporary conceptions of work throughout the long-eighteenth century, instead situating most work within broader moral and subsistence economies. The merging of responsibilities of paid staff and resident children at the same time points to the absence of a binary between paid and unpaid work, instead situating both within a broader, collective pursuit of 'making' a living.

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[92] NRS GD417/168,1840.
[93] *Ibid*.
[94] NRS GD417/1, 365.
[95] *Ibid*. 365.
[96] NRS GD417/15, 300.

Children continued to take part in the maintenance of the house throughout the period, with an emphasis on efficiency as well as the use of labour as a didactic tool. In March 1749, a member of the visitors' committee suggested boys' employment in garden maintenance, for which they should receive a 'two pence or a farthing' in order to get accustomed to 'reaping the benefits of labour'.[97] The visitor suggested that whilst the girls were employed in spinning in the morning and evening hours, the boys had no employment and their time should be better used, with both girls and boys receiving small payments for their work.[98] Similarly, in September 1840, William Fraser, a member of the visitors' committee suggested the boys should be engaged in weeding the garden, which could 'be done at little trouble and expense', whilst saving the time of the gardener and warder.[99] Additionally, children were sometimes required to aid in managerial and educational as well as manual tasks, as shown by the example of William Wright, a resident boy, who was required to aid the master MacDonald in various duties including teaching the younger children, when the master was incapacitated by caring for his dying wife. Upon leaving the hospital, William was paid 3 guineas for his aid.[100] The continuity in division and gendering of work as well as the deployment of labour as a didactic tool illustrates the continuity in the orphanage's management as well as its place within the community. Coming back to the familial composition of the establishment, the ways in which labour was shared fostered a sense of interdependency and collaboration, which prepared the children for future employment.

Relations between resident children and domestic staff in the orphanage were imagined in collaborative and convivial terms, where they shared in the maintenance work, and oftentimes, older female children took up the position of servants, which was rarely the case in hospitals that took in children of higher status. Similarly servants, often not much older than the resident children, took part in spinning and textile production, which enabled them to pursue more profitable employment in the future. For example, in 1734, the hospital's manservant left his post to work as a wool-comber, a skill he acquired at the hospital. As an expression of gratitude for receiving gratuitous training, he continued carrying water for the hospital, maintaining links with the establishment through reciprocal relations of obligation organised in conjunction with skill, labour, cash and kind as concurrent currencies. Resembling the complex composition of the household-family consisting of legal and blood relations, paid help, apprentices and casual labour, relations

[97] NRS GD417/18, March 1749.
[98] *Ibid*.
[99] GD417/168, September 1840.
[100] NRS GD417/4, December 1812.

were not always strictly hierarchized, instead operating through varied bonds of familial, contractual and residential origins characterised by their physical temporality and flexibility, as well as lasting ties of gratitude and friendship, obligation as well as affection. Patterns of labour, their symbolic value and the makeshift and subsistence economies within which they operated can thus serve as a way of accessing residential patterns and relations between the hospital's residents, employees and managers, fleshing out a mosaic of complex bonds that went beyond the institution's walls. The internal economy of the hospital at first glance resembles the theoretical framing of Erving Goffman's 'total institution'.[101] Goffman's insistence on 'binary management', which prescribes a strong degree of polarisation between the staff/managers and the inmates, seems reductionist in describing the complex relations of cohabitation, sharing of labour and blending of nuclear and institutional families across the domestic/institutional dichotomy. Applying the household-family model, I argue, provides a more encompassing lens for capturing relationships of co-residence, labour distribution, and spatial arrangements, as well as practices of discipline, education and affective care than the Foucauldian narrative of control through confinement. Relations of parent-like oversight by the master and mistress included servants as well as children, with both answering to the master and mistress, receiving discipline and instruction. Mirroring the hierarchies between masters and servants, apprentices, as well as children, the institution's formation thus followed a traditional imagining of a household economy organised along complex hierarchies of seniority, status and gender.

5.4 Family and Friends: Kinship Ties and the Temporality of Care

In January 1786, Janet Campbell, the widow of John Campbell, 'late soldier in the Royal' petitioned the hospital for the reception of her son Daniel, supported by a minister, a deacon and two of the city's elders. Janet's petition, or rather a petition written on her behalf, stated that she was a mother of five, 'who are all still alive', and for 'whose maintenance and her own She has toiled in the best manner she was able, and by the blessing of God has been enabled to Keep them alive'. But as '[s]he is utterly incapable to procure for them a proper education', she requested a place for her eight-year-old son.[102] Like Janet, the mother of Margaret Farquharson, another presentee, was a 'poor widow with five helpless orphans', who 'labours hard to support them'. After the loss of her husband's income, however, she was unable to keep the family afloat and her second born,

[101] Goffman, *Asylums*, xiii.
[102] NRS GD417/185, Janet Campbell, 1786.

the seven-year-old Margaret, was thus recommended for a place at the hospital.[103] Similarly, Janet Hastie, widow of William Hastie, 'late labouring servant to Lord Gardenston', was left with seven children between the ages of fourteen and four months 'in very poor indigent circumstances'. Two of Janet's children were employed in service and 'one of them a friend keeps out of Charity'. Unable to maintain the remaining four, she petitioned the hospital to take in her nine-year-old son James, recommended by John's employer Lord Gardenston.[104]

Janet Campbell, Mrs Farquharson and Janet Hastie were not unusual amongst the hospital's petitioners, as most children admitted were not orphaned, but had lost one parent, which led the remaining family to financial strain. The archive of the Orphan Hospital contains 126 petitions sent to the hospital by families and friends, hoping for the admission of children. Majority of the surviving petitions were received between 1774 and 1834. They detail the circumstances of the children's families and provide evidence of the occupational structure of the hospital's admittees. Most children came from families of servants, farmers and small artisans such as shoemakers, tailors and bakers, but also service people such as coachmen, porters and carters.[105] Many fathers served as soldiers, but also teachers and schoolmasters. Mothers generally described earning a living through piecework, such as Jean Comb, who had been maintaining her children through work in 'spinning, washing and dressing clothes and other such like work'.[106] Many mothers also worked as servants and some were engaged in care work, such as Isobel Brunton who was employed as a sick-nurse and servant in the Royal Infirmary, gaining support from the physicians Henry Cullen and James Hamilton in her petition to the hospital.[107]

Only 27 involved children described as having lost both parents.[108] The word orphan appeared in nearly all petitions, broadly signifying parental loss. John Cant, a child presented in 1788 by the frequent patron William Forbes was described as 'an orphan in the most complete sense of the word', suggesting that he lost both parents.[109] Eight presented children lost neither parent, though often one of the parents had abandoned the family, or they were unable to work due to illness. Eighteen had lost a mother and the remaining 69 had lost a father. This can be attributed both to the greater precarity faced by single mothers struggling to find suitable employment, but also the higher life expectancy

[103] NRS GD417/185, Margaret Farquharson, 1786.
[104] NRS GD417/185, Janet Hastie 1786.
[105] Most petitions available from the period between 1784 and 1789; GD417/175 Admissions book, 1829-33.
[106] NRS GD417/186, Jean Comb, 1788.
[107] NRS GD417/186, Isobel Brunton, 1788.
[108] NRS GD417/183-8.
[109] NRS GD417/186, John Cant, 1788.

of women, lower age of women compared to men upon entering marriage, and men's greater propensity for remarriage, resulting in greater numbers of widows than widowers. As suggested by Williams, 'women were far more likely to fall into poverty than men due to insecure employment (with large numbers of domestic servants) and lower pay, plus they were open to the risks of bastardy as well as the death or desertion of a spouse'.[110] Petitions presented by widows and widowers both emphasised the remaining parent's inability to provide both material subsistence and physical care, demonstrating the dependence of the family economy on the 'two supporter model'.[111] Echoing Tim Hitchcock's conclusion that it was virtually 'impossible to be a single mother in the modern sense', single fathers met with similar hardship, although they had a greater earning capacity.[112] In 1785, John Sanders petitioned for the admission of his daughter, being unable to provide for his 6 young children having lost his wife, which 'greatly adds to the petitioner's dificultys'. Having earned his living as a soldier for 26 years, John was advanced in age and only able to earn a 'small pittance', a struggle too often described by single mothers having to combine making a living and providing for young children.[113] William Sutherland, a widower who presented his son David in 1787, struggled after having lost his wife after a long illness, 'rendering her unable to do anything for a family of five young Children the Eldest only about 12 years of age'. Additionally, the family spent their remaining reserves on her care and funeral expenses, leading to their destitution.[114] The financial strain of burying a spouse was invoked by many petitioners, in terms of lost income and diminished resources, with families selling the little furniture and clothes they owned to provide for the dying member as well as the rest of the family. The petitions sent to the hospital by poor fathers demonstrate that such outcomes were the result of losing a second earner and a care provider, highlighting the value of both paid and unpaid labour to the domestic economy. In 1789, Peter McGlashan, a flax dresser, petitioned for the admission of his son James, being unable to provide for his 5 infant children. Peter's wife died of cancer after receiving frequent treatment in the Royal Infirmary. He continued to labour whilst also receiving a pension of 6 shillings a week from an unspecified source, leaving little time to care for his children, though allowing him

[110] Williams, *Unmarried Motherhood,* 113.
[111] Maria Ågren, *Making a Living, Making a Difference: Gender and Work in Early Modern European Society*, (Oxford, 2017), M. Ågren, 'Making Her Turn Around: the Verb-Oriented Method, the Two-Supporter Model, and the Focus on Practice', *Early Modern Women: An Interdisciplinary Journal, Arizona Centre for Medieval and Renaissance Studies*, 13:1 (2018).
[112] Hitchcock, 'Unfawfully Begotten on her Body', 77-8.
[113] NRS GD417/184, John Sanders, 1785.
[114] NRS GD417/185, David Sutherland, 1787.

to keep 'a person to take care of them'.[115] Paid childcare was an option selected by many single parents who could obtain the money to afford it, supplementing the unpaid care work provided by the missing spouse. For most petitioners to the hospital, this option remained out of reach, resulting in their reliance on unpaid networks and complex welfare strategies, including institutional care.

The case of the Hastie family reveals in just a few lines the complex welfare strategy collectively undertaken to survive and maintain one another in the absence of a father. Paid work and especially live-in domestic service, fostering, as well as institutional care were employed as strategies to alleviate the pressures faced by poor families. As suggested by many such petitions addressed to the orphanage, most mothers and widows were engaged in employment, which they combined with childcare and domestic work. The income gained through paid work, was however, insufficient to provide for themselves and their numerous and often very young children. Placing some of their children with relatives or 'friends' or in institutionalised care was thus a way of providing for them, but also freeing up time for additional paid work that would enable the maintenance of the children that remained in the household. Whilst extended families and networks of fictive kinship were habitually employed to alleviate the pressures of destitution as cited by the petition of Janet Hastie, these were not always adequate. Drawing on the interweaving frameworks of institutional provision and patronage of landed gentry, such families were able to decrease the number of members to be clothed, fed and maintained whilst furnishing them with a better chance of securing gainful employment in the future. The desirability of the education provided by such an institution was clearly recognised, raising suspicions amongst the contributors and managers that the claimants were true 'objects of charity'.[116] For such families, institutions such as the Orphan Hospital thus represented both short and long-term solutions by offering a temporary relief to their composite budgets, as well as allowing one of their members to contribute to the family income once ready for employment. As suggested by Marfany and Carbonell, therefore, 'rather than seeing institutional care as a negation of family ties, expressed most starkly in the notion of 'abandonment', use of the workhouse could be the best means by which families could meet a duty of care to dependents'.[117] As shown by Williams, in spite of the dismal conditions in workhouses and their primary function to deter the poor from drawing relief, the ability of poor mothers to rely on the basic medical provision they offered should not

[115] NRS GD417/187, Peter McGlashan, 1789.
[116] NRS GD417/1, 251.
[117] Montserrat Cabonell-Esteller, Julie Marfany, 'Gender, life cycle, and family 'strategies' among the poor: the Barcelona workhouse, 1762-1805', *Economic History Review*, 70:3 (2017), 1.

be overlooked. Additionally, the use of the workhouses as places of temporary abode when out of service or post lying-in was a crucial component of the survival strategies devised by poor women.[118] Alongside workhouses and foundling hospitals, orphanages were similarly utilized in times of need and represented a key resource poor families could utilise in the hope for their children's better futures.

The complex relations between families and institutions as care providers is key in our understanding of the welfare economy, but also the imagining of the hospital as a family unit in its own right. As previously stated, the hospital's role was supplementary, a tool of maintaining social order and preventing greater numbers of the lower classes from falling into destitution as a result of downward social mobility, death, un- and underemployment, or the pressure of caring responsibilities felt by single parents, especially mothers of large families. In 1788, Primrose Cameron petitioned on behalf of her son, Robert. Primrose's late husband was an upholsterer and once prosperous, and she herself had had a dowry upon marriage. He, however, failed in his business, spending all of the family's money in the process, resulting in the destitution of his wife and four children. Primrose believed, that 'as a person who has seen better dayes but is reduced by misfortune, has surely a strong claim for compassion', thus arguing for her son's right to be admitted.[119] The hospital would have recognised Primrose's claim as legitimate, playing a role in preventing the family's situation worsening, acting as a defence from downward mobility. This rhetoric was echoed in numerous petitions, with claimants increasingly emphasising 'having seen a better life'.[120] For many the hospital became a hope for granting their children education and improving their chances in life, as opposed to preventing destitution, reflecting the diverse background of petitioners ranging from impoverished single parents often labouring under various health conditions, to those once prosperous whose fortunes had turned. Having experienced downward social mobility, which caused their needing to rely on institutional structures, many claimants' social identity remained unaffected despite the change in economic circumstances. Institutional support thus served as a way of propping up those vulnerable to the volatile economy.[121]

Whilst most of this thesis draws on top-down sources that offer insights into the developments of welfare policies, institutions and the place of care and provision in contemporary economic thought, it is clear that institutions such as the orphanage were not

[118] Williams, *Unmarried Motherhood*, 111-165.
[119] NRS GD417/186, Primrose Cameron, 1788.
[120] NRS GD417/186, Dr Grant, 1788.
[121] See for example: Tawny Paul, 'Losing Wealth, Debt and Downward Mobility in Eighteenth-Century England' in David Hitchcock and Julia McClure, *The Routledge History of Poverty, C. 1450-1800* (London, 2020).

only instruments of reform as maintained by historians of the poor laws, but also important components of the welfare strategies devised by poor families.[122] The everyday reality of institutional life as experienced by children and staff who likely shared past experiences of poverty and precarity cannot be divorced from its top-down orchestration by the better off gatekeepers of the institutions' walls. At the same time, however, the choices made by institutional residents and their families need to be recognised, in an attempt to move away from histories of care experienced people and their poor carers as acted upon, choiceless subjects of their benefactors. Availability and adequacy of welfare provision alongside socio-cultural patterns of family formation were key components that shaped residential relations and survival strategies of the poor.[123] As demonstrated by Hitchcock in London, Zucca Micheletto in the case of the Savoy-Piedmont state and Marfany and Carbonell in the context of Barcelona, orphan institutions and workhouses can be viewed as spaces that were utilised by the poor, in varying degrees and lengths of stay as ways of easing off the pressures faced by families and single parents in times of hardship caused by economic crises, failed harvests as well as incidents of sickness and death.[124] Again refuting the 'total institution' paradigm, the relationship between the institution and the children's families and patrons suggests a greater permeability of institutional space and the longevity of the children's familial ties, in spite of being only allowed limited contact whilst at the hospital.

Crucially, children were accepted with the promise of long-term provision until they were able to gain employment, however, when their family situations changed or a relative was able to take in a child, the hospital readily accepted the families' right to care for their own children. In May 1739, Richard Douglas was taken out by his uncle, who promised to keep him in school until his relative John Young Mertt, living in Cadiz, was able to provide for him.[125] In 1740s, Isobel Guthrie and Mary Paterson were taken out from the hospital by their mothers and returned to their familial households. The hospital continued to contribute to their maintenance despite their departure, paying the mothers a shilling each per week, about £2 13s annually, roughly half the expenditure per child in the hospital.[126] In the same year, Alexander Dick was taken out by his grandmother, also receiving a shilling a week for his maintenance as well as a pair of breeches. The managers

[122] Frank Crompton, *Workhouse Children* (Phoenix Mill, 1997), 228; Hitchcock, 'Unfawfully Begotten on her Body'; Williams, *Unmarried Motherhood;* Cabonell-Esteller Marfany, 'Gender, Life Cycle, and Family 'Strategies''.
[123] Elena Moore, *Generation, Gender and Negotiating Custom in South Africa* (Oxford, 2022).
[124] Hitchcock, 'Unfawfully begotten on her body', Zucca Micheletto, 'Husbands and Cabonell-Esteller, Marfany, 'Gender, Life Cycle, and Family 'Strategies''; Ulbricht, 'The Debate about Foundling Hospitals'.
[125] NRS GD417/17, 53.
[126] NRS GD417/17, Feb 1740.

were informed that his grandfather living in Annandale was a person of substance and thus fit to provide for the boy who had spent five years in the hospital.[127] Accordingly, children's removal did not always result in severing ties with the hospital, which often continued to provide modest contributions to the children's upkeep and clothing.[128]

Throughout the years, families' removing children when their situations improved remained commonplace and was generally favoured by the managers. Such arrangements made economic sense to the hospital, who paid less for the children looked after by their parents whilst still preserving their role as arbiters in the children's families' relations, in this case aiding the families to stay together rather than separate. In June 1828, Robert Barrowman was taken out by his uncle, Thomas Barrowman, who had found an apprenticeship with 'one of his Relations who is a Hatter in Dalkeith, and in good business to take him as an apprentice'.[129] In 1849, John Wilson was taken from the hospital to join his uncle in America, supported initially by another uncle living in Scotland. Given his early departure, the hospital contributed to his clothing and the passage to America by allocating between £5 and £10 for the purposes. Marion Watson was also taken out from the hospital to join a relative in Australia, receiving a guinea from the institution upon departure.[130] When children continued on to an apprenticeship, the hospital occasionally involved their families in providing their bed and board, and contributing towards the costs, with the hospital's oversight. In 1811, David Ferguson was apprenticed to Robert Stewart, shoemaker, who agreed to commence paying his salary after the first half-year of service, until which point, David's mother, widow Ferguson provided the boy 'in bed, board, clothing etc.'.[131] Likewise, Alexander Hall, shoemaker, requested Mrs Hamilton, the mother of two boys indentured to him by the hospital, to 'uphold them in Bed board washing and Clothing during the whole term of the Indentures' for which he would pay her 'half a Crown a week' during the first year and 'during the remaining five years […] half of their earnings'.[132] As indicated above, such arrangements served as a contribution to the family's livelihoods whilst furnishing the apprentices with training that would afford them a stable income in the future.

When children remained in the hospital, however, family ties were often severed, with the hospital's administrators perceiving the children's families as corrupting influences, suggesting that 'if their parents especially Mothers are in or near the city, they

[127] *Ibid*.
[128] NRS GD417/17-18.
[129] NRS GD417/5, 487.
[130] *Ibid*.
[131] NRS GD417/189, 1811.
[132] NRS GD417/189, June 1810.

become great plagues of the hospital, and even when the children are put out to business, carry them away from their masters or mistresses to the great dishonor of the hospital and trouble to the treasurer'.[133] Families of admitted children thus had to accept physical separation as the cost of gratuitous education and enhanced employment prospects offered to the children upon leaving. The families were making a trade off in the hope for better futures for their children, who thus faced physical separation and the imposition of a strict institutional regimen. Judging by the many cases of children leaving the premises, going off 'on explorations' or visiting their families and friends without permission, the transition to the strictures of the hospital's regimen cannot have been easy.[134]

As reflected in the minutes, children leaving the hospital without authorisation was the most common cause of reprimand or punishment, occasionally resulting in expulsion.[135] Whilst in the early days of the institution children were free to visit their families and leave the premises in afternoon hours, this changed with the tightening of the daily regimen and growing anxiety about contagion, both medical and moral, with mid-nineteenth century statues preventing children from leaving the premises altogether.[136] As shown by Felix Driver, isolating children from 'moral infection' was an objective of hospitals such as the Orphan Hospital, with the increased social and moral rather then economic perception of pauperism.[137] In 1843 three boys were severely reprimanded for leaving the hospital by being placed in solitary confinement for ten days on a diet of bread and water and one of them received flogging as an additional punishment.[138] In spring 1849, two boys received public scolding for leaving the premises without permission, showing the limits on the master and mistress' benevolent 'parenting'.[139] The hospital's walls were only permeable when the management permitted, with children as well as staff likewise disallowed free movement in and out of the premises, a reality that points towards the element of control of the inhabitants' time, space, activity and association that lay beneath the surface of institutional cohabitation. Whilst more porous than portrayed by the traditional narrative of the total institution, the limitations on mobility of both staff and children highlight the frontiers of institutional families, in contrast to more organic, flexible and ever-changing relations in households formed outwith institutional structures.

[133] NRS GD417/3, August 1789.
[134] NRS GD417/5, Jan 1823.
[135] NRS GD417/1-6.
[136] NRS GD417/3-6.
[137] Felix Driver, *Power and Pauperism* (Cambridge, 1993), 100.
[138] NRS GD417/6, 1843.
[139] NRS GD417/6, 1849.

5.5 Conclusion

Building on the discussion around public care provision in this thesis, this chapter focused on the overlapping of familial and institutional forms of care in a residential establishment. It has aimed to shed light on the practical implementation of Scottish reformism and its implications for our understanding of care work, cohabitation and the notion that the family was where most of the labours of care and social reproduction took place. Labour, carried out by both children and staff residing in the Orphan Hospital and Workhouse at Edinburgh, thus formed the entry point of my enquiry into institutional structures, hierarchies and relations of cohabitation, control as well as affection. Refuting the binary view of the institutions' inhabitants as divided between the powerful and powerless or Goffman's model of impenetrable 'total institution', it was my aim to reinsert the study of institutional care within the context of the family and the mixed economy of welfare.[140] Thinking about the parallels between familial and institutional structures, I have highlighted the myriad ways in which individuals and families struggled to optimise their welfare strategies, provide for their dependants and relieve the pressures of economic hardship. Focusing on the experiences of the hospital staff, I have highlighted their lived experiences of residential employment, alone or alongside their families and dependents. I have aimed to point towards the complexity and variedness of institutional employment, and the associated patterns of co-habitation, resulting on the one hand in the incorporation of biological families into institutional structures, and on the other the separation of families as a result of institutional employment. I have examined the role of institutions as spaces utilised by the poor as part of their survival strategies, thus refuting their sole perception as top-down spaces of coercion and control. The household-family model of institutional formation encompasses the experiences of both staff and resident children, allowing the study of institutional cohabitation in less binary terms than habitually perceived. Studying the idealised forms of the family in the institutional example admits for a better understanding of the notions and concepts of the family held by contemporaries, as well as the social structures that upheld the care economy that forms the subject of this thesis. Through case studies such as this one, I have argued, we are able to gain a greater understanding of the composite forms of care as conceptualised, experienced and practiced. At the same time, centring the experiences of residential staff, we can shed light on the various forms of care work that upheld the emerging structures of the expanding state and its role as a provider, overseer and arbiter of care.

[140] Foucault, *Discipline and Punish;* Foucault, *The History of Sexuality*; Foucault, *The Archaeology of Knowledge*; Goffman, *Asylums*; Horden, 'Household Care and Informal Networks'.

6 Tending to 'His poor and sick brethren': Medical Philanthropy, 'Improvement' and the Poor Law Reform

> Where with the Blessing of GOD, their bodily Diseases may become the Means of improving their Minds, and correcting their Morals, and of making them experimentally to feel and know, That it is good for them to have been afflicted.[1]

As proposed by the managers of the Edinburgh Royal Infirmary, the aim of medical philanthropy was not only mending bodies of the sick poor, but also reforming their minds and souls. Situating thus the voluntary hospital movement within the 'improvement' context, the last chapter of this thesis takes a look at the emerging medical institutions of Edinburgh and Glasgow. Through a long durée institutional case study, I aim to flesh out the history of the care regime transition described in Chapter 2. Through the lens of institutional history, I demonstrate the shaping of care infrastructures at the centre of the emerging welfare state, in response to socio-economic, demographic and epidemiological pressures. As previously shown, Scottish attitudes towards the poor differed from the discourse south of the border, focusing on fostering a sense of independence and self-reliance in the poor through strong opposition to welfarism and preference for familialism. Rooted in the combination of reason and religion, charitable provision was conceptualised as both social glue and a tool of reform, imbuing its beneficiaries with the sense of gratitude that would divert them from the path of idleness. In the absence of a developed network of workhouses, the Scottish institutional landscape built for the purpose of reforming the poor relied on establishments such as infirmaries, orphan hospitals and industrial schools. These establishments were to function as instruments of reform, at the same time relieving the poor and building a labour capital that would enable the economy to flourish.[2] Medical provision, as highlighted, was integral to relief and was equally shaped by the 'improvement' mindset.

Eighteenth-century medical philanthropy has been studied from a variety of angles. In 1980, H. W. Hart suggested that 'one of the noblest characteristics of the eighteenth century was the great growth of organised voluntary effort for the relief and care of the sick'.[3] More recent scholarship emphasized the secularizing tendencies of the British

[1] Lothian Archives (LA) LHB1/5/2(i), History of the Royal Infirmary of Edinburgh, 1749.
[2] Eliska Bujokova and Juliette Desportes, 'Poor Relief as 'Improvement': Moral and Spatial Economies of Care in Scotland, c. 1720s-1790s', *Continuity and Change,* 38:2 (2023).
[3] Amanda Berry, 'Community Sponsorship and the Hospital Patient in Late Eighteenth-Century England', in Peregrine Horden, Richard Smith (eds.), *The Locus of Care*, (London, 1997), 3; H.W. Hart, 'Some Notes on the Sponsoring of Patients for Hospital Treatment under the Voluntary System', *Medical History*, 24 (1980), 447.

voluntary movement, envisioned as examples of civic humanity of the *modern* state.[4] As suggested by Louis Greenbaum, the voluntary hospital movement combined social, moral, economic, political, religious and legal motives with increased attention to the urban physical environment.[5] Focusing on institutional finances, Amanda Berry has shown the rootedness of the institutions in their local economic climates, built in response to local medical needs.[6] By situating medical philanthropy within the broader context of the 'improvement' project, however, its depiction as a humanitarian secular institution no longer holds. Contrarily, as highlighted by Fissell, returning recipients of medical relief to productive work was the objective behind hospital foundation.[7]

My conceptualisation of medical philanthropy builds on Fissell's, positioning the phenomenon as an extension of the growth-oriented and nation-building endeavour of the elites, who saw the population as a resource to be managed, cultivated and employed to fuel Scotland's economy. As shown by Erica Charters, the eighteenth-century British state was a bigger agent in the advancement of medicine and welfare structures then assumed under the medical marketplace thesis discussed in Chapter 4.[8] State populationism on the domestic scene was inextricable from the imperial context, linking medical developments and philanthropy to colonial sources of revenue on the one hand and the conceptualisation of human capital on the other. In this climate, medical institutions emerged as instruments of reforming the population, cultivating the nation's greatest asset. Rather than replacing traditional and familial forms of care that encompassed practices of healing, private and public philanthropy devised ways in which these practices were supported in order to preserve the role of the family and community as the principal locus of care, in sickness and in health. Medical charity was given out in exchange for gratitude and deference that was to secure the future industry of the afflicted, both as providers for their kin as well as workers. Following the transition from populationism to population control, medical institutions in turn became spaces of containment, preventing the spread of contagion from the urban poor to their social betters. As such they were at the forefront of the debates surrounding poor law reform firmly linked to the conceptualisation of public health that removed the responsibility to care from the private realm, placing it firmly as a concern of

[4] Porter, Roy, *Disease, Medicine and Society in England, 1550–1860*, second edition (Cambridge, 1993).
[5] Louis S. Greenbaum, *The Commercial Treaty of Humanity; La Tournée des Hopitaux Anglais par Jacques Tenon en 1787* (Paris, 1974).
[6] Berry, 'Community Sponsorship'.
[7] Mary Fissell, 'The 'Sick and Drooping Poor' in Eighteenth-Century Bristol and its Region', *The Society for the Social History of Medicine* (1989).
[8] Erica Charters, *Disease, war and the Imperial State: The Welfare of the British Armed Forces during the Seven Year's War* (Chicago, 2014).

the body politic. This chapter thus places the development of medical philanthropy at the core of the nation's transition to extractive capitalism that increasingly relied on outsourcing social and medical provision to institutional structures. Instead of situating the emergence of voluntary hospitals in the modernisation narrative of rising humanitarianism, I thus highlight its rootedness in the imperial 'improvement' project, in this case enacted through focusing the transformation of the sick poor through bestowing charity.

This chapter commences by outlining the origins of the Edinburgh and Glasgow Infirmaries and the Glasgow Town's Hospital, their internal structures and labour relations. It then highlights their colonial legacies, placing medical philanthropy within the context of the imperial project. The latter part of the chapter focuses on the nature of the 'fever' epidemics as a catalyst for change in the infirmaries' structures and their broader implications for the metropolitan contexts. Situated against the backdrop of public health debates, it traces the infirmaries' transformation from 'voluntary hospitals' constructed to provide for a limited number of sick poor, to their becoming public institutions embedded in the structures of the New Poor Laws. Increasingly becoming spaces of *public* provision rather than instruments of private patronage, the hospitals thus serve as an example of the expanding legalistic, rights-based approach to welfare. This shift, I argue, was driven by the growing association between poverty and disease and subsequent corruption of the public space, undermining the traditional notion of the utility of poverty. In conjunction, the two sections of the chapter shed light on institutional care provision within the context of changing care regimes, highlighting the historicity and contingency of care.

As proposed by Fissell, medical relief had always featured in the composite provision for the poor and its separation from the rest of welfare and care provision seems anachronistic.[9] The 'sick poor' were recognised as a transient category, moving between the 'deserving' and 'undeserving' poor, and their public provision represented a preventative measure, aimed at precluding them from permanent pauperisation which could be brought on by a variety of crises. Unlike in the case of the 'able-bodied', provision for the sick and infirm was recognised as a legal responsibility by parishes, which translated in medical relief being dealt less sparingly than ordinary payments for everyday sustenance.[10] Accordingly, 'poor relief, as well as the health care provided by it, needs to be understood as part of a larger propping-up of domestic economies in an environment in which disaster, be it illness or the lack of work, might occur at any time'.[11]

[9] Fissell, 'The 'Sick and Drooping Poor'.
[10] Steven King, *Sickness, Medical Welfare and the English Poor, 1750-1834* (Manchester, 2019), 95.
[11] Fissell, 'The 'Sick and Drooping Poor'.

Illness was indissoluble from poverty, and its direct experience or it leading to caring needs of the sick person's dependants often meant downward social mobility for individuals and families. Relief in sickness was generally only temporary, however, with the bounds between the 'deserving' and 'undeserving' being only loosely defined, depending on discretion of those in charge of relief distribution. As a result of eighteenth-century medical developments, sickness ceased to be recognised as an everyday reality of poverty that should be endured, coinciding with the increased curability of conditions and effectiveness of medical intervention. As Steven King suggests, 'against this backdrop of rapid change in understandings of health and ill-health for the wider population', diseases of the poor became a subject of greater attention, not least in medical institutions.[12] As recognised by the Edinburgh Destitute Sick Society, a charity established in 1704 to provide temporary relief for the sick poor, 'poverty creates and aggravates many kinds of disease; while disease, again, by adding largely to the expenditure of a family, often leads down in not very long time to destitution, especially when it is the head of the family, who is usually the breadwinner, that is laid prostrate'.[13] As this chapter will show, it was the combination of increased curability of diseases, greater availability of *public* medical relief and the growing anxiety around contagion that contributed to the medicalization of poverty.

Historically, therefore, the sick poor received more sympathetic treatment than the 'ordinary' or able-bodied poor, as a tool of top-down family preservation in times of hardship. It was in the context of 'improvement', however, that this aid came to be imagined as a form of investment meant to restore the recipient into productive health for the benefit of the wider society rather than the immediate family unit.[14] Over the course of the century, spending on self-help and medical advice by the poor grew exponentially, and so did the medical component of poor relief sponsored by the parish or friendly societies.[15] By the early nineteenth century, medical attention to the poor was expanded further yet, primarily as a way of curbing the danger of spreading contagion to their social betters. The foregrounding of medical relief thus gave rise to numerous establishments, wherein the voluntary hospitals examined here only represented a small segment of medical relief available in the mixed economy of welfare. Whilst they were envisioned as top-down structures of reform, they also served as spaces that poor patients used and navigated,

[12] King, *Sickness,* 13.
[13] LA GD10/3/1 *Society for the Destitute sick centenary publication*, 1885, 4.
[14] Steven King, Alannah Tomkins, *The Poor in England: An Economy of Makeshift* (Manchester, 2003).
[15] King, *Sickness.*

reshaping their very fabric.[16] This chapter interrogates the origins of such institutions, their rootedness in the politico-economic structures of their cities and states and their indispensable role in the politics of 'improvement' on the one hand, and the shift to legalism that shaped the Scottish poor law reforms on the other. In a broad sense, I aim to point out the centrality of care, conceptualised as an investment, a preventative measure as well as a nation-building fabric, to the history of social and economic change of the long-eighteenth century.

6.1 The Two Hospitals

6.1.1 Relief and Reform in the Royal Infirmary of Edinburgh

> To visit the Sick, to feed the Hungry, to clothe the Naked, are Duties founded in the Principle of Reason as well as of Religion.[17]

As suggested by its managers, the establishment of the Royal Infirmary of Edinburgh, the first of its kind in Scotland, was rooted in the 'improvement' notion of rationalism combined with religion. Medical provision was a means to an end, rather than an end in itself. The hospital was situated within the broader infrastructure of emerging public institutions aimed at 'correcting' and 'improving' the minds, bodies and souls of the urban poor. From its inception the infirmary was set to combine the Christian and civic responsibility towards the poor 'reduced to, naked, Starving, in the utmost distress from Pain and Trouble of Body and Anguish of Soul', with economic patriotism aiming 'to save so many working hands of the country', and the strong incentive to advance medical research and education and ensure that 'students in Physick and Surgery might hereby have rather a better and easier Opportunity of Experience than they have hitherto had had by studying abroad'.[18] These three axes remained at the forefront of the hospital's running and admissions policy throughout the eighteenth century, serving the changing interests of the city and its elites striving to advance their socio-cultural and economic interests. The elites' self-fashioning was in line with the emerging notion of bourgeois virtues of respectability, scientific progress and civic benevolence extended toward the deserving poor, which was reflected in the ventures they sponsored. The infirmary's role as a

[16] See for example: King, *Sickness*; King, Tomkins, *The Poor in England*; Samantha Williams, *Unmarried Motherhood in the Metropolis, 1700-1850: Pregnancy, the Poor Law and Provision*, (Cambridge, 2018); David Green and Alasdair Owens (eds.), *Family Welfare: Gender, Property, and Inheritance Since the Seventeenth Century,* (Santa Barbara, 2004).
[17] LA LHB1/5/2(i), History of the Royal Infirmary of Edinburgh, 1749.
[18] LA LHB1/5/1, History of the Royal Infirmary of Edinburgh, 1730.

research and teaching hospital remained central to its running throughout the century. In spite of the persisting exclusionary nature of the institution, the infirmary's admissions policy saw a direct link between disease and poverty, and thus served as a place for the administration of cure, but also a place where 'due care be taken of them by [removing] their Want of proper Diet and Lodging'.[19] As suggested by Jacques Ténon, the French hospital reformer, a hospital bed was no longer defined as 'a receptacle of human misery but as a therapeutic implement, which, in providing each individual warmth, relaxation of muscle tension and rest, was the essential component of healing'.[20] It was thus the combination of 'the advantages of lodging, attendance, diet, medicine and the ablest advice and assistance' that distinguished the eighteenth-century hospital from earlier forms of institutional medical provision or the workhouse or the house of refuge, where the poor were to be provided with basic necessities. Whilst in the Edinburgh context, the infirmary and the workhouse remained interlinked through their revenue, their management and their role in transforming the city's human geography, the infirmary offered short-term stays to the afflicted, who were to be reformed through the feeling of gratitude towards their patrons. Contrarily, the workhouse, less common in the Scottish context than south of the border, was increasingly becoming a tool of deterrence from idleness, as well as a space where the most destitute could be 'put away' to prevent their 'polluting' of their 'respectable' surroundings.

Depending on members of the Edinburgh Royal College of Physicians providing free medical advice and pharmacopoeia to the urban poor, the hospital was built upon revenue of the recently dissolved fisheries stock company, church collections and contributions from the Honourable Ladies of the Assembly at Edinburgh, alongside prominent Edinburgh citizens counting 352 subscribers in total. This general collection brought together the £2,000 required to open the two-storey establishment called the 'Little House' rented from the City of Edinburgh for 19 years. The infirmary opened its doors to the first handful of patients in August 1729 and continued to receive the limited number of four to six patients at one time for the first ten years of its operation. Despite this limited capacity, it still attracted considerable recognition and growing numbers of students were apprenticed to the physicians and surgeons volunteering to service the hospital. Students soon became an important source of income for the hospital, paying 1 guinea annually if they were apprenticed to the visiting surgeons, and 2 guineas otherwise. The practice of

[19] *Ibid.*
[20] Greenbaum, *The Commercial Treaty of Humanity;* Louis S. Greenbaum, '"Measure of Civilisation": The Hospital Thought of Jacques Tenon on the Eve of the French Revolution', *Bulletin of the History of Medicine*, 49:1 (1975).

selling student tickets began as early as the 1730s and allowed the students to observe operations and attend clinical lectures, which gained in regularity and prominence in the 1740s. To secure this growing interest and cash flow, the institution petitioned for a royal charter, which was granted in 1736, promoting the city's general hospital to its royal status.

Fig. 6.1 P. Fourdrinier, The Royal Infirmary of Edinburgh, 1727

In 1738, nearly ten years since its opening, the construction of a new building that could house a total of 228 residents begun. The first patients were admitted in 1741 before the hospital fully opened in 1748. The new building was designed by the famous architect William Adam, also responsible for Robert Gordon's Hospital in Aberdeen, Glasgow University's New Library and numerous private estates including Hopetoun House built for the Earl of Hopetoun, one of the principal donors to the infirmary as well as to the Orphan Hospital. It comprised a large U-shaped edifice with two wings on each side. Described as 'undoubtedly the most noble of the institutions in Edinburgh reared by the hand of charity', the infirmary building resembled a country estate. It constituted four floors connected through a large staircase leading from the admissions hall at the entrance and topped with a great domed operating theatre accommodating up to three hundred students and observers, also used as an astronomical observatory. A separate collection was made to fund the construction, and contributions in cash or kind came from across

Britain and the colonies, resulting in the hospital admitting patients regardless of their nationality or settlement status.[21]

From the moment of its inception, the management and running of the infirmary was divided into a 'tripartite system' consisting of the 'external economy', 'internal economy' and 'medical economy'.[22] The language of economy relating to administrative and financial management as well as the medical care of patients, invoked the eighteenth century concept of 'oeconomy' understood as 'the practice of managing the economic and moral resources of the household for the maintenance of good order'.[23] The interrelation between the management of revenue, provisions and cleanliness, as well as orderly behaviour of all residents, regardless of position or status and inclusive of staff and patients, again likens the hospital's running to the management of a private household or institutions such as the orphanage that intentionally adopted the household-family model. The inclusion of the 'medical economy' in this triad is key for outlining the strong notion of overall order depending on the three separate axes connected through hierarchized and gendered relations.

The 'external economy' was related to revenue and investment, communication with contributors and the general public, administrative and legal matters and nominally also the hospital's management. At its core was the committee of twenty General Managers, elected annually from the hospital contributors and prominent office holders from the city. The everyday running of the infirmary was overseen by the treasurer, accountant and a clerk of corporation. The treasurer was the main liaison between the external and internal economies, keeping records of all income and expenditure in his books and communicating with the internal and medical officers. Initially a voluntary role, the treasurer was allowed a small salary not exceeding £40 annually until the 1840s owing to the strong emphasis on his charitable devotion to the role. By the 1840s the position of the treasurer changed from an honorary role, acquiring formal recognition and a salary increase. By 1848 he was paid £200 compared to the £120 received by the clerk and £80 by the matron.

Unlike many similar institutions, the infirmary relied on diversified resources, functioning as a chartered company, rather than a public charity. Despite continued pleas for contributions from the public printed in the newspapers, the infirmary was by no means reliant on these for its existence, and the 'external economy', or revenue management was

[21] LA LHB1/5/2(i).
[22] LA LHB1/5/4, History of the Royal Infirmary of Edinburgh, 1778.
[23] Karen Harvey, *The Little Republic: Masculinity and Domestic Authority in Eighteenth-Century Britain* (Oxford, 2012), 24.

conducted with a high level of entrepreneurship. Managing real estate bought or bequeathed and offering financial services and private loans, the infirmary generated considerable revenue independently from its many supporters. Patient care continued to be funded by student tickets, profits made from bazaars and assemblies organised by Edinburgh gentlewomen in conjunction with the Charity Workhouse and a significant annuity of £400 donated by the Earl of Hopetoun, one of the hospital's prominent patrons.[24] The Hopetoun bequest, like other large legacies, was donated conditionally, requiring the hospital to spend £50 annually on the maintenance of 5 'incurables', patients with chronic or long-term conditions otherwise ineligible to be taken into the infirmary, which primarily provided acute care.[25] Unlike in other institutions of similar character, collections, small private contributions and gains from the charity box only constituted a small part of the institution's budget. Contrarily, large private bequests became increasingly common with the institution's growing prominence. Similarly, the hospital became a large investor in the property and finance markets in the city of Edinburgh and made considerable sums through rentals and interests on loans. Lastly, important contributions were made for specialised wards for sick soldiers, seamen and servants funded separately from the general admissions wards. Smaller contributions were made by the middling sorts keen to exercise patronage over those less fortunate for but a guinea per annum that afforded them the right to recommend patients to the hospital.[26] Craftspeople and labourers also contributed, both individually and increasingly also through industrial unions formed as a sort of insurance providing access to the hospital for their members when sick or injured.[27] Similarly, parishes and episcopal congregations from around Scotland contributed to the funds, gaining the right to recommend patients, thereby extending access to medical care to the 'deserving' poor from outside of Edinburgh.[28] The last source of income was the hospital's large bagnio available to paying visitors, demonstrating the diversified and increasingly entrepreneurial composition of revenue.[29] Unlike many charitable institutions, the spatial and physical qualities of the grandiose new building bear testimony to the infirmary's place in enacting the 'improvers'' pursuit of

[24] LA LHB1/5/2(i); LA LHB1/1/2, Minutes of Royal Infirmary of Edinburgh Board of Managers, 1742-1749.
[25] LA LHB1/5/2(i)
[26] Guenter Risse, *Hospital Life in Enlightenment Scotland*, (Cambridge, 1986); Guenter Risse, *Mending Bodies, Saving Souls: A History of Hospitals*, (Oxford, 1999); Megan Coyer, 'Medicine and Improvement in the Scots Magazine; and Edinburgh Literary Miscellany (1804-17), in Alex Benchimol, Gerard Lee McKeever (eds.), *Cultures of Improvement in Scottish Romanticism, 1707-1840* (London, 2018).
[27] LA LHB1/1/15, Minutes of Royal Infirmary of Edinburgh Board of Managers, 1846-1848.
[28] LA LHB1/5/1.
[29] *Ibid.*

progress, commercialism and scientific knowledge inseparable from the charitable care of the poor. Throughout the course of the long eighteenth century, the infirmary continued to grow as a voluntary hospital for the poor from the city of Edinburgh and abroad, whilst also becoming the largest and most renowned teaching hospital in Scotland. Free from strong ties to religious and reformist societies, the infirmary was able to grow as a research and teaching hospital, very much perceived as an extension of the medical faculty, as much as a medical care provider, which was exemplified by its continually low intake of regular in-patients recommended by subscribers without the need to pay an additional fee for their care.

The 'internal economy' was headed by the matron (also called the governess or housekeeper), qualified as a woman in her middle age, 'unmarried, without a family, and capable of keeping accompts'. She was in charge of the 'family', which similarly to the Orphan Hospital constituted all residents, who were to 'obey her orders'. She presided over inventories, provisions, household accounts and general domestic management following the traditional gendering of household labour.[30] The position was rather well remunerated with matrons in the 1730s paid £20, gradually increasing to £80 by 1840s with the addition of bonuses and perquisites. The matron was also in charge of the rest of the 'internal economy' constituting the porter, cook, washers and servants, but also medical nurses. This signified the nurses' categorisation as body servants as opposed to medical care providers, demonstrating the complex division of labour in the hospital. [31]

A female household head appears unusual outside of the context of domestic management, highlighting the hospital's staffing along the household-family model discussed in Chapter 5. Increasingly, however, the prominence of a female manager came under scrutiny. As I have demonstrated elsewhere, with the heightened attention paid to the institution during the 'fever' epidemics, the hospital's internal running was discussed continuously in the popular press.[32] The hospital's management, sources of revenue and responses to the epidemic featured in articles published by the *Caledonian Mercury* and the *Scotsman* amongst others, with internal labour structures at the centre of many of these debates. Hospital matrons and their competencies were likewise subject to public scrutiny, departing from the habitually private running of the institution.

The 'medical economy' comprised the physicians, initially members of the college who attended the hospital on rotation for free until 1751, when two salaried in-house

[30] Eliska Bujokova, 'On the Respectability of this Person Every Thing Depends': Hospital Matrons and Power Relations in the Royal Infirmary of Edinburgh, c. 1817-1820', *Women's History Review*, 32:5 (2023).
[31] LA LHB1/5/1.
[32] Bujokova, 'On the Respectability of this Person Every Thing Depends'.

physicians were employed at £30 per annum. From 1824 only one senior physician was employed at £100, assisted by an unsalaried junior physician. The physicians were in charge of admitting patients and visiting and prescribing treatment for outpatients, daily visitations to the medical wards and instructing clerks and nurses in the patients' regimes. The hospital's surgeons remained engaged on rotation through the College of Surgeons, although from 1769 the College appointed and remunerated four surgeons who took turns at visiting the hospital at £20 per annum.[33] The hospital post represented only a small segment of the income of physicians and surgeons primarily engaged as private practitioners, though it stood as a key career milestone for many medical men. Both physicians and surgeons were in charge of clerks responsible for administrative tasks, patient care and communication with nurses and the matron. They resided and dined in the house paying a yearly fee, and received no or modest pay for their long hours and abundant responsibilities, factors likely contributing to the tensions arising between clerks and paid staff.[34] The clerks were employed as trainees, rewarded by receiving instruction rather than pay, once again highlighting the complex dynamics between paid and unpaid forms of care. An in-house apothecary was responsible for the provision of medicines prescribed by the physicians.

The rest of care and bodywork was carried out by ordinary and supernumerary nurses, who were under the matron's charge, though they received instructions from physicians, surgeons, clerks and the apothecary. Nurses were often recruited form amongst the city's pool of domestic servants, receiving £3 8s in 1768 and between £12-15 in the 1840s depending on their years of service in addition to bed and board. By 1811 the conditions of nursing staff were increasingly debated by the managers, who continuously portrayed them as drunken and incompetent, questioning whether better pay would attract better staff, considering 'the very great difference between the allowance given by private families and the terms of the Infirmary' (at this point day nurses were paid £7 in addition to bed and board).[35] The matron, Mrs Hume opposed the motion to raise nursing salaries, suggesting that she had nine applicants waiting to fill one vacancy, though proposed that the non-resident night nurses were to be paid 1d a day more (in addition to their salary of £9) as they had to secure their own accommodation. Similarly, she proposed that 'some allowance might be made to Nurses who should become old and infirm in the service of the Hospital, of which description, these were at present two in the infirmary, one of whom

[33] LA LHB1/1/4, Minutes of Royal Infirmary of Edinburgh Board of Managers, 1761-1775; LA LHB1/5/2(i); LA LHB1/5/4, History, 1778.
[34] *Ibid.*
[35] LA LHB1/1/7, Minutes of Royal Infirmary of Edinburgh Board of Managers, 1801-1813, 404.

had been doing duty in it for 34 years'.[36] Whilst their salaries were modest and the work of nursing regarded as disagreeable, institutional residence offered to day nurses was likely preferable for many otherwise at mercy of their private employers. No prior skills were required and female relatives of patients were often admitted as paid supernumerary nurses to care for patients needing round-the-clock care, demonstrating the perception of nursing work as part of a naturalised skillset of women.[37] The long years of engagement in the infirmary by some nurses however contradicts the continuous depiction of pre-reform nursing as casualised and precarious, suggesting that albeit modest, medical institutions offered stable employment and residence to some of their employees, likely an attractive aspect of residential care work. When compared to domestic service, the likely alternative for hospital work, nursing was equally demanding but offered more clearly defined tasks and working hours. Both were likely life-cycle occupations for many, but allowed others the stability that was less likely to be had in the private sector.[38] As discussed in Chapter 4, the care labour market comprised various forms of work allowing staff to move between varied forms of employment across public institutions, private establishments and domestic service.

Patients were counted amongst the medical economy with strict rules to follow.[39] Put to work when in recovery, their status fluctuated between being regarded as the beneficiaries of charity and institutional inmates, determined by the ambiguous perception of the sick poor. Much like in the Orphan Hospital, they shared social backgrounds and experiences of precarity with the servants and nurses employed by the hospital, complicating the binary between the care providers and receivers. The infirmary was thus incorporated into the welfare strategies of urban dwellers for patients and employees alike. Even though the hospital was conceptualised as a refuge for all sufferers unable to pay for private care, it primarily accepted patients upon recommendations from their patrons who had contributed to the hospital, with patients without recommendation only accepted in

[36] *Ibid.*
[37] LA LHB1/5/4.
[38] Margaret Versluysen, 'Old Wives Tales? Women Healers in English History' in Celia Davies, *Rewriting Nursing History* (London, 1980); Deborah Harkness, 'A View from the Streets: Women and Medical Work in Elizabethan London', *Bulletin of the History of Medicine*, 82:1 (2008); Margaret Pelling, *The Common Lot, Sickness, Medical Occupations and the Urban Poor in Early Modern England* (Harlow, 1998); Sue Hawkins, *Nursing and Women's Labour in the Nineteenth Century: The Quest for Independence* (London, 2010); Sue Hawkins, 'From Maid to Matron: Nursing as a Route to Social Advancement in Nineteenth-Century England', *Women's History Review*, 19:1 (2010); Barbara Mortimer, *New Directions in Nursing History* (London, 2004); Barbara Mortimer, 'The Nurse in Edinburgh c. 1760-1860: the Impact of Commerce and Professionalization', PhD Thesis, School of History, Classics and Archaeology, The University of Edinburgh, (2001).
[39] LA LHB1/1/3, Minutes of Royal Infirmary of Edinburgh Board of Managers, 1749-1760; LA LHB1/5/2(i); LA LHB1/5/4.

cases of emergency.[40] Recommendations were provided by individuals, collectives as well as parishes, who sent in patients in need of medical care. Those contributing a sum of £50 or £5 annually gained the right to present a patient at any time. According to the 1749 rules and regulations, those with no recommendations were only to be admitted upon supplying a deposit of £10 to cover burial expenses should they die on the premises. During this time, patients with infectious conditions were to be refused altogether in order to prevent the spread of contagion. Women with dependent small children were likewise refused, with the hospital fearing the children being abandoned there in the event of mothers dying or abandoning their unwanted offspring.[41] With these limitations, the general population of the city did not have direct access, challenging the hospital's self-fashioning as a universal place of refuge. Additionally, the number of regular patients did not surpass 60 until 1768 when the limit was raised to 80, with supernumerary patients admitted at a fee of 6d per day and a deposit of 1 guinea. [42] Even after expanding the hospital's capacity, it by no means adequately matched the medical needs of the growing population of the city and its vicinity. Whilst increasingly conceptualised as an institution of *public* nature, its reach and engagement with the population remained extremely limited. As shown by Risse and Fissell, admissions were largely determined by the hospital's teaching objectives, seeking such patients that would provide interesting case studies for clinical lectures. Additionally, the complex system of separate funds and the cap on general admissions was used in order to balance the books of income and outgoings, allowing the hospital more independence from public collections and public scrutiny.[43]

The hospital also provided accommodation for 'lunatic patients' at £5 per quarter, allowing the patients' relatives to care for them or employ additional staff at their own expense. The strict admissions protocol meant that the hospital primarily served as an extension of existing networks of patronage, providing only for those deemed deserving of charity. Until the first decades of the nineteenth-century, the hospital did not assume the role of a public provider, instead functioning as a locus of private philanthropy on the one hand and medical research and education on the other. The limited number of admissions or the nature of recommendations raises questions such as who in fact were the receivers of the hospital's care. Those 'undeserving' or with no ties to the hospital's patrons were denied access, with the city's paupers falling through the cracks. Instead it was the

40 Risse, *Hospital Life;* Risse, *Mending Bodies, Saving Souls*; 1742-1749 LA LHB1/1/2, Minutes of Royal Infirmary of Edinburgh Board of Managers,.

41 LA LHB1/5/2(i); LA LHB1/1/8, Minutes of Royal Infirmary of Edinburgh Board of Managers, 1813-1818, 266.

42 "LA LHB1/1/4, Minutes of Royal Infirmary of Edinburgh Board of Managers, 1761-1775, 156-8.

43 Fissell, 'The 'Sick and Drooping Poor'; Risse, *Hospital Life;* Risse, *Mending Bodies.*

labouring poor, who, in sickness unable to provide for themselves, were taken in with the hope that they would return to gainful employment upon recovery. With the rejection of 'incurables' and higher rates for 'lunatics', the general wards served as a place of short-term refuge, that was to uphold the social status quo and prevent disease from reducing the majority population of servants, labourers, small trades- and craftspeople and other wage earners to destitution in the absence of a broader system of social provision. A tool of exercising patronage and control over their subjects, the hospital was run in line with the interests of its patrons.

From the mid-eighteenth century, additional wards were allocated to sick servants from the city of Edinburgh and soldiers or seamen returning from armed conflicts homeless and impoverished. These three categories of patients were paid for by separate funds established in the 1750s. All represented social groups vulnerable to downward social mobility and subsequent pauperisation through loss of employment, sickness or pregnancy in the case of female servants. Collections for sick servants were raised from the servant-employing classes exclusively resident in Edinburgh, unlike the rest of the hospital, which admitted patients from across Scotland and abroad. Those who contributed to the fund gained the right to send their servants to the infirmary, thus delegating their duty of care towards non-kin household members. According to surviving admissions books, the sick servants came from the households of crafts and tradespeople (barbers, brewers or inn-keepers, etc.), professionals (writers, advocates, surgeons, teachers, midwives) as well as gentry and nobility resident in the city.[44] The fund enabled the hospital to apply the principle of economy of scale onto the notion of sick-care outwith kin-based relations. Householders could thus delegate their responsibility to care onto the hospital for a fee, which met the expectation of their provision for their staff in sickness and in health. Additionally, it was suggested that 'those of superior stations, who possess more spacious houses, are apt to be alarmed when diseases, especially those of a contagious nature, appear among their servants'.[45] Envisioning the hospital's later role in public health management and collective medical provision, the sick servants' fund is an early example of the direction the hospital was to take in the future. Its role in this case, however, still remained that of a proxy-carer, paid for by those bearing the naturalised duty of care for resident domestic workers, their employers, patrons and social betters. The household structure in cities like Edinburgh was changing and the early modern extended household that encompassed servants and other staff into the familial unit of discipline as

[44] LA LHB1/126/1 Register of servant patients, 1762-1775; LA LHB1/126/2 Register of servant patients, 1775-81; LA LHBI/126/3, General register of patients between 1770-1.
[45] LA LHB1/5/4, 22.

well as provision gave way to a more contractual, hierarchized form of cohabitation in which the duty of care towards kin and non-kin members differed, resulting in the increased preference of employers to delegate their providing responsibility to a third party. The erosion of the familial model of care provision was thus being supplemented through the emerging institutions, which, whilst conceptualised as places of refuge for the poor, served as a space utilised by the better off to outsource the care of their staff.

Funds for soldiers and seamen were likewise largely supplied through collections with the addition of royal grants.[46] Garbed in the rhetoric of patriotic duty, which obscured the pressing economic need to accommodate the dispossessed, narratives surrounding the care of soldiers and sailors contributed to the image of the hospital's role in providing for the armed forces. Their claim was recognised as an 'earned right' to care and sympathy, for 'they had borne a share in rendering this war [Seven Year's War] successful, and in advancing the glory of the British arms'.[47] Again in this instance the hospital served as a way of tackling the social ill of high criminality associated with wounded and dispossessed men returning from war, often falling into destitution. The institution provided a space whence former soldiers could not only be 'cured' but contained, buying their families and friends time to reclaim them, or for further armed conflicts to emerge where they could be redeployed. Similarly to the servants' fund, the sailors and soldiers' funds financed primarily by the crown demonstrate the centrality of care provision in the formation of the nation's armed forces and the fiscal-military state. Men returning from combat were uprooted from their social networks, falling on the responsibility of the state, which outsourced the care work from third parties. The seamen and soldiers' funds constitute a key example of state populationism as the guiding force of public provision described by Charters as the origins of the welfare fiscal-military state anxious to restore those wounded in combat to the armed and labouring population of the nation.[48] The two funds demonstrate the hospital's embeddedness in the emerging state and by extension its imperial apparatus, as a space where the crown's subjects could be provided for.[49]

Bringing together the sick urban poor through their patrons, the city's 'respectable' work force of servants when afflicted, and the wounded armed forces, the infirmary lay at the core of eighteenth-century notions of 'improvement' that increasingly recognised care

46 LA LHB1/1/3, Minutes of Royal Infirmary of Edinburgh Board of Managers, 1749-1760, 303-6; Daisy Cunynghame, 'The Roles of the Edinburgh, Kelso, and Newcastle Dispensaries in Charitable Relief, 1776-1810', PhD Thesis, School of History, Classics and Archaeology, The University of Edinburgh, (2020), Lisa Rosner, *Medical Education in the Age of Improvement: Edinburgh Students and Apprentices, 1760-1826* (Edinburgh, 1991).
47 LA LHB1/5/4.
48 Charters, *Disease, war and the Imperial State.*
49 *Ibid.*

provision as a public responsibility, devising an institutionalised form of traditional patronage and overlordship that came to replace its traditional forms eroded by urbanisation and industrialisation. Additionally, downward social mobility was a real fear of the emerging middle classes living in the volatile credit economy. Providing for the 'deserving poor' thus served as a way of creating a security blanket for those socially mobile though lacking in security of status inherited wealth. As shown by the petitions to the Orphan Hospital drawn on in the previous chapter, socio-economic identity was seen as more permanent than one's access to cash, and many of the poor who were once rich saw themselves as worthy of charity that would offer the restoration of their former status. Contributing to charity by the middling sorts thus perhaps represented the hope that they should not need it, preventing their fortunes from turning.[50]

Furthermore, removing the duty of care form the servant-employing classes of the city through applying the principle of scale economy onto care provision, functioning as a proxy for the provision for those conscripted by the crown to fight its battles and extend its borders, as well as 'improve' and reform the nation's sick poor, the Edinburgh infirmary was a key part of the emerging institutional care infrastructure in the city. It was constructed alongside establishments such as the workhouse and the Magdalene, in a large-scale move towards the institutionalisation of urban space. Inextricably linked to the imperial project, its aim was to care for the nation's labour force, whilst fostering a spirit of independence, industriousness, deference and gratitude in those who came through its doors.

6.1.2 Glasgow Royal Infirmary, Medical Relief and Collective Provision

Whilst the Royal Infirmary of Glasgow was not founded until 1791, it was the Town's Hospital established in 1733 that provided parallel services to the Edinburgh infirmary in the early eighteenth century. Built following a motion put forth in 1730 by the city's corporations to erect a workhouse 'capable of accommodating six hundred poor persons', the Town's Hospital combined the objectives of a workhouse, orphanage, house of refuge and infirmary and was built as a joint venture of the Glasgow Town Council, Merchant House, Trades House and Kirk Sessions, uniting the philanthropic schemes of the municipal, entrepreneurial and religious axes that controlled the city of Glasgow.[51] The

[50] Tawny Paul, 'Losing Wealth, Debt and Downward Mobility in Eighteenth-Century England' in David Hitchcock and Julia McClure, *The Routledge History of Poverty, C. 1450-1800* (London, 2020).
[51] Geogre Crawfurd, *A Sketch of the Rise and Progress of the Trades' House of Glasgow* (Glasgow, 1858).

four corporations provided the annual sum of £570 (sessions £250, Town Council £140, Trades' house £120 and Merchant house £60), which continued until the introduction of compulsory assessments in 1840s, alongside additional funds from public collections. This institution was the primary provider for the poor in the city that generally opposed the introduction of compulsory assessments. Unlike in Edinburgh where a workhouse was not erected until the 1740s and only provided for the Edinburgh City parish, Glasgow provided institutionalised support for its poor much earlier on, in spite of the unwavering anti-welfarism that characterised Scottish approaches to poor relief until the 1840s. Glasgow did not face the challenges of rapid population growth until the late eighteenth century and thus a single institution with multiple functions was considered an adequate strategy. The two cities' urban development and systems of governance thus determined the emerging care infrastructures. Nevertheless, the ethos of reform and improvement of the poor as expressed by the Edinburgh infirmary founders was shared by the Glasgow institution:

> The Regulations shew how clean the *Poor* are kept; and what Care is taken as to frequent washing of the several Rooms and Apartments of the *House*, as well as the regular and orderly Diet of the *Poor*. The good Effect of all these things is, *That People who used to wander about in Rags and Deformity, under the Hardships of Cold, Hunger and Nakedness, are now so much altered to the Advantage, and have so decent and cleanly an Appearance, that they seem, to those who knew them formerly, as if they were not the same Persons*…And whereas this *House* was intended not only for the comfortable Subsistence of the *Poor*, but also for promoting Industry, Sobriety, Christian Knowledge, and true Piety among them.[52]

The capability of the institution to transform beyond recognition those who entered through the combination of piety and industry echoed the contemporary discourse on poor management, that required public expenditure to be justified by the promise of a greater good for the majority rather than the individual. The Town's Hospital practiced the principle of economy of scale that underlined institutional provision for the poor throughout Britain, suggesting 'that L. 200 wisely employed this way, has afforded a better Maintenance to the Poor, than L. 300, or L. 400, distributed in Pensions to the same Numbers living either in separate Cottages, or in a wandering Condition'.[53] The hospital maintained that it was able to provide for its inhabitants at only £3 16s pear head annually during its first 8 years of running, as

[52] *The Regulations of the Town's Hospital at Glasgow* (Glasgow, 1734), 6.
[53] *A Short Account of the Towns Hospital in Glasgow* (Glasgow, 1841), 2.

> Tis plain, that in a way of Joint-Lodging and Joint-Maintenance upon certain *Funds*, when all the Necessaries of Life are prudently bought in large Quantities in the cheapest Seasons, any given Number of real *Poor* can be comfortably maintained at one third less Charge at least, than is requisite to maintain the same Number, even in a miserable uncertain Manner, when dispersed in separate Cottages, or wandering without fixed Habitation.[54]

Unlike the RIE, the Town's Hospital only admitted those resident in Glasgow for six years or above recommended by one of the four founding bodies. By 1739, it opened a separate infirmary unit that could treat up to 70 patients from amongst those already resident in the hospital, or poor patients admitted to receive acute medical care. Those not duly indigent but in need of medical treatment were admitted upon paying between 7 and 20 shillings and those not resident in the city liable to pay higher chargers and only eligible to receive acute treatment. Sick poor resident outside of Glasgow could receive treatment if unable to travel to their parishes of settlement, prior to being made to return. The infirmary was attended by physicians and surgeons upon voluntary basis, with the introduction of a salary of £5 to the junior physician and £15 to the attending surgeon in 1742. Whilst tied to the city's Faculty of Physicians and Surgeons through this provision, the Town's Hospital and its infirmary remained municipal institutions, born out of the recognition of a collective responsibility for the city's poor. Unlike the Edinburgh institutions such as the Royal or the Orphan Hospital, which grew out of the voluntary movement and the institutionalising tendencies of private philanthropy, Glasgow's public care infrastructure was organised around the principle of municipal collectivism as opposed to private voluntarism. Whilst the Trades and Merchants Houses were funded through donations and bequests, there was a greater level of public scrutiny than the privately run Edinburgh institutions. The infrastructure of the city that grew at a much faster pace and was fully transformed by industrialisation was inevitably distinct from the historic capital that housed the majority of the Scottish 'improvers'. With the establishment of the Glasgow Royal, this divergence between the two cities continued.

Whilst the Town's Hospital remained the primary administrator of poor relief until the 1840s, its capacity to administer adequate medical care to the growing population of the poor begun to diminish with the city's rapid population increase. The first impulses for the establishment of an infirmary emerged in the 1780s with a committee of subscribers coming together in 1787, including representatives of the University, Town Council, as well as members of the merchant and trades' incorporations.[55] The institution was to

[54] *Ibid,* 13.
[55] LA LHB1/1/1, Minutes of Royal Infirmary of Edinburgh Board of Managers, 1728-1741, 5-6.

follow the voluntary model and was to be managed akin to its Edinburgh counterpart. As put forth by the hospital's Royal Charter,

> An infirmary for the relief of persons labouring under poverty and disease, has been long wanted in the City of Glasgow, and in the adjoining Counties of Scotland, and is become more necessary at present than at any former period, on account of the prosperous state of Manufacturers in Glasgow and its neighbourhood, and the increased population of those Classes of Manufacturers and Labourers, of every kind, who are most likely to require charitable assistance.[56]

Much like the Town's Hospital, the infirmary's construction was enabled by the coming together of various incorporations of the city of Glasgow, in combination with the Royal College of Physicians and Surgeons who previously serviced the Town's poor. The original subscribers combined the most prominent influences in the city of Glasgow, the industrialists, and members of the council, medical men and members of the University. Large contributions were made by the city (£500), the University (£500), The Trades House (£400), the Merchants House (£400) as well as private contributors, such as the imperial industrialists David Dale (£200) and Archibald Speirs (£100). Dale and his successor Robert Owen of the New Lanark cotton mills took active roles, standing as the hospital's managers. The original subscribers gained a permanent seat in the hospital's managerial committee, which overlapped with the leadership of the city of Glasgow, Merchants' and Trades' Houses (both the Dean of Guild and Deacon Convener were permanent members) and Glasgow's representation in Westminster. The two medical bodies of the city were represented, the Faculty of Physicians and Surgeons of Glasgow and the University's chair of Anatomy and Medicine. Church of Scotland ministers were permanent members of the committees of managers and subscribers, allowing congregations to recommend individual patients in the early days of the infirmary. Ecclesiastical influence was, however, heavily outweighed by the civic, industrial and academic members.

[56] Glasgow NHS Archive (GNA) HB14/14/2,Charter of the Glasgow Royal Infirmary, December 21, 1791.

Fig. 6.2 David Allan, Glasgow Royal Infirmary, 1781

The new infirmary was located in the medieval centre of the city in close proximity to the Cathedral of St. Mungo and the University. The construction was initially commissioned from the London architect William Blackburn who specialised in prison architecture, though his unexpected death led to the post being passed on to Scottish born Robert Adam, then a royal architect as well as the son and apprentice to the Edinburgh infirmary's architect William Adam.[57] The edifice, described as 'a building much admired both for the excellence of its situation and the taste', was completed at the cost of £7,900, under the auspices of James Adam taking over from his brother Robert, who died shortly after the construction commenced. The building was decorated with neo-classical features in which 'convenience, simplicity, and elegance are seen mutually to harmonize and assist each other', betraying the civic pride of the emerging second city of the empire.[58] Much like its Edinburgh counterpart, the infirmary possessed a large operating theatre able to accommodate over 200 spectators, alongside medical and surgical wards, quarters for 'lunatic' patients, baths and an apothecary. Reflecting new findings of the sanitarians, proponents of urban reform for the promotion of public health, an emphasis on ventilation,

[57] Jacqueline Jenkinson, *The Royal: The History of the Glasgow Royal Infirmary, 1794-1994* (Bicentenary Committee on behalf of Glasgow Royal Infirmary, 1994); GNA HB14/14/1, Minutes of the Glasgow Royal Infirmary, 1787-1802.
[58] Moses Steven Buchanan, History of the Glasgow Royal Infirmary, from its Commencement in 1787, to the Present Time, with an Appendix, Containing the Charter and Laws of the Institution (Glasgow, 1832).

hygiene and contagion prevention was introduced. The hospital was initially built to accommodate 136 patients, which number rose to 226 with the 1816 extension of the original building. The aim of the institution was thus to provide acute care for the city's inhabitants as a way of promoting their productive capacity as well as upholding family-based welfare economies:

> It is scarcely necessary to add that the support of such an Institution as this is in itself the practice of many charities. To recover from sickness to health- to restore in strength and vigour the diseased industrious poor to their families and their useful labours, is in its consequences to feed the hungry, to clothe the naked, and to comfort the stranger and those who have none to help them.[59]

Like in Edinburgh, patients were admitted upon recommendations from subscribers and after obtaining consent from the attending admissions committee. Contributors of £10 or one guinea annually, five times less than in Edinburgh, gained the right to admit one patient at all times. Similarly to Edinburgh, women with children and those suffering from chronic illnesses were not admitted. Increasingly, subscribers were members of the merchant and professional classes, reflecting the changing nature of the city's propertied class. Additionally, patients suffering from injuries and in emergency cases did not need recommendations, and their numbers grew rapidly, reaching 572 admissions out of the total of 2,635 in 1845, reflecting Glasgow's industrial centre.[60] The managers believed that 'the urgency of accident and operation cases, renders it necessary to give to these a preference over cases of a lingering and chronic character'.[61] The hospital's surgeons and physicians also attended large numbers of outdoor patients who far outnumbered those admitted to the hospital. Collective contributions made by unions and trade societies such as the Benevolent Society of Millworkers contributed collectively to provide treatment for their members, functioning as a participatory form of patronage and an alternative to traditional hierarchical networks of support.

The managerial structure of Glasgow infirmary was equally divided into 'economies', though rather than the tripartite system, a simpler internal and external economy was followed.[62] The institution was headed by a board of managers, who represented the medical, municipal and business elites of Glasgow, demonstrating the rootedness of the institution in the civic life of the city. Permanent staff serving the

[59] GNA HB14/1/1, Glasgow Royal Infirmary Annual Report 1802.
[60] Numbers of accidents were not reported until 1845, but the written commentaries on admissions reflect the state of affairs.
[61] Jenkinson, *The Royal*, 63.
[62] GNA HB14/1/1, Minutes of the Glasgow Royal Infirmary, 1787-1802.

external economy were the treasurer and clerk. The treasurer was responsible for overseeing the financial and administrative running of the hospital, mediating between the internal and external economies and providing a point of contact for the institution. The clerk kept minutes and accounts and drafted reports.[63]

Similarly to Edinburgh, the internal economy was headed by a matron in charge of all internal staff and directly responsible to the managers. Her main prerogatives revolved around household management, provisions and food preparation as well as staff management. Unlike in Edinburgh, she was also responsible for paying internal staff and budgeting for the hospital's running as well as wages.[64] With a salary never exceeding £50, Glasgow matrons were not as highly remunerated as their Edinburgh counterparts, although they received generous bonuses ranging between £10 and the £150 gifted to the matron Mrs Brodie upon her resignation in 1847.[65] The more regional character of the infirmary as well as its looser management structure resulted in the matron's authority exceeding official statutes. The less corporate structure of the institution allowed her greater responsibilities in traditional female domains, including that of paying staff and securing provisions, roles generally bestowed upon managerial committees and the treasurer in the Edinburgh infirmary.[66] Like in Edinburgh, however, the matron's role came under scrutiny in the early decades of the nineteenth century, resulting in the new office of superintendent being set up in 1830 to take on the role of an internal manager with some oversight of the medical aspects of the hospital's running. As will be further shown, this structural change resulted from the pressures faced by the hospital responsible for fever management, leading to a greater professionalization of the institution.

The medical staff was included in the internal economy, though its majority only visited the hospital. It constituted two physicians visiting the hospital daily and four surgeons who visited on rotation. Physicians admitted patients, discussed case notes and prescribed treatment, whilst surgeons were in charge of operations. Like in Edinburgh, they were initially unpaid and when they received salaries from 1807, they were lower than those of administrative staff and most of their income, though aided by the prestige of hospital appointment, came from private practice. Physicians were paid £30 upon completing two years of service and surgeons £10 per annum.[67] This increased to £50 and £30 in 1840s.[68]They were assisted by clerks, junior medical men appointed for six months

[63] *Ibid.*
[64] GNA HB14/1/1, 148, 173.
[65] GNA HB14/1/9, Minutes of the Glasgow Royal Infirmary, 1842-1847.
[66] Jenkinson, *The Royal*; GNA HB14/1/1.
[67] Jenkinson, *The Royal*, 42.
[68] GNA HB14/1/9.

authorised to perform minor treatment and admit patients in emergencies, and dressers selected on rotation from students. Students were admitted to attend lectures and wait on practitioners upon purchasing a ticket. A resident apothecary was in charge of preparing and distributing medicines to both in and out-patients. In 1801 the resident apothecary also took on the role of hospital chaplain, at first without pay and later for an additional £10 onto his salary of £40.[69] Highlighting the running of the infirmary as a household economy, patients were also cited as part of the 'internal economy' and were to follow strict rules akin to those set for servants.[70]

The majority of care work in the hospital was carried out by 6-8 nurses (including day and night staff), nominally classed as servants with their responsibilities including washing and cleaning overlapping with those of domestics.[71] Like in Edinburgh, female relatives of patients were admitted as supernumerary nurses, highlighting the perceived nature of their work as embodied rather than skilled.[72] Unlike in Edinburgh, it was up to the matron's discretion to raise the nurses' wages in order to procure more qualified staff as well as engage supernumeraries. Whilst nurses were often criticised for drunkenness and misconduct, the institution introduced systems of reward. In January 1798, Nurse Agnes McKenzie was publicly awarded 7s 6d for her good service. Contrarily, nurses' misconduct was reprimanded publicly and published in the press as a form of damaging their reputation.

Whilst the Edinburgh infirmary originated as a private venture run by the city's elites associated with the Medical Faculty and the Colleges of Surgeons and Physicians, the Glasgow infirmary was born out of the growing need to accommodate and provide for rising numbers of the urban poor. As a result, Edinburgh's hospital continued primarily as a teaching establishment on the one hand and an institution for the reform of the poor on the other. Its contemporary, the Glasgow Town's Hospital was similarly imbued with the reformatory goals of the early improvers, keen to resist welfarist approaches to poor relief whilst adopting the increasingly institutionalising approach to the urban poor. Established in reaction to the unbridled urban growth of late-eighteenth-century Glasgow, the infirmary was founded as a municipal body from its inception, and stayed closely linked to the city's corporations and the Town Council. Equally, Glasgow infirmary's finances faced public scrutiny and the institution aspired to be a public body. As the annual reports continued to suggest, 'the Directors are anxious that the Public should possess full and

[69] Jenkinson, *The Royal*; GNA HB14/1/1.
[70] GNA HB14/1/1.
[71] Jenkinson, *The Royal*; GNA HB14/1/1-9.
[72] GNA HB14/1/1, 137.

clear information with regard to the Funds of the Infirmary, and the expenditure of the Establishment as it is at present carried out'.[73] Both hospitals alongside numerous voluntary institutions that emerged in the Scottish urban landscape over the eighteenth century were linked to the imperial project, through a portion of their revenue, management and ethos. With their emphasis on management and reform of the Scottish poor, they were more than just places of charity and care, instead functioning as tools of human capital formation inextricable from the growth oriented focus of the empire.

6.3 Philanthropic Legacy, Slavery and Scottish Imperialism

The populationist logic of Scottish medical philanthropy was strongly rooted in the human capital investment promoted by the imperial project. Private and public bequests were made to benefit the institutions such as the infirmaries by Scots who made fortunes in the colonies and the hospitals' revenue was thus directly linked to Scotland's colonial ventures through sums both large and small. Additionally, the development of population and labour theory that formed the institutions' ethos was part of the imperial forms social engineering that ensured labour supply to keep the empire going through both territorial expansion and labour capital investment. In the context of this thesis, the importance of recognising the links between colonial legacies and Scottish philanthropy is twofold. First, it speaks to the pseudo-humanism of Scottish philanthropic ventures, contradicting their depiction as the foundation of European modernity from which the welfare state originated.[74] Secondly, it demonstrates the scope of the 'improvement' project that combined a vision of economic growth with human capital investment, coercive labour and centralised social reproduction. As recently shown by John Marshall in his case study of Lockean labour theory, the use of the workhouse, employment of the 'indigent' poor and training schemes for orphaned children educated in textile production were inextricable from the development of slavery-dependent economies.[75] The crisis years of the 1690s led many political economists across Britain to harden their views on the relief of the poor, increasingly seen as a burden to the struggling nation, whilst also advocating for the

[73] *Glasgow Herald*, 9.1. 1826, 1.
[74] H.W. Hart, 'Some Notes on the Sponsoring of Patients for Hospital Treatment under the Voluntary System', *Medical History*, 24 (1980), for recent work on the British welfare state see: Bernard Harris, *The Origins of the British Welfare State: Society, State and Social Welfare in England and Wales*, 1800-1945 (London, 2018); Derek Fraser, *The Evolution of the British Welfare State: A History of Social Policy since the Industrial Revolution* (London, 2017).
[75] John Marshall, 'London, Locke and 1690s Provisions for the Poor in Context: Beggars, Spinners and Slaves', in Justin Champion, John Coffey, Tim Harris, John Marshall (eds.), *Politics, Religion and Ideas in Seventeenth- and Eighteenth-Century Britain*, (Woodbridge, 2019).

employment of enslaved labour. According to the merchant and political economist John Pollexfen, it was the 'well managed labour of blacks and vagrants' that was to produce 'movable riches' and fuel British trade.[76] Whilst the crisis years of 1690s ended with improved harvests, the theory of human capital investment and labour control remained at the forefront of the 'improvement' debates, in Britain and the colonies. As this thesis shows, care provision was at the heart of the 'improvement' project, developed across the imperial landscape.

Both Edinburgh and Glasgow Infirmaries were tied into the economies of their respective cities through individual bequests and contributions made by corporations such as the Trades and Merchants Houses. Through both channels, they received large sources of revenue that originated from colonial production and trade, including proceeds gained via enslaved labour. Most notable among the private bequests in terms of value and longevity of revenue was the legacy of Dr Archibald Kerr of Jamaica, who in 1749 left to the Royal Infirmary of Edinburgh his Red Hill pen estate in Jamaica inclusive of 39 enslaved people. The estate was initially valued at £3512 2s 1 ¾d, and remained in the hospital's possession until 1892.[77] Little is known of Kerr, apart from his association with the Edinburgh medical school, and he thus remains one of the numerous medical men counting amongst propertied Scots in the Caribbean.[78] Many resident and absentee planters chose to donate their fortunes to philanthropic endeavours in Scotland during their lifetimes and others left large legacies in their wills. Though we can only speculate about their motivations, many Scots expressed a sense of responsibility towards their homeland, inextricable from the formation of Scottish, British and Imperial consciousness shown in paternalistic attitudes of overseas philanthropists. Voluntary institutions became in the public consciousness the incarnation of sentiments such as philanthropy, social responsibility and the promotion of progress materialised through expanding access to colonial riches.

As indicated by Kerr's will, the bequest was conditional on the estate remaining in the possession on the infirmary, rather than being sold. In the period between 1749 and the abolition of slavery in 1834, the hospital thus retained its role as an absentee planter, with a population of enslaved people ranging between 39 and 46. Upon its reception, the hospital rented the estate inclusive of the enslaved people, gaining between £260 and £350 annually, making up 8 per cent of the total income of the infirmary throughout the period

[76] *Ibid.*
[77] LA LHB1/5/4; LA LHB1/1/2-25, Minutes of Royal Infirmary of Edinburgh Board of Managers, 1742-1900.
[78] Stephen Mullen, *The Glasgow Sugar Aristocracy: Scotland and the Caribbean Slavery, 1775-1838* (London, 2022).

between 1749 and 1795.[79] In 1834, the hospital received £500 in compensation for the manumission of 44 enslaved people, followed by an additional £332 received in 1836.[80] In the 1850s, the managers decided to sell the property, which was realised in 1892, yielding £650 which marked the end of the infirmary's involvement with the property. According to available evidence, the RIE received the total of £20,298 from Kerr's bequest between 1749 and 1892, with Red Hill representing the single largest bequest made to the infirmary. The estate was by no means the only donation made to the infirmary from money seeped in slavery, with countless Scottish planters and traders based in Britain as well as the Caribbean marking their support for the charity with contributions.

Whilst no Glasgow philanthropic institution, as far as current research shows, stood in the position of an absentee planter, like the RIE, private bequests as well as collective funds that underpinned the city's growing care infrastructure were equally linked to colonial pursuits including the slave trade. More research is needed to shed light on the matter and provide detailed evidence of individual institutions and their sources of revenue. Evidence of private bequests to charity, however, shows that colonial funds we key to the developments of the city's care infrastructure and poor relief. To draw some examples, James Ewing of Strathleven, Lord Provost of Glasgow between 1832 and 1835, plantation owner and enslaver in Jamaica as well as a lobbyist for the preservation of the slave trade in early 1800 was one of the most prominent patrons of Glasgow's philanthropic institutions. He bequeathed £18,100 to the Free Church of Scotland and £10,000 to the Glasgow Royal Infirmary. Additionally, he left £31,000 to the Merchants House, one of the infirmary's primary sponsors and an institution engaged in distributing relief to its numerous members who had lost their fortunes, or reached old age. The Glasgow Royal Infirmary was the single most popular institution in the city amongst West India planters, many of whom bought a right to nominate patients to the institution, which they were able to execute or pass onto a parish, as was the case of the 1837 legacy of Patrick Playfair, enabling the Barony Parish to make six recommendations annually.[81] Glasgow institutions established in the early nineteenth century such as the Lunatic Asylum, Deaf and Dumb Asylum or the House of Refuge all received large donations and bequests from colonial merchants. More so than in Edinburgh, the origins of the city's growing care infrastructure are inextricable from the pursuits of Glasgow merchants in the

[79] Simon Buck, 'Uncovering Origins of Hospital Philanthropy: Report on Slavery and the Royal Infirmary of Edinburgh', Report for the Lothian Health Services Archive (2022).
[80] LA LHB1/1/2-25.
[81] Mullen, *The Glasgow Sugar Aristocracy,* 286, 287.

colonies. Similarly, the institutions' subsequent running, involving many men with possessions and interests in the colonies, was aided by colonial proceeds.

As shown by Karly Kehoe in her case study of the Scottish Highlands, medical philanthropy as one of the tenets of 'improvement' was interlinked with the imperial involvement of Scots as large entrepreneurs, as semi-successful individuals, and even as minor figures. Contributions to the developments of local infrastructures at home tied into notions of national identity, local responsibility and the belief in mutual aid embedded in traditional communities.[82] Equally, they were driven by economic patriotism that distinguished between the imperial periphery and core. Both the periphery and the core were scenes of exploitation and expropriation that underpinned the nation's industrialisation. Scotland's poor, targeted by social engineering strategies for the improvement of human capital, represented the 'periphery within the core', experiencing subjugation despite being identified, both culturally and geographically, with the imperial project.[83] As late as 1833, Peter Borthwick, a pro-slavery lobbyist of the West Indies asked,

> What is your Bristol, your Liverpool, your Manchester, your Glasgow, your Paisley, your Dundee, your eastern end of the great metropolis, even London itself- if you take from them the West India Colonies? Nothing- worse than nothing; one universal scene of beggary and starvation.[84]

The empire served both as a central pillar of national consciousness and a tool of improvement of the state of affairs in Scotland itself, including the growing care infrastructure. The social dislocation in Scottish cities triggered by mass industrialisation and urbanisation was recognised as a social ill, and increasingly the colonies were seen as both an uncultivated land to be populated by white Scots, as well as a source of revenue that would help fund the 'improvement' of Scottish cities and their populations. The successes of Scots abroad were a consolation for the social crises at home.

Crucially, the financing of medical developments through revenue seeped in slavery has been read as paradoxical by historians.[85] In his report on the links of the Edinburgh infirmary to transatlantic slavery, Simon Buck juxtaposed the 'horrific

[82] Karly Kehoe, 'From the Caribbean to the Scottish Highlands: Charitable Enterprise in the Age of Improvement, c.1750 to c.1820', *Rural History* 27:1 (2016).
[83] Nancy Fraser, 'Contradictions of Capital and Care', *New Left Review* 100 (2016); Nancy Fraser, *Cannibal Capital: How our System is Devouring Democracy, Care, and the Planet-and What We Can Do about it* (London, 2022).
[84] Mullen, *The Glasgow Sugar Aristocracy,* 1.
[85] Buck, 'Uncovering Origins of Hospital Philanthropy'; Marshall, 'London, Locke and 1690s Provisions.

enslavement and cruel exploitation of enslaved and colonised people of African descent in Britain's colonies' with the 'Royal Infirmary of Edinburgh- a place of humanity, charity, and healing'.[86] The contrast between *dehumanisation* and *humanism* that are used to characterise the institutions of slavery and medical philanthropy respectively, chimes with the narrative of the seeming rift between the continued lack of humanity of white Britons *en face* colonial subjects and their increased display of humanity, or care, towards the predominantly white 'sick poor' in Britain. Situating medical philanthropy in the context of 'improvements' challenges this juxtaposition, I argue, instead pointing out the varied mechanisms of human capital investment across the imperial landscape. Scottish medical institutions were directly rooted in the increased tendency to institutionalise and later medicalise the poor that characterised the voluntary hospital movement inextricable from the developments of the carceral systems of workhouses, gaols and houses of correction, Magdalene asylums and bedlams that speckled the British metropole in a network of public and private establishments. The misidentification of European philanthropy as motivated by altruistic and humane motives, results in the failure of linking its origins to the apparatuses of extractive capitalism. As suggested by Foucault,

> It should never be forgotten, that while colonisation, with its techniques and its political and juridical weapons, obviously transported European models to other continents, it also had a considerable boomerang effect on the mechanisms of power in the West, and on the apparatuses, institutions, and techniques of power. A whole series of colonial models was brought back to the West, and the result was that the West could practice something resembling colonisation, or an internal colonialism, on itself.[87]

The belief in populationism and human capital investment did not develop independently from institutionalisation and incarceration for the purposes of labour productivity maximisation in Scotland and in the colonies, instead being generated by the exchange of ideas, tools and methods devised across the two contexts in their interlink. The systems of capitalist exploitation and expropriation stemmed from the contemporary authoritarianism, extractive capitalism and ideological hierarchisation of peoples that informed the labour theory and political economy of the eighteenth century, enabling the predominantly racialised oppression of enslaved peoples in the colonies and the mainly class-based oppression of the urban poor in Scotland.

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[86] Buck, 'Uncovering Origins of Hospital Philanthropy', 3.
[87] Michel Foucault, Lecture series entitled 'Il Faut Défendre la Société', 4th February 1976, Collège de France.

For the context of this thesis, acknowledging the colonial legacies of medical philanthropy in urban Scotland is used in order to highlight the embeddedness of philanthropic endeavours in the economic climates of Scotland. Crucially, the distinction made between slavery-associated profits and other sources of revenue was not apparent to contemporaries, and whilst voices condemning the enslavement of people began to emerge, these primarily denounced the harsh treatment of the enslaved rather than their subjugation per se.[88] Similarly, mechanisms of coercive labour applied in Scotland such as workhouses and textile training schemes were readily accepted by contemporaries, eager to employ the growing number of the 'indigent' poor in order to advance the national economy. Institutions such as the infirmaries discussed here were indivisible from the cultures of 'improvement' within which they emerged, and the medical aid they offered to the select patients served as a tool of relief as well as reform, furnishing its beneficiaries with a sense of gratitude and industry and promoting thus the project of national progress. Although established by private philanthropists and urban elites, voluntary hospitals were not independent from the state, not least by caring for its armed forces. As this chapter goes on to show, medical philanthropy remained a crucial aspect of the emerging care infrastructure that underpinned the formation of state welfare, at first as a tool of population growth and retention and later population control, increasingly aimed at the sick poor.

6.4 The Effects of Fevers: Pulteney Alison, Scottish Poor Laws and Public Health

By the early 1800s, the strands of populationism and anti-welfarism that characterised the system of poor relief in Scotland in the eighteenth century began to give way to legalism, with William Pulteney Alison as its greatest advocate. Rapid population growth, overcrowding and Malthusian scepticism meant that a growing population was no longer seen as the greatest asset of a nation. Instead it was perceived as a burden or public expense. Concerns surrounding the health of the population, especially of the poor that constituted the majority, characterised emerging debates that called for the curbing of unbridled population growth. This anxiety was set in stone as the construction of the Edinburgh New Town and Glasgow West End progressed, increasingly segregating the cities' inhabitants along class lines. Equally, the changing attitudes to the poor, no longer to be reformed but instead managed and contained, were reflected in changing narratives of poor relief and medical provision. According to Dr Cowan, one of Glasgow's prominent

[88] Mullen, *The Glasgow Sugar Aristocracy.*

physicians, 'the prevalence of fever presents obstacles to the promotion of social improvement among the lower classes', and its prevention and treatment through institutional relief thus continued as an extension of the improvement project.[89] At the same time, however, the prism of charity motivated by reason as well as religion remained at the core of poor relief. The last section of this chapter uses the 'fever' epidemics to think about the role of medical concerns in altering the attitudes to the poor and their relief. It looks at the Edinburgh and Glasgow Infirmaries and their transformation through assuming responsibility for managing the epidemics.

The term 'fever' referred to a range of infectious diseases associated with local and seasonal circumstances. In the British context, 'continued fever', as described by William Cullen, was a general inflammatory condition accompanied by delirium, stupor, and nervous and cerebral weakness and included a range of conditions not distinguished until the mid-nineteenth century.[90] Informed by miasmic theory, the severity and range of symptoms were thought to be influenced by weather conditions and *atmosphere*, understood as a combination of air purity and sanitation of the public space. Especially in the urban centres, miasmatism was an accepted explanation of the higher incidence of contagion in the slums of Edinburgh and Glasgow. Cullen identified the disease as typhus, which was the commonly accepted diagnosis for a range of fever-like symptoms until the 1830s, when the Glasgow physician Robert Perry distinguished between typhus and typhoid fever. Whilst typhus is a bacterial disease spread to humans through vectors such as fleas and lice, typhoid fever is a bacterial disease contracted through contaminated food or water. Likewise, cholera, which became more common in both cities in the 1830s, is caused by bacteria present in contaminated food or water. Whilst increased sanitation and personal hygiene alongside quarantine measures were effective in the prevention of contagion of typhus, cases of typhoid and cholera required further-reaching sanitary reform and improved sewage systems, which were only implemented in the mid-nineteenth century.[91]

As proposed by Kathleen Brown, health crises and epidemics heighten the attention paid to the individual and collective body, leading to an increase in discussions around health and medicine.[92] In the context of the British Isles, the overcrowded cities of Scotland and the poverty of famine-stricken Ireland were the most affected by the health

[89] William Pulteney Alison, *Observations on the Management of the Poor in Scotland* (Glasgow, 1840), 17.
[90] Leonard Wilson, 'Fevers and Science in Early Nineteenth-Century Medicine', *Journal of the History of Medicine*, 33 (1978).
91 Christopher Hamlin, *Public Health and Social Justice in the age of Chadwick, Britain, 1800-1854* (Cambridge, 1998).
[92] Kathleen M. Brown, *Foul Bodies: Cleanliness in Early America* (New Haven, 2009).

crises of the first half of the nineteenth century. With the persisting depiction of the poor as indigent, morally corrupt and to blame for their misfortunes, the connection between poor living conditions, malnutrition and physical toil and susceptibility to disease was rarely made outside of medical debates. Equally, the traditional view of disease as divine retribution continued to linger, as suggested by the Reverend Mr Lewis in the 1840s, who proclaimed that contagion was 'to be regarded as the visitation of God for the sin of neglecting a population fallen in character and habits'.[93] Increasingly, however, concerns about the poor's corrupting potential, both moral and physical, came to the forefront. The moral and economic category of the 'poor' was replaced by the term 'destitute' defined by Alison as:

> Persons who have a deficient supply of the necessaries of life…whose food is scanty and precarious, who are obliged to part with bed clothes, body clothes and furniture to procure food; who are inadequately clothed, and generally obliged, at least in towns, to associate together in masses, for the sake of food and shelter.[94]

Increasingly, precarity, malnutrition and residence in cramped conditions in densely populated areas were identified as the underpinnings of contagion, as well as symptoms of poverty. For Alison, a new medical conceptualisation of poverty resulted in merging medical and political solutions to the problem of contagion, a solution that was not readily accepted by his contemporaries. Gradually, however, it was the acceptance of the direct causation between poverty and the dangers of contagion that laid the groundwork for the acceptance of legalism. For poor relief was no longer only for the benefit of the poor or their reform from indigence to industry, but instead for the protection of the body politic. Fever as a cause of downward mobility of individuals and families was increasingly recognised, with Dr Harty, a Glasgow physician, suggesting that fever 'consigns tens of thousands to a worse fate, to hopeless poverty' especially for children of deceased parents, 'leaving the wretched offspring to fill the future ranks of prostitution, mendicancy, and crime'.[95] Treatment and relief of the poor increasingly meant lessening the medical danger they represented and thus those who benefited from the increased access to medical relief were the rich, as much as the poor. The transition from voluntarism to legalism was thus rooted in the practical reality of a health crisis, mostly experienced in the cities of Glasgow and Edinburgh. In the first decades of the nineteenth century, moral arguments of

[93] Robert Deuchar, *Observations on the Prevalence of Epidemic Fever in Edinburgh and Glasgow: And Means Suggested for Improving the Sanitary Conditions of the Poor* (Glasgow, 1844), 22.
[94] William Pulteney Alison, *Further Illustrations of the Practical Operation of the Scotch System of Management of the Poor* (Edinburgh, 1841), 289.
[95] Alison, *Observations,* 17.

evangelical reformers were joined by calls for a sanitary reform, which continued to develop as the leading voice of the public health development in England.

The sanitation and public health movement south of the border was associated with the 'bureaucratic radical' Edwin Chadwick, a disciple of Jeremy Bentham and author of the *Report on the Sanitary Condition of the Labouring Population* of 1842. The English version of public health remained surprisingly separate from the medical developments of the time.[96] Concerned primarily with contagion prevention through miasmatism, Chadwick paid little attention to social and community medicine and broader health promotion. The Scottish branch of public health, likewise emerged from the fever management strategies of Edinburgh and Glasgow and subsequently underpinned the poor law debates of the 1840s. Unlike Chadwick's, however, the Scottish approach was primarily devised by medical men, who placed *health* at the centre of public health, with the infirmaries taking up a leading role in epidemic management.[97] By the early nineteenth century, Alison already warned against the association between immorality and poverty and placing the blame on the poor themselves, instead focusing on mapping and alleviating the squalid conditions of urban slums where contagion was most widespread. Whilst he worked on separating the complex category of 'fevers' into more accurate medical definitions, he was less interested in the actual clinical nature of the diseases, instead focusing on the conditions within which diseases flourished. Such were the origins of his social and political approach to medicine, focusing predominantly on prevention rather than remedy.[98] Crucially, his approach to poor relief was inextricable from his medical practice, shaped by the epidemic crisis. He worked to shift the focus from the moral inadequacy of the poor to their desperate material need, which he identified as a source of contagion as well as a moral ill. He wrote,

> Not that destitution is an adequate cause for the *generation* of fever, nor that it is the *sole* cause of its *extension*,- but that it is *one* cause of the diffusion of fever; of such power, that an epidemic of that disease, invading a community where the provisions against destitution are inadequate, is very generally found to spread, *ceteris paribus*, to an extent remarkably greater than where adequate provisions of that kind exist.[99]

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[96] Hamlin, *Public Health and Social Justice,* ch. 3.
[97] *Ibid*. chs. 2&4.
98 Christopher Hamlin, 'William Pulteney Alison, the Scottish Philosophy and the Making of Political Medicine', *Journal of the History of Medicine and Allied Sciences*, 61:2 (2006).
[99] William Pulteney Alison, *Observations on the Generation of Fever', in Reports on the Sanitary Condition of the Labouring population of Scotland* (London, 1842), 1.

Through advocating for better living conditions for the poor, he remained true to the project of 'improvement' and reform rather than humanitarianism. His pragmatism remained in line with his predecessors, marking efficiency as the foremost measure of success of the system of relief. With the growing incidence of fever, the category of the sick poor was eroded, expanding beyond precedent and becoming increasingly transient. The need for a more comprehensive system thus became more pressing in order to preserve the social status quo and prevent the porous category of the poor from expanding further, with poverty and disease threatening to spread to their social betters. As proposed by Robert Deuchar, the secretary of the Edinburgh Fever Board, 'although [fever] has hitherto been chiefly confined to those localities where the poor reside, it is manifest that unless increased exertions are made, it cannot fail ere long to spread itself among the higher classes of the community'.[100]

As shown by Daisy Cunnynghame, the roots of the public health movement in the Scottish context were laid in the late eighteenth century and are notable in the works of Andrew Duncan, the Edinburgh medical man and founder of the Edinburgh Dispensary (established around 1775). Based on his varied practice, Duncan gave extensive lectures on the social and environmental causes of disease as early as the 1790s. Whilst more centralised efforts to improve public health only developed in response to the crises of the early nineteenth century, early endeavours to address the varied susceptibility to disease amongst the population by practitioners like Duncan provide an important example of the nascent concerns around health as a social, rather than an individual matter.[101] As shown later by Alison, contemporaries were highly aware of the changes brought on by industrialisation, urbanisation and population growth. It was in this context that questions around contagion began to emerge, slowly replacing miasmatism with rudimentary concepts of disease transmission through contagion and exposure to infection. Contagion theory was not universally accepted, however, coexisting with traditional beliefs in diseases caused by strong passions or bad air. Linking contagion to overcrowding, poor sanitation, ventilation and close contact with infected individuals in the industrial hubs became central to the emerging concepts of medical police and public health of the early nineteenth century. The medicalization of poverty thus contributed to the formalisation of public health theory as well as the gradual removal of healthcare from the realm of voluntarism to the domain of state responsibility. With centralisation came heightened pressure on efficiency, firmly establishing the question of public care provision at the core

[100] Deuchar, *Observations,* 3.
[101] Cunynghame, 'The Roles of the Edinburgh, Kelso, and Newcastle Dispensaries', 60-70, 200-220.

of national budgeting. As demonstrated by the infirmaries discussed here, public health in the early nineteenth century was central to the reinvention of large medical hubs from educational and philanthropic establishments to instruments of civic virtue and public provision, shifting the focus from providing for the individual to the idea of common good resulting from accessible health care.[102]

6.5 Hospitals, Fevers and the Changing Nature of Care Work

The two cities with distinct medical and welfare infrastructures responded to the crises differently. In Edinburgh, the smaller population of the poor, more stable population growth as well as the more developed and diverse network of welfare establishments including the infirmary, enabled a more holistic approach that involved the removal of the afflicted to fever hospitals, increased hygiene and disinfection of the affected areas and more long-term provision for the sick. On the other hand, however, the number of societies and institutions involved in the fever management was blamed for its inefficiency by some, suggesting the political backdrop of the debate.[103] Frequently criticised for the lack of public accountability, the Edinburgh infirmary remained the target of those desiring a public or municipal response to the epidemic, using the Glasgow infirmary as an example in opposition to the private nature of the Edinburgh infirmary's management.[104] In Edinburgh as opposed to Glasgow, the epidemics remained relatively contained, however, claiming significantly fewer lives than in other large cities. By contrast, in Glasgow, the underdeveloped infrastructure, unparalleled levels of poverty and destitution of the continuously growing population and the overreliance on home visitations to the afflicted led to the spread of contagion and unmatched mortality. The fevers and their varied handling had brought to the forefront the inadequacy of the welfare infrastructures across Scotland. The centrality of the institutions to the changing discourse on poverty, population management and public health thus highlights the placing of care and welfare politics at the centre of the developing nation state.

In both cities, the incidence of fever grew to a concerning degree in 1816 and remained the defining subject of debates over public health and the poor law until at least the 1860s.[105] In Edinburgh, the infirmary found itself unable to accommodate the growing number of fever patients by the end of 1817, having only 36 beds fitted for the purpose.

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[102] Ibid., ch. 7.
[103] Royal Infirmary of Edinburgh', *Caledonian Mercury*, 2. 4. 1818, 1; 'Royal Infirmary', *The Scotsman,* 18. 4. 1818, 126; 'Royal Infirmary', *The Scotsman*, 4. 4. 1818, 108.
[104] *Ibid.*
[105] Jenkinson, *The Royal*; LA LHB1/1/8-15, Minutes of Royal Infirmary 1813-1850.

That year, the hospital admitted 590 patients suffering from fever, though its managers argued for the necessity of a specified establishment. In response to the continued belief in miasmic spread of the fevers, Alison begun to take a more socially informed approach, developing a theory of contagion that negated the overreliance on environmental and sanitary factors. In 1817 he wrote,

> For example, until the middle of October we had no case of fever from Blackfriars Wynd, the population of which is probably three times that of Bell's Wynd (which by that time had furnished forty-five), equally crowded and dirty, and suffering equal privations of every kind…On the other hand, a district not exceeding 140 yards in length, and 100 in breadth (including the lower part of Bell's Wynd, and of the adjacent and opposite closes, and the intervening portion of the Cowgate), has furnished up to this date 135 cases to the Dispensary since May last, besides at least forty more to the Infirmary directly, to the Public Dispensary, or to private practitioners.[106]

He believed that the spread of contagion could be prevented through quarantine rules, removing patients to the hospital and fumigating their abodes, as well as improving living conditions through more comprehensive poor laws. The Edinburgh infirmary and Destitute Sick Society had implemented his theory, largely expanding on the capacity of beds to accommodate sick patients. By 1818, the Queensberry House, a former military building, was repurposed as a fever hospital run by the Royal. Additionally, the infirmary itself housed a number of fever wards and occasionally used other premises around the city. Primarily managed by the infirmary and the Destitute Sick Society, voluntary charity remained at the forefront of fever management in Edinburgh. As such the institution also became the centre of theorising about the treatment and prevention through testing out methods of separating patients, ventilation and fumigation. By the end of 1818, 2,417 patients had been admitted to the infirmary and additional 809 to the fever hospital, counting 1,203 more than in any previous year. Although the epidemic became milder in the following year, and the Queensberry house was vacated by 1823, the subject of fevers remained at the forefront of the hospital's management. Reaching high numbers again between 1826 and 1828, the Queensberry house was reopened and by 1,826 the number of patients admitted across the infirmary and the Fever Hospital reached 4,373, out of which 2,050 were suffering from fever.

In March 1830, a Fever Board presided over by the Lord Provost was established as a separate body to deal with the unceasing contagion. It joined together members from the

[106] William Pulteney Alison, 'Report of Diseases Treated at the Edinburgh New Town Dispensary, from September up to December lit, 1817' (Edinburgh, 1817).

Town Council, Destitute Sick Society, the Royal Infirmary, the Royal as well as New Town Dispensaries, in response to calls for public management of the crisis. Alison was one of the special members of the Board, which followed his socio-medical understanding of the epidemics. Funded by collections, city funds as well as an annuity of £100 from the Police, the Board reflected the development towards a public form of healthcare provision. The Royal Infirmary and its staff as well as the Society, however, remained at the forefront of the treatment of the sick poor, especially due to the Board's reluctance to treat the afflicted within their homes. Alongside visiting and removing patients to the hospital, the Society was responsible for sanitary measures such as fumigating the homes and possessions of the sick. As claimed by the Society's 1844 report,

> In short, it is not saying too much to aver, that the destitute sick society may be regarded, under Providence, as one of the guardians of the public health in the city. It has not merely relieved the sick; it has, we repeat, prevented the spread of contagion, and stood, in some cases, like devoted men of old testament, between the healthy and the infected in our crowded lanes.[107]

Similarly, the infirmary remained responsible for the treatment of the sick, staffing and management of the premises and largely also securing resources. As is made apparent from the infirmary's records, the infirmary and the Board often squabbled over the responsibility to fund cases admitted without prior recommendation by subscribers, interfering with the institution's system of financing the care they provided. At the same time, the pressures on the revenue as well as capacity continued with the outbreak of cholera in the 1830s. Collections at church doors were repeatedly made and public sponsorship became more important than ever before, owing to the breaking down of the system of referrals.

Alongside financial duress, the staffing of the infirmary came under pressure, with growing need for additional staff as well as increasing mortality, endangering especially nursing staff and clerks who were resident in the house and in frequent contact with patients. In 1819, the matron Miss Simpson as well as several members of the nursing staff died of fever, which was also contracted by many medical men. The management recorded that they 'so duly appreciate the risk to which these gentlemen have thus gratuitously exposed their health and their lives in the cause of humanity, lives not only valuable to their families and to society, but from the stations which many of them fill, very important to the country in which they reside'.[108] Alison himself lamented the death toll of the epidemic amongst medical men, including the prominent physicians John Home and James

[107] LA GD10/2/1, Annual Report of the Society for the Relief of the Destitute Sick 1844.
[108] LA LHB1/1/9, 54.

Gregory.[109] No such accolades were paid to the nursing or administrative staff, reflecting the explicit hierarchy between medical men and the rest of the staff and highlighting the disproportionate valuing of care provision. For the most part of the 1810s and 20s, nursing staff continued to be regarded with contempt reflected in their low remuneration.

As a result of the pressures on labour relations in the fever wards, the subject of nursing staff came once again to the forefront in the 1830s. Contrasting with the earlier reluctance to reform their working conditions expressed by the managers and matron, in 1839 a consensus was reached that the long working hours and poor pay was not conducive to finding quality staff. In January 1839, the working conditions of nurses were reviewed and especially those of night nurses were found inadequately remunerated. Night nurses had the sole charge of a full ward from 11 p.m. until 9 a.m. when they were employed in other work until 4 p.m. when they were allowed time to rest until their night shift started again. As suggested 'for all this it will be seen that they do not receive more than the ordinary wages of a household maid servant', being paid only £9 per annum.[110] The day nurses worked from 9 a.m. until 11 p.m. without interruption 'and for this arduous and important duty they only receive £10 per annum it seems unsurprising that any description of a person qualified for the duty can be found to perform an uninterrupted course of severe labour for a recompense so small'.[111] The committee raised the wages of both by £1 and introduced a yearly pay rise of £1 annually for senior day nurses. They also hired additional superintendent nurses paid £20, who were in charge of overseeing the 44 members of nursing staff previously only responsible to the matron and her assistant. By 1841 another two female superintendents were hired to oversee night nursing in the hospital at £40 per annum. These reforms show a significant departure from the derogatory view of nursing staff only twenty years prior. This is clearly linked to the changing nature of the work in the context of fevers, when care providers risked contagion and death. Nurses in fever wards received regular pay-rises to £15, reflecting the difficulties with filling the positions. Most wards were generally staffed with only one nurse, which was seen as unsatisfactory.[112] Strategies developed in the hospital for contagion prevention included frequent debates around safety measures to prevent staff from contracting the disease, though these were often insufficient. In the context of the infirmary, this shift represents an important reminder of the changing nature of pre-reform nursing, highlighting the continuous debates on the nature of nursing work and its value, contrary to

[109] Alison, *Observations*, 18.
[110] LA LHB1/1/12, Minutes of Royal Infirmary, 1838-42, 144.
[111] *Ibid*.
[112] LA LHB1/1/13, Minutes of Royal Infirmary, 1842-44, 335.

its depiction as static and unskilled by traditional historiographies.[113] It was the pressures of the fever that pushed for the nature of institutional care work to be considered and reformed, in a climate when providing care posed a health hazard.

The pressures of the epidemics resulted in an increased level of professionalization of the administrative structures across the board. As reported in the *Mercury*, 'all the spare wards were successively opened until there were nine wards appropriated for fever patients-that the Dispensaries and the Commissioners of Police were applied to facilitate the early removal of fever patients to the hospital' reflecting the devolved system adopted, requiring greater administrative efficiency.[114] By 1837, the managers introduced a new position of governor or superintendent, to represent the formal head of the internal economy, marking a departure from the institution's running akin to a large household. The superintendent was to be a man of medical education, preferably with a military background, unmarried and not older than 40 years of age. The position was merged with that of an apothecary and a Mr John Brown, formerly a navy surgeon, was hired at £120 per annum, at that point the highest salary in the infirmary. Similarly to the Orphan Hospital, the position was not easy to fill despite the competitive salary and the hospital thus faced staff fluctuations and rebranded the post to fit pre-selected candidates. In 1843, Mr Farnie was appointed the treasurer-superintendent paid £220 per annum, a hundred pounds more than the next highest paid employee, the clerk. After his death in 1846, Mr Farnie was replaced by a Mr McDougall at the reduced salary of £200. The new treasurer-superintendent bridged the internal and external economies, being in charge of the executive, fiscal and managerial tasks in the hospital. The growing emphasis on concentrated administrative power in the infirmary is symptomatic of the increasing shift of the hospital's directorship from the board of managers and the external economy, to the in-house governor/superintendent and the internal economy. The gendering of the prominent internal staff thus followed its growing executive dimension. Interestingly the role of the matron remained formally largely unchanged, despite its flexibility allowing for a high degree of personal variations. By contrast, the role of the male governor was moulded by the officeholders themselves as well as the managers who sought increasingly to centralise the hospital's executive, contributing to making the hospital a centralised institution rather than a joint stock company.[115]

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[113] Versluysen, 'Old Wives Tales?'; Harkness, 'A View from the Streets'; Pelling, *Common Lot*; Barbara Mortimer, *New Directions in Nursing History* (London, 2004); Barbara Mortimer, 'The Nurse in Edinburgh c. 1760-1860: The Impact of Commerce and Professionalization', PhD Thesis, School of History, Classics and Archaeology, The University of Edinburgh (2001).
[114] *Caledonian Mercury*, 4.1 1838, 4.
[115] LA LHB1/1/14,Minutes of Royal Infirmary, 1844-46.

In an attempt to alleviate the financial pressures of treating patients without recommendation and often not resident in Edinburgh, especially after the poor law reform, the infirmary negotiated with parishes for their financing of patients sent in for treatment. Functioning as the principal medical provider in Scotland under the New Poor Law, the hospital admitted patients at a flat rate of £1 1s notwithstanding the length of their stay, or 9d per day, payable by their parish of settlement. As reflected in the numerous letters exchanged between the infirmary and local parochial boards, the enforcement of the payments was not always successful, however.

Alongside the health threat posed to the municipal community, the fever board was well aware of the economic repercussions caused by the panic that ensued. Deuchar highlighted the ill effects of fever and the associated panic on trade and commerce, suggesting that,

> Nothing can be more injurious to the prosperity of the city than to permit exaggerated statements to be spread abroad, which are calculated to impress strangers at a distance with the belief that fearful epidemic is at present raging in Edinburgh, and that it would be unsafe for strangers either to visit or reside among us. Misrepresentations of this kind are exceedingly injurious to trade.[116]

Deuchar supported Alison in advocating for a more centralised welfare system, criticising the voluntary basis of medical relief, especially in Glasgow where the prevention of contagion was largely unsuccessful. As one of the Edinburgh fever administrators, he wrote largely in favour of the Edinburgh system of removing patients to the infirmary and separating the 'sick from the healthy'. Commenting on the Glasgow and Dundee systems that lacked similar centralisation, he proposed this had negative effects on trade and commerce.[117] The subject of panic was heavily debated, reflecting the desire to minimise the economic effects of the epidemic. The Magdalene Asylum surgeon Robert Hamilton proposed that panic had a strong nocebo effect that accounted for a large portion of contagion in the asylum, echoing Deuchar's worries about the injuriousness of fever panic to civic and commercial life. His theory highlights the awareness of the two-way relationship between economic cycles and health crises that underpinned both the efforts to lessen the economic ramifications of the fevers but also the growing recognition of poverty and destitution as contributing factors.[118]

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[116] Deuchar, *Observations,* 3.
[117] *Ibid.*
[118] Robert Hamilton, *Notice Concerning the Fever that Occurred in the Magdalene Asylum of Edinburgh, in the Spring of 1821, as Illustrating the Influence of Panic in Propagating Contagious Diseases* (Edinburgh, 1824).

In Glasgow, epidemic fever proved equally transformative to the care infrastructure. Unlike in Edinburgh where voluntary bodies predominated early on in the epidemic, fever management had been regarded as a municipal concern from the beginning of the crisis. In 1818, Richard Millar, a physician to the infirmary and a district physician to the poor, addressed the Lord Provost to devise a centralised municipal response to the epidemic that was becoming prevalent in Glasgow since 1812 despite being nearly absent in other cities. With the inadequate accommodation, patients were being turned away and those without recommendation were not granted admission. He proposed that sufficient accommodation was provided for the sole purpose of containing the contagion, admitting patients without patronage. In this early account, Millar remarked on the fear and panic aroused by the contagion as well as 'much selfishness and hardheartedness' so that 'not a few of the poor sufferers have wanted even the common offices of humanity' when suffering from fever. Foreseeing Alison's later writing on the inadequacy of voluntary relief in the urban context, at the very start of the epidemic, Millar already called for a centralised response.[119]

By 1818, admissions policy changed in the Glasgow infirmary, reflecting the rapid increase of urgent cases of fever, which resulted in accepting patients without a recommendation. This policy came into effect gradually, with continued reluctance to give preference to non-recommended patients. In spite of the greater spread of contagion in Glasgow, the infirmary and Town's Hospital remained the main bodies managing the treatment of patients as well as the spread of contagion in the city, with the infirmary treating in-house patients and the hospital employing district surgeons attending patients in their homes. A fever committee was appointed by the subscribers to the infirmary as an appointed body to deal with the contagion, still based at the infirmary as opposed to a separate municipal authority. Unlike in Edinburgh, the numbers of admissions continued to grow steadily and by 1825 represented a third of all patients admitted, counting 899 fever cases.[120] A designated fever hospital was not opened until 1829, under the immense pressure experienced by the Royal. This was made possible by donations from the Relief Committee for Unemployed Operatives run as a friendly society in Glasgow.

The Glasgow Infirmary was the first to introduce the post of superintendent in 1830, with Edinburgh following suit. The new post was formed to accommodate the increased administrative pressures on the managers, treasurer and clerk. Similarly, it

[119] Richard Millar, *Statements Relative to the Present Prevalence of Epidemic Fever among the Poorer Classes of Glasgow: Together with some Suggestions, both for Affording More Adequate Assistance to the Sick, and for Checking the Farther Progress of the Contagion in a Letter Addressed to the Honourable, the Lord Provost of Glasgow* (Glasgow, 1818).
[120] Jenkinson, *The Royal*; LA LHB1/1/10, Minutes of Royal Infirmary, 1824-31.

reflected a change in the running of the hospital, increasingly as a public institution rather than as a private household, a context in which a female manager was customary. The superintendent was to be 'a man of good character, of middle age and a good accountant'. He was required to reside in the house and 'devote his whole time and talents to his duties of the House'. Importantly, whilst not engaged in medical examinations, he was to oversee admissions and make sure they were made according to the rules except in acute emergencies. The committee report on the matter reveals the rising importance of the gendering of space and staff relations in the midst of the institution's restructuring. The superintendent replaced the matron in paying staff, presiding over male servants and ensuring that no female patients were examined by male practitioners without a female overseer. Similarly, he was in charge of the morgue to prevent scandals associated with the abuse of dead bodies through unauthorised dissections. He was charged with account keeping and drafting annual reports, both fiscal and medical, bringing a higher level of continuity between the separate 'economies' of the infirmary.[121] The position was not advertised until 1832, however, and then no suitable candidate was found and so the post remained unfilled until 1838, when Mr Robert Martin, a 'man of active business habits' was found.[122] He only stayed in the post for five years, however, being replaced by the apothecary, who thus, in a similar fashion to Edinburgh, became Apothecary-Superintendent with the salary of £120.[123]

Similarly, the work of nurses came to the forefront of debates relating to fever management. With the growing numbers of patients, nurses were overworked and by 1829 the managers debated their pay and working conditions being augmented.[124] At this point, the fever wards only employed 3 nurses, each responsible for up to 40 patients at one time with the managers deciding to hire additional 3 nurses. Whilst concerns over night nurses' drinking and incompetence persisted, the continued efforts at their superintendence were met with motions to improve their working conditions. By 1837 a female superintendent in charge of the nurses was hired, reflecting the growing hierarchisation of the staff. Like in Edinburgh, reward schemes were developed for long-serving nurses, with nurses employed for five years receiving a bonus of 12s and those employed for over 10 years 24s annually. Additionally, by the 1840s, long-serving nurses gained a pension entitlement, with nurse Nelly receiving £1 monthly after serving the institution for 35 years. The board allowances

[121] LA LHB1/1/12, Minutes of Royal Infirmary, 1838-42, 61.
[122] Jenkinson, *The Royal*, 69; GNA HB14/6/11, Miscellaneous letters pertaining to the role of the superintendent; GNA HB14/1/8, Minutes of the Glasgow Royal Infirmary, 1838-41.
[123] Jenkinson, *The Royal*, 70; GNA HB14/1/8-9, Minutes of the Glasgow Royal Infirmary, 1838-47.
[124] Jenkinson, *The Royal*; GNA HB14/1/6, Minutes of the Glasgow Royal Infirmary, 1829-33.

were also increased from £8 to £10 per nurse per year. Like in Edinburgh, staff conditions were altered as a result of the fever epidemics. With the recognition of the dangers that accompanied hospital work during the epidemic, the general contempt for service and nursing staff became less pronounced. With the professionalization of the hospitals' administration, relations between staff members were likewise altered with decreasing exercise of individual discretion and greater formalisation.

By 1831 a Glasgow Board of Health was established that brought together municipal, medical and clerical authorities and was funded by the rates in order to construct a more efficient strategy for the unremitting fever. In 1836, the numbers of patients treated in Edinburgh decreased to 658, whilst in Glasgow, 3,125 patients were treated in hospital and 6,967 at home, affecting 10 per cent of the city's population.[125] By the following year, this number grew to 21,800. Cases continued to grow until 1837, when a record number of fever patients (5,408) were admitted to the infirmary, resulting in the establishment of an additional fever hospital in the former Police quarters. The death rate reached a record 41 for every 1,000 of the city's population, By 1838 the number of available beds was again increased with a strategy developed by the Board and the cases finally started to fall, counting 2,173 in 1838. As suggested by Robert Deuchar, the Glasgow system partly managed by the Town's Hospital relied primarily on treatment within the homes of the afflicted, which resulted in a much greater spread of contagion than in Edinburgh. Whilst engagement of 'public' authorities in fever management became more pronounced, its funding continued to rely on poor rates and collections. The infirmary remained the most prominent agent in treating patients and conducting research with Robert Perry, the physician between 1834 and 1848, publishing widely on the distinction between typhoid fever and typhus. Whilst stopping contagion was regarded as a matter concerning all inhabitants of the city, it continued to be financed as part of the limited system of poor relief, increasingly equating the category of the 'poor' with those susceptible to fever contagion. Whilst more 'publicly' run than its Edinburgh counterpart, the Glasgow infirmary continued to rely on voluntary charity and church collections, and a permanent fever hospital was not erected until 1847, in spite of repeated calls to that effect. Despite being more incorporated into the city's poor relief infrastructure, including the publication of annual reports and balance of revenue in the newspapers, a practice never adopted in Edinburgh, the Glasgow infirmary lay somewhere in between the traditional voluntarism and legalism associated with the new poor laws.

[125] Deuchar, *Observations,* 4; GNA HB14/1/6, Minutes of the Glasgow Royal Infirmary, 1829-33.

The distinct responses to the epidemics in the two cities reflected the diverse care infrastructures in place, their economic capacity as well as the number of the poor inhabiting the industrial slums. Edinburgh with its better-established and independently run hospital and the active and well-funded Destitute Sick Society was able to face the pressures of the epidemics and devise a strategy that prevented the rapid spread of contagion experienced in Glasgow. Glasgow, on the other hand, was faced with a greater population growth and poverty levels, resulting in increased pressures on the infirmary and the Town's Hospital, to which the two institutions were unable to respond, resulting in the fevers claiming over 40 in a 1000 inhabitants of the city. Funded primarily through the rates and collections for the poor, the management of the epidemics was done under the umbrella of poor relief, and perceived as a problem primarily affecting the poor inhabitants of the city. Increasingly, however, the potential danger of the contagion for the better off began to be recognised, contributing to the rising popular interest in the fever management. With the recognition of the symptoms of urban poverty as contributing to the spreading of contagion, the poor were increasingly defined through the lens of medicine. It was the threat of contagion that shifted the narrative of care provision as only available to the deserving to something given out more freely, on the basis of a legal entitlement rather than merit. The benefactors thus also became the beneficiaries of charity, resulting in its expansion. The changing structure of the hospitals, established as a place of refuge for the deserving, duly recommended by their patrons, was transformed by the epidemics. Sufferers from the two cities and across Scotland were admitted without the need for a character, with their parishes becoming responsible for reimbursing the hospitals replacing thus private contributors. This shift resulted in the democratisation of access to medical relief and laid the groundwork for a more 'public' approach to healthcare as a prevention of contagion. Moreover, the fevers contributed to the reshaping of the general approach to the relief and maintenance of the poor.[126] Rather than an untapped resource to be moulded into a labour force, the poor thus became a fixed category to be managed, reduced and relieved, in order to promote the health and order of public space and the public body.

6.5 Conclusion

In this final chapter, I used institutional histories in order to demonstrate the changing landscape of top-down public provision over the course of the long eighteenth century. Whilst focusing specifically on institutional medical provision for a limited number of 'the

[126] Pelling, *Common Lot.*

poor', this chapter draws broader implications that speak to the history of the transition from anti-welfarism to legalism that marked the onset of the welfare state. Commencing with the establishment of urban voluntary hospitals, it demonstrated the rootedness of medical philanthropy in the broader discourse of 'improvements', a distinctly Scottish strand of theoretical and practical reform of the national landscape, in its physical, human and economic sense. The provision of care was central to the quest for economic growth and development of a nation that placed itself at the centre of an expanding empire.[127] Whilst motivated by the reform of Scotland, the 'improvement' ideal was deeply embedded in the colonial markets, through its proponents, their revenue and business ventures as well as beliefs in social engineering. As shown by John Marshall, labour theory at home and in the colonies was inextricably linked. With the provision of care as the underpinning of labour capital development, the stories of indenture and enslavement in the colonies and at home were likewise indivisible.

Throughout this thesis, the use of local case studies speaks to a bigger story; namely that of the value of the labour of social reproduction and human capital formation that underpinned the socio-economic phenomenon of industrialisation and colonial expansion of Scotland. It is the case that so much of this labour has gone unnoticed, leaving little trace in the archival record, assumed to be undertaken informally, within familial homes, mostly by women. Using the institutional archive to uncover the histories of care and care labour, however, shows just how much of this work took place in a very public space, facing public scrutiny. The foundation of Edinburgh and Glasgow Royal Infirmaries was a very public undertaking, funded by the individual and collective ventures linked to trade and commerce, religion, science as well as community provision. As demonstrated by Kehoe, medical philanthropy was directly linked to business ventures at home and in the colonies, funded as part of the national development project. Medical relief, at once a tool of reform and a form of public provision was thus not envisioned as a sort of expenditure, but rather a key investment in the population of a nation that underpinned its economic performance. Whilst the institutional space was by no means the primary locus of care, its growing prominence reflects the changing nature of socio-cultural and economic relations this chapter illuminates.

The latter part of this chapter examined the effects of infectious disease on the institutional structure of the Infirmaries, highlighting their centrality to the emerging notion of the public body and public health. Focusing on the changing view of the poor as a source of contagion and a problem to be solved, the nature of welfare and medical relief

[127] Charters, *Disease, war and the Imperial State.*

was being transformed. With heightened pressures on the institutions resulting from contagion, their internal structures, admission policies and sources of funding changed, resulting in their redefinition as public bodies. Again, these institutional histories were symptomatic of a broader socio-economic change, resulting in an increasingly centralised, rights-based conception of public provision that largely replaced individual responsibility to care with the notion of the caring social body. Through combining institutional, municipal and national histories, this chapter returned to the changing regimes of care highlighted in Chapter 2. With the central questions around the value of and responsibility to care at its core, it offered a final empirical case study that demonstrated the centrality of care to the changing social fabric of Scotland in the process of industrialisation.

7 Conclusion

Fig. 7.1 Alexander Carse, Oldhamstock Fair, 1796

As Carse illustrates in his 1796 pastoral scene of the village fair, practices of care in communal space were unexceptional, as opposed to their being confined to domesticity and thus excluded from the historical record. Genre art has always posed a challenge to historiographical impositions of separate spheres that narrated the public space as male dominated, void of the work of social reproduction, coinciding with the present day separation of production and reproduction in mainstream economic discourse. In the Scottish artistic tradition, genre has always had a special place, with its emphasis on egalitarianism and senses of belonging expressed in the pastoral scenes of the everyday, representing a rich source for the social historian alongside textual records.[1] The colourful busyness of these works provides a commentary on the complexity of human nature, often finding company in misery, or simply coexisting in the public space in various states of health or sickness, dependency and need. Carse's work is useful here in demonstrating the very public nature of living in late-eighteenth century Scotland. It depicts the pluriactivity of the public space, with the overlapping of labour and commerce, local governance, charity and care. In the *Oldhamstock Fair*, Carse centres the market's hustle and bustle around a quiet scene of a woman with two children, placing the pastoral image at the heart

[1] Duncan Forbes, ''Dodging and Watching the Natural Incidents of the Peasantry': Genre Painting in Scotland, 1780-1830', *Oxford Art Journal*, 23:2 (2000).

of a frenetic place of work, business and trade. The composition is deeply intentional. In a vertical line, the Madonna-esque trio is followed by a scene of a woman distributing charity, both directly below the village church placed right in the middle of the artwork. The piece echoes the late eighteenth-century nostalgia for the idealised parochialism and familialism, caritas and neighbourliness of early modernity, reflecting contemporaries' perception of the socio-economic change underway. In a Scottish tradition of social reformism shaped by religion, Carse evokes Christian virtues of charity and faith at the very core of the polity.[2] The painting provides a visual representation of the changing regimes of care this thesis has mapped out, echoing Chalmers' traditionalism and efforts to 'bring back the parish'. At the same time, it underscores the public nature of care, including in its familial forms. It highlights its concurrence with social and economic lives of communities, placing the imagery of natural affection at the centre of the community, a building block of social order.

When I began this research, I was aiming to conduct a quantitative study, interested in unearthing the value of care, in its monetised forms as well as when unpaid, in relation to the dynamics of the family and women's labour force participation. My main focus was the family, not as a homogenous unit of people with shared interests, but rather a heterogeneous one, with its members collectively devising strategies for survival and welfare. Initially, I hoped to look for care in the Scottish past in relation *to* labour, rather than *as* labour in itself. Following from the perceived feminisation of care work, I was curious to comprehend the ways in which the care burden shaped women's engagement in paid work across the life cycle, in turn providing new findings about labour relations in the context of Scottish industrialisation. I was driven by the idea of bringing care to the forefront of historical enquiry, approaching it as a phenomenon that was ubiquitous, yet invisible. As I progressed, the idea of care's invisibility in the historical record was beginning to wane, and I was struck by its ubiquity. My focus shifted to the subject of care in its own right, exploring its meanings, practices and economies in the Scottish urban space. I came to define care in broader terms, spanning activities that were paid and unpaid, market-oriented and domestic, habitually demarcated into arbitrarily neat occupational categories of domestic service, nursing, healing or lodging letting. Through the range of sources I drew on in this thesis, I concluded that in the eyes of eighteenth-century Scots, care was clearly recognised as work. The binary between 'production' and 'reproduction' was largely absent in the cash-poor economy that relied on myriad ways of making a living that did not involve a wage. Furthermore, as this thesis has shown, care

[2] Bob Harris and Charles McKean, *The Scottish Town in the Age of the Enlightenment 1740-1820* (Edinburgh, 2014), 444-55.

was distributed between various actors and heavily commodified. As Chapter 3 demonstrated, care and bodywork spanned myriad occupational categories, including domestic service, nursing and healing or letting lodgings, arrangements in which domestic spaces and places of work often merged. Moreover, as Chapter 4 showed, institutional care was largely viewed as an extension of familial provision, with families incorporating charitable institutions into their welfare strategies. Fundamentally, the distribution and loci of care were largely shaped by material circumstances faced by individuals, families and collectives trying to make do in times of hardship.

The thesis commenced by discussing the socio-economic change underway over the period between 1720s and 1840s. Marked by the aftermath of the Union of 1707, the eighteenth century was a period of weakened political sovereignty, of challenged national self-determination, and of warfare triggered by questions of succession, religion and nationhood. At the same time, it was a period of economic transformation, facilitated by expanded access to British and colonial markets that enabled individual Scots to build on the newly gained potential for economic exploitation and expropriation. Following a short period of economic downturn immediately after the Union, by 1720s Scotland began to see benefits that the pre-Union debates had promised.[3] In the absence of a Scottish state sovereignty, a strong emphasis on national economic progress that would distinguish Scotland from its southern counterpart developed, marking the beginning of a commercially driven notion of nationhood. Additionally, it was a period of bourgeoning social enterprise, with public reformism and philanthropy being used as ways of cultivating and transforming the public space. The spirit of 'improvement' that begun in the striving for better land management and enhanced agricultural production and extended to virtually all spheres of public life, shaped many of the ventures discussed in this thesis. It was the 'improvement', social reformism and engineering that shaped the landscapes of care, viewing human life and labour as a resource of economic growth.

As shown in Chapter 2, the 'improvement' discourse of the eighteenth century shaped the ways in which public forms of care provision were conceptualised and practiced, through mechanisms of private patronage, public philanthropy, and increasingly institutionalisation that perceived human capital as the greatest asset of the Scottish nation. By the early nineteenth century, the belief in populationism faltered, following rapid population growth, overcrowding and the influential Malthusian logic of population control, both exacerbated by the crises of epidemic fever. The resulting reconceptualization of poverty as a medical as opposed to a socio-economic category, I argued, was the

[3] Christopher A. Whatley, *Scottish Society 1707-1830: Beyond Jacobitism, towards industrialisation* (Manchester, 2000).

primary impulse that challenged the anti-welfarism of the century prior, resulting in a rights-based approach to the provision of public care. The temporal framework of this thesis ends in the poor law reforms, which, I argued, represented a nominal shift to legalism, paving the way for the development of state welfare. Situating care provision at the core of the history of economic change, it was my aim to challenge its continued erasure from economic history and economics.

Crucially, therefore, this thesis has viewed care as an economic activity as well as the underpinning of all other economic processes. As recently stressed by Shepard, care is a resource 'fundamental to human survival and well-being', as well as a service in both its paid and unpaid forms.[4] Yet, as demonstrated by Fraser, in spite of representing one of 'capitalism's economic subsystems', care continues to be overlooked in capitalist structures, contributing to the 'care crisis' of today.[5] As this thesis has argued, however, just as capitalism has a history, so does its relationship with care and care labour. Situating the study within the context of the emergence of industrial capitalism in Scotland on the one hand and the ideology of 'improvement' on the other, this thesis aimed to speak to the nation's economic transition over the course of the eighteenth century, a story thus far told without the inclusion of care and reproductive work. I highlighted the centrality of care to eighteenth-century political and economic thought, suggesting that care has always been a public concern. Whilst largely feminised, care work was performed by various actors and in varied ways across time and space, contrary to its depiction as unchanging, naturalised and ahistorical. In the context of this thesis, care work, both paid and unpaid is thus viewed as part of the varied avenues of making a living, engaged in by individuals across gendered and socio-economic distinctions.[6] At the heart of this thesis thus lies the subject of care labour, as performed and experienced, imagined as well as valued, through monetary exchanges, in-kind payments or with no remuneration at all, spanning relations of natural affection, kinship obligation, communal responsibility or a political act. Whilst this thesis has focused on the public nature of care, the family, or domesticity, are by no means absent. Ending thus with the *Oldhamstock Fair*, I want to highlight the role the imagined family played in the organisation of the public space of institutions, markets and the body politic, once again stressing the limitedness of the public/private binary.

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[4] Alexandra Shepard, 'Care' in C. Macleod, A. Shepard, & M. Ågren (eds.), *The Whole Economy: Work and Gender in Early Modern Europe* (Cambridge, 2023), 57.
[5] Nancy Fraser, 'Contradictions of Capital and Care', *New Left Review* 100 (2016); Nancy Fraser, *Cannibal Capital: How our System is Devouring Democracy, Care, and the Planet-and What We Can do about it* (London, 2022).
[6] Maria Ågren, *Making a Living, Making a Difference: Gender and Work in Early Modern European Society* (Oxford, 2017).

The chapters of this thesis read together do not provide a linear history, instead offering a series of case studies of care practices and their socio-economic contexts. Given the paucity of historical studies that centre care as a subject in itself, this thesis is intended to spark further debates rather than provide a complete account of Scotland's care infrastructures. The choice to focus on Mrs Laidlaw and Alexander, Edinburgh and Glasgow Infirmaries of the Edinburgh Orphan Hospital amongst others was made on the basis of available archival evidence and the aim to showcase the diversity of care provision in Scottish cities. Many more institutions, private practitioners or informal arrangements of care could have been included and many more are needed to map out the Scottish landscape of care. Both are beyond the scope of this thesis. Through selecting different levels of analysis across my chapters, it was my aim to highlight the centrality of care to micro and macro histories of economic change, histories of gender, work and medicine and the history of the welfare state. By doing so I aimed to stress the need for an interdisciplinary approach to the subject of care that spans so many aspects of human experience across time and space.

Against the backdrop of Scotland's industrialisation, this thesis contributes to fleshing out the picture of the 'other economy' that went unrecognised in traditional histories of industrialisation. Contributing to the histories of gender and work, it demonstrates the vast labour opportunities in the care sector, a large and largely overlooked component of the tertiary sector that marks the development of metropolises such as Glasgow and Edinburgh. Through focusing primarily on paid care work as performed by both women and men, I challenged the continued portrayal of care work as women's domestic labour. The thesis highlights the commodified nature of much of care work done within or outwith the familial and/or domestic contexts across the eighteenth century. It calls into question the present day imaginings of past caring relations as existing outwith market relations. It demonstrates that in eighteenth-century Scotland, caring *about* and caring *for* overlapped significantly, with material provision understood as a manifestation of ties of natural affection, familial obligation as well as an expression of inclusion and belonging to communitarian systems of welfare. My case studies spanned market forms of provision; institutional childcare and medical care viewed as a proxy for the changing care infrastructures of the period. In different ways, the family and community, the market and increasingly the state were present as shaping the practices of care and their cultural, socio-economic and political meanings. In the context of eighteenth century Scotland, care was both understood and experienced as the building block of social

order, ‘knitting together all parts of the vast structure of society’ and forming the bedrock of the whole economy, across time and space.[7]

[7] William Pulteney Alison, *Observations on the Management of the Poor in Scotland* (Glasgow, 1840), 163.

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