

**Medicine and Poverty: A Study of  
the Poor Law Medical Services  
of the Leicester Union, 1867-1914**

**Thesis submitted for the degree of**

**Doctor of Philosophy**

**at the University of Leicester**

**by**

**Angela Negrine**

**Centre for English Local History**

**University of Leicester**

**May 2008**

**Angela Negrine**

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**Abstract**

This thesis presents a micro-study of the poor law medical services provided by a large provincial union in a rapidly growing industrial town during the central phase of poor law administration. The poor law medical service has been perceived as a second-class service that stigmatised and exploited both medical staff and patients. Working conditions for medical officers were arduous and unrewarding and sick paupers either received limited outdoor medical relief or were treated in institutions that were designed and managed on principles of deterrence and economy. Yet posts were competitively sought after by doctors, who often remained in the service for many years, and it could be argued that sick paupers at least received medical treatment that would otherwise have been denied them. This thesis focuses on local detail and personalities within the Leicester union to provide an insight into the reality of the service as experienced by the medical staff and patients. The thesis begins with a review of the historiographies of the social history of nineteenth-century medicine and the new poor law. Chapter 2 provides the context of the study by explaining the national framework of the poor law medical services and describing the social and economic circumstances of Leicester and its union. The remaining chapters present a thematic exploration of the medical care and treatment provided. Chapters 3 and 4 offer a detailed assessment of the working conditions and practices of the medical officers. Poor law nurses undertook the daily care of workhouse patients, and Chapter 5 explores how nursing developed at this union during this lengthy period. Having considered the providers of medical care, Chapters 6, 7 and 8 examine the perspective of the recipients: the general patients, children, and insane and epileptic patients. Chapter 9 focuses upon the transition at the beginning of the twentieth century from the workhouse-based infirmary to a purpose-built modern separate infirmary. The final chapter concludes that the stereotypical image of poor law medicine has been confounded by some of the evidence offered in this thesis which has revealed a more nuanced and balanced view than previously of the benefits and deficiencies of the poor law medical services.

## Contents

List of Illustrations	page	iii
List of Tables		iii
Acknowledgements		iv
Abbreviations		v

## Chapter

1	The new poor law and the social history of medicine	1
2	Medical relief and Leicester	23
3	Leicester union's medical officers - their status and administrative situation	47
4	Leicester union's medical officers - their work	71
5	Nursing in the workhouse infirmary	98
6	The conditions and treatment of workhouse patients	123
7	Sick pauper children	152
8	Imbeciles and epileptics	177
9	'The Palace on the Hill': North Evington Poor Law Infirmary	202
10	Conclusion	231
Appendix 1	Chronology of key events in relation to the Leicester union and workhouse.	238
Bibliography		241

## List of Figures

Figure 1	Leicester union workhouse, c. 1870s	44
Figure 2	Plan of Leicester workhouse, 1894	131
Figure 3	North Evington Infirmary frontage	204

## List of tables

Table 2.1	Population growth in Leicester, 1851-1921	32
Table 2.2	The main institutions providing medical care in Leicester before the National Health Service	38-40
Table 3.1	District medical officers appointed to the Leicester union	52
Table 3.2	Medical officers appointed to the Workhouse and Cottage Homes	53
Table 4.1	Figures taken from half-yearly returns for 1 <sup>st</sup> January 1870-1910 in five-yearly intervals showing the total number of inmates in the workhouse under the various categories	74
Table 4.2	Figures taken from half-yearly returns for 1 <sup>st</sup> January 1870-1910 in five-yearly intervals showing the total number of inmates in receipt of out-door relief under the various categories	75
Table 4.3	Annual report returns for 1870-1873 showing numbers of adult infirmary cases	77
Table 4.4	Annual report returns for 1870-1873 showing numbers of children in the school infirmary	78
Table 5.1	Nursing applicants	118
Table 6.1	Workhouse infirmary deaths	140
Table 6.2	School infirmary deaths	141
Table 6.3	Total number of deaths in adult and school infirmaries and ages of deceased	141
Table 6.4	Number of workhouse deaths by year	142
Table 6.5	Amended list of causes of death	143
Table 6.6	Deaths at North Evington Infirmary, 1905-1911	143
Table 6.7	Subscriptions paid in 1905	150
Table 7.1	Children in Leicester workhouse, 1874 and 1877	153
Table 8.1	Numbers of imbeciles in Leicester workhouse	182
Table 9.1	Medical officers appointed to the North Evington Infirmary, 1905-1914	208
Table 9.2	Patients sent from North Evington Infirmary to workhouse	220

## **Acknowledgements**

The research for this study would not have been possible without the benefit of a three-year grant from the Arts and Humanities Research Council for which I express my grateful thanks. I would also like to give particular thanks to my supervisors, Professor K.D.M. Snell and Dr Sally Horrocks for their unfailingly generous guidance and encouragement throughout the period of research and writing. Throughout this process I have been heartened by other research students within the Department of Historical Studies at the University of Leicester who have shared their experiences and views with me. The majority of the research was undertaken at the Record Office of Leicester, Leicestershire and Rutland and I would like to thank the staff for their helpfulness and interest in this project. I am also grateful to Professor Ed Miller for his pertinent comments and constructive advice on the aspect of the new poor law and insanity. Finally, this thesis could not have been completed without their steadfast patience, love and belief in me and I give heartfelt thanks to my husband, Ralph, and to my son, Chris.

## Abbreviations

<i>BMJ</i>	<i>British Medical Journal</i>
COS	Charity Organisation Society
LGB	Local Government Board
LRO	Record Office for Leicestershire, Leicester & Rutland
MO	Medical Officer
MOH	Medical Officer of Health
N-A-B	Not-able-bodied
NEI	North Evington Infirmary
NRO	Northamptonshire Record Office
OAP	Old Age Pensioner
PLB	Poor Law Board
PLC	Poor Law Commission
PLMOA	Poor Law Medical Officers' Association
PP	Parliamentary papers
RC	Receiving homes
RMO	Resident Medical Officer
RMS	Resident Medical Superintendent
TNA	The National Archives
VCL	Visiting Commissioners in Lunacy
VMS	Visiting Medical Superintendent
WH	Workhouse

In references throughout the text the place of publication is London unless otherwise stated.

# Chapter 1

## The new poor law and the social history of medicine

### Introduction

This study aims to provide a contribution towards understanding the nineteenth-century medical profession's involvement in state medicine as well as an insight into the experience of their pauper patients, through an exploration of the medical services provided by a provincial poor law union. The intention is to present a thematic social history of the providers and recipients of poor law medical relief, that is, a 'history from below' of a particular group of patients and doctors. This thesis is therefore of relevance to more than one field of history. It examines an aspect of the social history of medicine in the nineteenth and early twentieth-centuries, but also aims to extend the fields of poor law and local history, as detailed research specifically of a local poor law medical service is lacking in the scholarly literature. Moreover, provincial practitioners of that time have received less attention than metropolitan medical practitioners.<sup>1</sup>

Leicester union was chosen as an example of a large urban union in an industrial town that experienced a rapidly increasing population together with a general rise in economic prosperity. Leicester's emergence as a factory industrial centre was mainly concentrated in the years between 1860 and 1914.<sup>2</sup> However, the town also experienced short periods of economic depression. These factors had significant effects upon the union and its medical service.

The first forty years after the inception of the Poor Law Amendment Act of 1834 have been widely studied. However, there has been less detailed local work in the

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<sup>1</sup> An exception is A. Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911* (Cambridge, 1994), a seminal economic history that examined the major influence of finance on provincial medical practice.

<sup>2</sup> S.J. Page, *Poverty in Leicester, 1881-1911: A Geographical Perspective*, Ph.D. Thesis, University of Leicester, 1987, p. 83.

period thereafter.<sup>3</sup> This period was the central phase of poor law administration up to the beginning of the First World War. More significant improvements, particularly in its medical service, did not really begin to appear until the late 1860s after pressure from reformers and some highly-publicised workhouse scandals revealed by *The Lancet*.<sup>4</sup> Even so, as Crowther pointed out, the poor law medical service still suffered a second-class reputation from 1867 to 1914, in spite of improvements in many infirmaries.<sup>5</sup> Coincidentally, a new workhouse medical officer was appointed to the Leicester workhouse in 1867 and the union's medical service gradually developed and improved during the subsequent years. Furthermore, the opening in 1905 of a separate poor law infirmary built at some distance from the workhouse offered a fortuitous opportunity to assess the effects of the transition from the town's workhouse-based infirmary to a new purpose-built poor law hospital. The new infirmary was later taken over as a war hospital and the pauper patients were transferred back to the workhouse. This retrograde move enabled further consideration of the extent to which the treatment of patients and medical staff had changed during the period.

An earlier study by Thompson of the Leicester union claimed that it had 'succeeded in solving the problem of pauperism by 1871.'<sup>6</sup> Her thesis was that the new poor law could work in an urban union, 'at least to the satisfaction of [the] central authority.'<sup>7</sup> However, Thompson argued that this success was mainly due to the developing prosperity of Leicester, that the Leicester medical officers were not as well qualified and committed as those in other unions, and, as a group, appeared 'somewhat inadequate.'<sup>8</sup> Her view supported the contention of other historians that poor law medical officers had limited success and the improvements they demanded through the

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<sup>3</sup> S. King, *Women, Welfare and Local Politics 1880-1920: 'We might be Trusted'* (Brighton, 2006), p. 6.

<sup>4</sup> B. Harris, *The Origins of the British Welfare State: Social Welfare in England and Wales, 1800-1945* (Basingstoke, 2004), p. 97.

<sup>5</sup> M.A. Crowther, *The Workhouse System, 1834-1929: The History of an English Social Institution* (1981), p. 181.

<sup>6</sup> K.M. Thompson, *The Leicester Poor Law Union, 1836-1871*, Ph.D. Thesis, University of Leicester, 1988, p. 2.

<sup>7</sup> *Ibid.*, p. 2.

<sup>8</sup> *Ibid.*, p. 203.



Poor Law Medical Officers' Association were mainly through self-interest.<sup>9</sup> Crowther conceded that less was known about the actual situation of local doctors. Nevertheless, she argued that they were not in a position to make more than minor changes even if they were so inclined.<sup>10</sup> Other historians have argued that the service did improve mainly through the endeavours of the medical officers.<sup>11</sup> This present study set out to assess whether the later poor law medical officers of the Leicester union were ineffectual and self-interested, or whether they achieved any significant improvements within this medical service.

The contemporary medical journals, *The Lancet* and the *British Medical Journal* (hereafter *BMJ*), claimed that poor law medical officers and their pauper patients were equally exploited by the principles of political economy that underpinned the new poor law.<sup>12</sup> Historians have agreed that poor law medical services were inadequate, ineffective and often harsh. This thesis concurs that the treatment of both medical officers and patients left much to be desired, but it suggests that this general view can obscure awareness and it is important to consider individual situations in order to expand knowledge. Although the new poor law imposed a centralised standard policy, historians recognise that its implementation was always differentiated locally. This study contends that an analysis of the minutiae of the daily life of patients and medical staff alike that are captured within the poor law records of the Leicester union will reveal new insights into the poor law medical service. For example, *The Lancet* claimed that the relationship between medical officers and paupers was 'reciprocal'.<sup>13</sup> This study will attempt to discover how that relationship operated in the Leicester union by considering the situation in which medical officers worked and how the

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<sup>9</sup> M.A. Crowther, 'Paupers or Patients? Obstacles to Professionalization in the Poor Law Medical Service Before 1914', *Journal of the History of Medicine*, 39 (1994), p. 37; J. L. Brand, *Doctors and the State: The British Medical Profession and Government Action in Public Health, 1870-1912* (Baltimore, 1965), p. 234.

<sup>10</sup> Crowther, 'Paupers or Patients?', p. 53.

<sup>11</sup> R. Hodgkinson, *The Origins of the National Health Service: The Medical Services of the New Poor Law, 1834-1871* (1967), p. 682; J. M. Peterson, *The Medical Profession in Mid-Victorian London* (1987), p. 3; I. Loudon, *Medical Care and the General Practitioner* (Oxford, 1986).

<sup>12</sup> P.W.J. Bartrip, *Mirror of Medicine: A History of the British Medical Journal* (New York, 1990), p. 54.

<sup>13</sup> *The Lancet*, 1 July 1865, p. 410

different categories of pauper patients were treated. The interactions between patients and doctors, the impact of illnesses and the development of the poor law institution and system, along with developments in medical practices, are all factors that are considered in the following chapters. The study is not, on the whole, concerned with more theoretical discussions about the nature of power and control in specific types of institutions as identified in the work of Foucault for example.<sup>14</sup>

The remainder of this chapter describes the primary sources researched and discusses the relevant historiography. Chapter 2 summarises the complex background of the new poor law and the social context of Leicester and its union in preparation for Chapter 3 which explores the situation of the medical officers of the Leicester union. Chapter 4 examines their work with patients and the medical treatments given. Poor law nurses provided the daily medical care of patients. Chapter 5 assesses their work and impact. The thesis then considers the experience of the patients. An underlying moral tone ran alongside the ethos of deterrence and political economy. Chapter 6 examines the conditions and treatment experienced by the ‘undeserving’ adult patients who included unmarried mothers, prostitutes, vagrants and venereal-disease patients as well as the ‘deserving’ patients, including the elderly and infirm. Chapters 7 and 8 analyse the situation of the ‘blameless’ patients - children and lunatics. The penultimate chapter discusses changes in the medical service when the new workhouse infirmary opened. Finally, Chapter 10 considers what new conclusions can be drawn about the provision of poor law medical services from this research. The thesis is set out thematically rather than chronologically. Appendix 1 therefore provides an annotated chronology of key events in relation to the Leicester union and workhouse.

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<sup>14</sup> Brief discussions of Foucault’s work on this theme can be found, for example, in Crowther, *Workhouse System*, pp. 65-6, and A. Borsay, *Disability and Social Policy in Britain Since 1750* (Basingstoke, 2005), pp. 14-19. Neither author discusses his ideas at length, indicating perhaps their view of its limited application to the workhouse.

## Methodology

This thesis intends to provide a qualitative study of poor law medical officers and pauper patients, rather than a quantitative analysis. The methodology employed therefore relies upon an analysis of contemporary documents to produce a narrative. Research of any area of the poor law is extremely daunting simply because of the substantial amount of available sources. These include parliamentary papers, poor law annual reports, local and national poor law union records of administration, reports and correspondence, letters and reports in national and local newspapers, and contemporary biographies and monographs. Problems can arise when researching poor law records, sometimes because of their lack of detail and lack of consistency, as well as their erratic level of survival.<sup>15</sup> As Crompton stated, writing a ‘history from below’ is not an easy task; typically such history is aggregated from a mass of disparate sources to develop an understanding of the lives of such people.<sup>16</sup> The primary sources researched for this study included the guardians’ minute books; letters between the guardians and the central poor law authority; the workhouse medical report book; local newspapers and union scrapbooks; various union committee books; and admission and discharge registers. They were found to be richly-detailed sources. Unfortunately fewer records have been preserved of outdoor relief and no district medical relief books have survived for the period studied. Nevertheless it has been possible to obtain a partial view of the district medical services from the guardians’ minutes and correspondence.

The historiography acknowledges the difficulty in making the ‘voices’ of ordinary paupers heard due to the lack of direct source material. As Smith stated, parliamentary enquiries into the poor law hardly ever took evidence from patients or inmates.<sup>17</sup> Attempts to relate the experiences of individuals therefore rely heavily on interpretation of sources that emanate from the ‘managers’ of those paupers. Who produced the records, for whom and why must be considered. Driver’s administrative

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<sup>15</sup> J. Lane, *The Making of the English Patient: A Guide to Sources for the Social History of Medicine* (Stroud, 2000), p. xiii.

<sup>16</sup> F. Crompton, *Workhouse Children: Infant and Child Paupers under the Worcestershire Poor Law*, (Stroud, 1997), p. vii.

<sup>17</sup> F.B. Smith, *The People’s Health: 1830-1910* (1979), p. 10.

study of the workhouse system was not a history from the viewpoint of the paupers who experienced it. In fact, he stated that the system ‘made their voices irrelevant to central policy’.<sup>18</sup> Yet, he acknowledged that the views of workhouse inmates were not wholly unrecorded, even though they only survive in fragmentary form, for example in extracts of graffiti messages on the walls of vagrant wards and photographs of paupers that provide other ‘haunting images’ of the workhouse system.<sup>19</sup> Similarly, earlier medical history was often written by medics, which Porter suggested presented ‘a major historical distortion’ since the sick person was also involved in the medical encounter. Porter dismissed claims that patient-oriented history could only be deduced from doctors’ records, as he saw no reason why interpretation of diverse materials should not yield information about the patient’s experience.<sup>20</sup> Likewise, Leavitt stressed that in order to explore the experience of the patient, historians must expand their notions of which texts are valuable and read such texts (for example, diaries, letters, and recipes), ‘deeply for the fullest possible understandings.’<sup>21</sup> Jordanova shrewdly pointed out that local history has advantages for the history of medicine because a ‘sharp geographical focus makes it easier in purely practical terms to pick up diverse and fragmentary primary sources’, and also because ‘many references to matters medical either come in sources that are non-medical, or are found in materials generated by what could anachronistically be called ‘local government’’.<sup>22</sup> These views on the creative identification and interpretation of sources are important to this study, which aims to focus on the voice of the patient as well as that of the medical practitioner. They support the contention that a close reading of a range of sources can draw out less obvious and immediate information that enables the views of paupers to be represented, to some extent at least.

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<sup>18</sup> F. Driver, *Power and Pauperism: The Workhouse System, 1834-1884* (Cambridge, 1993), p. 3.

<sup>19</sup> *Ibid.*, p. 3.

<sup>20</sup> R. Porter, ‘The Patient’s View: Doing Medical History from Below’, *Theory and Society*, 14 (1985), p. 183.

<sup>21</sup> J.W. Leavitt, ‘Medicine in Context: A Review Essay of the History of Medicine’, *American Historical Review*, 95 (1990), p. 1482.

<sup>22</sup> L. Jordanova, ‘Has the Social History of Medicine Come of Age?’, *Historical Journal*, 36 (1993), p. 441.

This study also researched contemporary editions of *The Lancet* and the *BMJ*. The two journals combined the role of a scientific journal with that of a weekly newspaper. They quickly became established as the voices of the developing medical profession and are still published today. Both journals provided invaluable contemporary medical views as many poor law practitioners wrote to the journals describing their work and their patients. Of course, it must be remembered that the journals had a particular perspective as they both stridently campaigned for improvements to poor law medical services and they were often highly critical of the poor law system. Indeed, *The Lancet* appointed its own private ‘commission’ in 1865-6, led by Ernest Hart (later editor of the *BMJ*), to investigate and report on the state of workhouse infirmaries. The journals were unwavering in their criticism of the treatment of medical officers by the central authority and local boards of guardians, especially when medical officers were cast as the scapegoats in the numerous scandals that occurred over the abuse and neglect of workhouse patients.<sup>23</sup>

## **The historiography**

Historiographies of the new poor law and the social history of medicine cover very broad fields. This review therefore concentrates on studies within both fields that are pertinent to the poor law medical service, whether as a major focus or as an aspect of a larger discussion, in order to assess how historians of medicine and of the new poor law have viewed the poor law medical service and its medical practitioners.

## **The social history of medicine**

The social history of medicine has advanced rapidly in recent years due to a shift in emphasis away from narrow physician-centred histories to new interdisciplinary approaches. Increased funding has enabled extensive research to integrate the history of medicine more fully with wider history. Much of the social history of medicine currently comes from historians from a variety of backgrounds. These

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<sup>23</sup> F.B. Smith, ‘The *BMJ* and Poverty’, *British Medical Journal*, 301 (3 October 1990), pp. 734-6.

include historians trained in the history of medicine, physicians with no formal historical training, and historians with no training in medicine or in the history of medicine.<sup>24</sup> Pelling attributed this trend to ‘the intrinsic interest of the subject as well as to the inter-disciplinary approach that is adopted in order to deal with the subject matter’.<sup>25</sup> Leavitt detected three recent areas of research that illuminate the interactive nature of medicine and distinguish practices in specific settings to broaden the vision of medical history. These areas expand the idea of medical healer; present the patient’s experience; and examine race, class and gender experiences of health.<sup>26</sup> Recent publications that provide a useful broad background to the social history of medicine in Britain include Lane’s thematic account that focuses particularly on the practitioner-patient relationship; Hardy’s chronological study that maps the developments in modern medicine against changes in the wider social, cultural and economic background that affects the lives of individuals; and a collection of scholarly essays that explore developments within medicine and its practice set within the contexts of the nineteenth and early twentieth centuries.<sup>27</sup>

To appreciate the situation of poor law medical officers, it is important to be aware of the development of the medical profession as well as to understand the poor law system. The social history of the medical profession in the nineteenth century has been well documented.<sup>28</sup> Many studies of the rise of the professions in Britain include the medical profession alongside the church and the law; although they point out that a

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<sup>24</sup> Leavitt, ‘Medicine in Context’, p. 1471.

<sup>25</sup> M. Pelling, *The Common Lot: Sickness, Medical Occupations, and the Urban Poor in Early Modern England: Essays* (1998), p. 7.

<sup>26</sup> Leavitt, ‘Medicine in Context’, pp. 1473; 1484.

<sup>27</sup> J. Lane, *A Social History of Medicine: Health, Healing and Disease in England, 1750-1950* (2001); A. Hardy, *Health and Medicine in Britain Since 1860* (Basingstoke, 2001); D. Brunton, (ed.), *Medicine Transformed: Health, Disease and Society in Europe, 1800-1930* (Manchester, 2004); a second volume of sources also edited by Brunton, *Medicine Transformed: Health, Disease and Society in Europe, 1800-1930: A Source Book* (Manchester, 2004), accompanies the former volume and provides extracts that illustrate contemporary ideas of medical practice.

<sup>28</sup> Historiographies of the development of the medical profession in the nineteenth century also include I. Waddington, *The Medical Profession in the Industrial Revolution* (Dublin, 1984); M. J. Peterson, *The Medical Profession in Mid-Victorian London* (1978); Loudon, *Medical Care*; D. Porter (ed.), *Doctors, Politics and Society: Historical Essays* (Amsterdam, 1993); W.F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge, 1994). Peterson and Loudon are particularly useful on the market aspect of medical professionalisation, as are the later publications by Digby, *Making a Medical Living*, and A. Digby, *The Evolution of British General Practice 1850-1948* (Oxford, 1999).

career in the medical profession did not have quite the same prestige as the church and the law for some considerable time.<sup>29</sup> The studies generally agree that the use of the term ‘the medical profession’ to refer to those engaged as physicians, surgeons or general practitioners implies a more unified or even a more true profession than the mid-Victorian medical profession actually was. The traditional picture is of a hierarchy that placed physicians at the top, followed by surgeons and then apothecaries. This hierarchy gradually evolved into a new division between hospital consultant (whether physician or surgeon) and general practitioner. However, several historians have argued that this is a misleading picture related more to the structural divisions of the profession than to its actual daily practice.<sup>30</sup>

Studies of the economics of nineteenth-century medical practice make it clear that at the time of the 1858 Medical Act, and for some time afterwards, the profession had yet to establish its professionalism, status and scientific credibility more fully in society.<sup>31</sup> Nevertheless, historians have generally regarded the mid-nineteenth century as the critical period of transition for the profession as medical practices and, consequently medical authority, grew as new scientific techniques were developed.<sup>32</sup> Jewson’s influential article identified a shift from bedside medicine practised in the eighteenth century, where the encounter between practitioner and patient was on equal terms, to hospital medicine in the early nineteenth century (where the patient became a case rather than an individual and the practitioner’s focus was on the sick body rather than the whole person); and finally, in the mid-nineteenth century, a shift to laboratory medicine where the disease was reduced to a cellular level and there was no contact

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<sup>29</sup> For studies on development of the professions see A. Carr-Saunders and P.A. Wilson, *The Professions* (1933, 1964); N. and J. Parry, *The Rise of the Medical Profession: A Study of Collective Social Mobility* (1976); W.J. Reader, *Professional Men* (1966); E. Friedson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (New York, 1975); P.J. Corfield, *Power and the Professions in Britain, 1700-1850* (1995).

<sup>30</sup> See Waddington, *The Medical Profession in the Industrial Revolution*, p. 10, who agreed that the tripartite classification did correspond to the three legally recognised medical groups and to the type of education thought appropriate for each category of practitioner, but he believed that, especially in the provinces, there were many physicians whose practice included, surgery, midwifery and pharmacy.

<sup>31</sup> Digby, *Making a Medical Living and Evolution of British General Practice*.

<sup>32</sup> J. Harris, *Private Lives, Public Spirit: A Social History of Britain, 1870-1914* (Oxford, 1993), p. 54.

between scientist and patient.<sup>33</sup> However, Pelling has more recently observed that the point when scientific knowledge became effective in medicine is ‘now placed at the end of the nineteenth century or even later.’<sup>34</sup>

Other approaches to the social history of medicine have analysed the economics of health care.<sup>35</sup> Pelling asserted that the concept of ‘the medical marketplace’ has merely been applied as a label, which has reinforced traditional sceptical stereotypes about medicine, and done little to connect medicine with other areas of economic life.<sup>36</sup> Peterson’s sociological approach focused on London’s medical men from 1858 to 1886, a time during which the profession’s internal relations and its relationships with lay society were redefined in significant ways.<sup>37</sup> She argued that the medical profession’s authority and prestige grew from the social evaluation placed on its work rather than from any efficacy of medical innovations and treatment.<sup>38</sup> Marland also emphasised the importance of lay, usually middle-class groups, in directing medical services within their communities. She suggested that the influence of such groups had an impact that determined the progression of the medical profession as much as the profession itself from developments in its training, qualifications and ethics.<sup>39</sup>

In contrast to Peterson, Loudon studied ordinary provincial general practitioners.<sup>40</sup> Historians have praised Loudon’s study for his contribution to a finer understanding of the business of a general medical practice. He made detailed analyses of a wide variety of sources to demonstrate the different kinds of medical care doctors provided. Digby’s research for *Making a Medical Living* complemented the earlier

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<sup>33</sup> N.D. Jewson, ‘The disappearance of the sick-man from medical cosmology, 1770-1870’, *Sociology*, 10 (1976), pp. 225-244; Brunton, (ed.), *Medicine Transformed*, pp. 2-6.

<sup>34</sup> Pelling, *The Common Lot*, p. 230.

<sup>35</sup> Peterson, *The Medical Profession in Mid-Victorian London*; Loudon, *Medical Care*; and Digby, *Making a Medical Living and Evolution of British General Practice*.

<sup>36</sup> Pelling, *The Common Lot*, p. 9.

<sup>37</sup> Peterson, *The Medical Profession*, p. 4.

<sup>38</sup> *Ibid.*

<sup>39</sup> H. Marland, *Medicine and Society in Wakefield and Huddersfield 1780-1870* (Cambridge, 1987), p. 252.

<sup>40</sup> Loudon, *Medical Care*, pp. 1-2, explained that the term ‘general practitioner’ was first used in its modern sense in the early nineteenth century although it was only used within the medical profession during the period 1750-1850. The public did not generally adopt the term until much later.



studies of Peterson and Loudon. Like Loudon, her focus was on provincial doctors. Digby also showed how the general practitioner had to become established as socially acceptable in order to reach and attract middle-class patients. Many of these medical men worked in posts as poor law medical officers in addition to attending private patients in order to make a sufficient living and to establish a name. Digby demonstrated that the medical market was highly competitive and much depended on relationships with patients and colleagues. Her later study drew on nineteenth-century evolutionary theory to explain the changes that took place in general practice. Here she examined relationships between general practitioners, other doctors, the state and patients. She also highlighted the diversities between general practitioners and their efforts to make a living while adapting to changing circumstances in the evolving health care system.<sup>41</sup>

Peterson suggested that Victorian medical memoirs offer little evidence that dedicated altruism provided a common motive for entering the medical profession.<sup>42</sup> Certainly some historiographies can give the impression that Victorian medical men often held callous attitudes towards pauper patients. Digby and Loudon, however, have presented doctors as men who struggled to make a living and establish their status in an insecure profession in a sceptical society.<sup>43</sup> Moreover, poor law medical officers lacked autonomy as they were subject to the lay authority of union guardians, which inhibited their drive for higher status and recognition of their 'professionalism'.<sup>44</sup> This lack of professional autonomy further undermined the medical officers' position in the medical profession which was endeavouring at the same time to establish its authority within the wider society. As Loudon pointed out, the status of an individual general practitioner was dependent on his income and the class of patient he treated.<sup>45</sup> By accepting lowly paid posts and treating the poorest patients, the status of a poor law medical officer within the profession and society could be identified as inferior.

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<sup>41</sup> Digby, *Evolution of British General Practice*.

<sup>42</sup> Peterson, *The Medical Profession in Mid-Victorian London*, p. 2.

<sup>43</sup> Digby, *Making a Medical Living*; Loudon, *Medical Care*.

<sup>44</sup> Friedson, *Profession of Medicine*, p. 71, argued that a high degree of professional autonomy is the distinguishing characteristic of modern professions.

<sup>45</sup> Loudon, *Medical Care*, p. 227.

The consensus among historians is that working conditions for poor law medical officers were incompatible with the provision of an adequate medical service. Loudon argued that while the old system had its faults, the new poor law treated both general practitioners and pauper patients with 'a singular scorn and brutality'.<sup>46</sup> The low status of poor law medical work persisted throughout the nineteenth century and into the twentieth century, although Crowther acknowledged that the rise of the medical officer was the 'vital link between the workhouse and the public hospitals which replaced it'. However, she maintained that they suffered professionally from working in a system with the reputation of a second-class service.<sup>47</sup> Hodgkinson suggested that the professional demands of the Poor Law Medical Officers' Association furthered their patients' interests and it was those medical officers who were responsible for the development and improvement of poor law medical services.<sup>48</sup> Crowther disagreed and argued that, in reality, the PLMOA achieved very limited success after the reform of the poor law infirmaries in the 1860s. She suggested that, in any event, the medical officers' demands had a 'self-interested ring'.<sup>49</sup> Similarly, Brand observed that medical officers devoted much time to improving their own status. Nevertheless, she felt that they did repeatedly urge improvements to the medical care of the poor.<sup>50</sup> Peterson agreed that medical men were certainly concerned about their incomes, but she argued that there is little doubt that many medical reformers saw the injury to the poor due to political economy and they worked to improve conditions of practice among the poor. She felt that at some points the interests of the poor and of the medical men were at one.<sup>51</sup>

### **The new poor law**

The years studied here were an important transitional period for medicine and the rise of the medical profession. Similarly, many historians view that period as a

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<sup>46</sup> *Ibid.*, pp. 235-240.

<sup>47</sup> Crowther, *Workhouse System*, p. 156.

<sup>48</sup> Hodgkinson, *Origins*, p. 682.

<sup>49</sup> Crowther, 'Paupers or Patients', pp. 41-2.

<sup>50</sup> Brand, *Doctors and the State*, p. 234.

<sup>51</sup> Hodgkinson, *Origins*, p. 682.

watershed for the new poor law when its measures began to be more generally implemented, although others doubt the extent to which that ever occurred. England's poor laws continue to be studied by historians from many different backgrounds. Numerous studies of the history of the poor laws in England and Wales have been carried out since the Webbs published their first volume in 1927.<sup>52</sup> For some time their study was regarded as the classic text on the poor law, although their contemporary, Helen Bosanquet, was critical of their work accusing them of taking a narrow and biased approach.<sup>53</sup> Opinions of the value of their history diminished from the mid-twentieth century,<sup>54</sup> and modern historians 'counsel caution in the use of their writings.'<sup>55</sup> Englander suggested that the subsequent criticism of the limited historical scholarship of the Webb's poor law history led to a 'spectacular growth' of studies that sought to 'place poor law history in its economic, social and political context' with 'greater sensitivity paid to regional and local diversity'.<sup>56</sup> Social, cultural and intellectual historians have used the controversies over the poor law and its reform to analyse changes in England's moral and social structure.<sup>57</sup> Economic historians have questioned whether the new poor law was successful in its aim to abolish relief to the able-bodied male or whether the old poor law was more generous.

Lees described much of the past historiography of the poor laws as underlain by an 'historical romance of persecution, struggle, and eventual triumph over the forces of injustice.'<sup>58</sup> By contrast, current trends in poor law historiography have 'diverged

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<sup>52</sup> S. and B. Webb, *English Poor Law History: Part II, The Last Hundred Years* (1927, 1963).

<sup>53</sup> D. Englander, *Poverty and Poor Law Reform in Nineteenth-Century Britain: From Chadwick to Booth, 1834-1914* (1998), pp. 82-3.

<sup>54</sup> A. J. Kidd, 'Historians or polemicists? How the Webbs Wrote their History of the English Poor Laws', *Economic History Review*, 50 (1987), pp. 400-17. Several historians had warned that the Webbs' political and social views clearly gave a bias to their account of the history of the poor laws. Kidd contended additionally that 'short cuts' in their methodology limited the scholarship of their work as much as their interpretative bias.

<sup>55</sup> Englander, *Poverty and Poor Law Reform*, p. 82.

<sup>56</sup> *Ibid.*, p. 84. For an example of an economic history of the early new poor law see G.R. Boyer, *An Economic History of the English Poor Law 1750-1850* (Cambridge, 1990). For a political and local history see A. Brundage, *The Making of the New Poor Law: The Politics of Inquiry, Enactment and Implementation, 1832-39* (1978).

<sup>57</sup> T. W. Guinnane, untitled review of Driver, *Power and Pauperism*, *Journal of Economic History*, 53 (1993), pp. 937-8.

<sup>58</sup> L. H. Lees, *The Solidarities of Strangers: The English Poor Laws and the People, 1700-1948* (Cambridge, 1998), p. 7.

sharply from older class-based, linear discussions of welfare', which she suggested, 'makes the welfare story much more complicated but also vastly more interesting.'<sup>59</sup> Lees attributes this development to the debates in the 1960s on the poor laws which turned from 'a political and moral framework to a predominantly economic one', whereby scholars used local economic data and theory to highlight the relative generosity of relief under the pre-1834 poor laws in contrast to the meanness of the new poor law.<sup>60</sup> Similarly Daunton observed that 'recent developments in social policy have forced historians to move away from Whiggish accounts based on a linear progression towards a welfare state which dominated the historiography in the 1950s, 1960s and 1970s.'<sup>61</sup>

Many different approaches have been taken in the abundant studies of the new poor law.<sup>62</sup> King has identified a 'rich tapestry of approaches', which he classified into *legalistic*, *administrative*, and *institutional* themes.<sup>63</sup> These multi-faceted strands mean that poor law history continues to be a rich subject for research, particularly as approaches change, challenges to perceived thinking are made, and new questions are posed in the continuing debate about the role of the state in welfare provision. As Stewart and King pointed out, 'cumulative surveys of the historiography of the new poor law have raised many questions about the operation and impact of poor law policy and emphasized just how much remains to be done in an empirical sense on the voluminous local and national archives.'<sup>64</sup>

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<sup>59</sup> *Ibid.*, p. 5.

<sup>60</sup> *Ibid.*, p. 8.

<sup>61</sup> M. Daunton, (ed.), *Charity, Self-Interest and Welfare in the English Past* (1996), p. 1.

<sup>62</sup> This is not an exhaustive list but see Boyer, *An Economic History of the English Poor Law*; A. Brundage, *The English Poor Laws, 1700-1930* (Basingstoke, 2002); Crowther, *The Workhouse System*; Driver, *Power and Pauperism*; Englander, *Poverty and Poor Law Reform*; D. Fraser (ed.) *The New Poor Law in the Nineteenth Century* (1976); S. King, *Poverty and Welfare in England, 1700-1850: A Regional Perspective* (Manchester, 2000); Lees, *Solidarities*; M. E. Rose, *The English Poor Law 1780-1930* (Newton Abbot, 1971); K.D.M. Snell, *Annals of the Labouring Poor: Social Change and Agrarian England, 1660-1900* (1985, Cambridge 1992); K. Williams, *From Pauperism to Poverty* (1981).

<sup>63</sup> S. King, *Poverty and Welfare*, p. 3. King provides a succinct overview of the historiography of the poor laws in Chapter 1. For a further discussion on approaches to poor law history see also Brundage, *The English Poor Laws*, pp. 3-8.

<sup>64</sup> J. Stewart and S. King, 'Death in Llantrisant: Henry Williams and the New Poor Law in Wales', *Rural History*, 15 (2004), pp. 69-98.

The literature on the new poor law typically draws attention to the problem that this vast amount of archival evidence produces for the historian, which explains why individual unions are often selected for research on particular aspects of the new poor law rather than wide national or regional studies.<sup>65</sup> Lees' statement that 'the poor laws were a fundamental structure of the English state for 350 years, and as such they both shaped and were shaped by local communities',<sup>66</sup> confirms the importance of paying attention to local situations as well as to national policies. Many current scholars have recognized this need. As Lees has observed, 'most scholars have targeted a particular town, region or institution for a limited number of decades.'<sup>67</sup> However, she cautions that this approach is not without its limitations as one difficulty with such local studies has been to obtain a broader picture of how welfare systems changed over time.<sup>68</sup> Similarly, Kidd has warned that a common feature of poor law historiography is the temptation to generalise from local studies because of the absence of reliable central statistics of relief.<sup>69</sup> However, Stewart and King have highlighted the need for more local and regional research.<sup>70</sup> Indeed, King has questioned whether a 'national' history of poverty, welfare and the poor laws can ever be written.<sup>71</sup> It is apparent from the poor law historiography that, despite the central legislation and overarching central administration of the new poor law, local administration and experiences were extremely varied and disparate. Nevertheless, local studies can and do undoubtedly contribute towards the bigger picture while also providing an individual history.

Lees argued that the new poor law attempted to govern and regulate paupers and in effect enforced a social distance between paupers and the rest of society by presenting an image of poverty as a vicious disease. But she asserts that the poor were not always passive recipients of welfare and they did not necessarily subscribe to this

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<sup>65</sup> *Ibid.*, p. 70.

<sup>66</sup> Lees, *Solidarities*, p. 7.

<sup>67</sup> *Ibid.*, p. 9.

<sup>68</sup> *Ibid.* Lees does point out that notable exceptions to this approach are Snell, *Annals of the Labouring Poor*, and Crowther, *Workhouse System*.

<sup>69</sup> A. Kidd, *State, Society and the Poor in Nineteenth-Century England* (Basingstoke, 1999), p. 30.

<sup>70</sup> Stewart and King, 'Death in Llantrisant', p. 70.

<sup>71</sup> King, *Poverty and Welfare*, p. 4.

image of themselves.<sup>72</sup> Lees concluded that this lack of attention to gender, the welfare receivers, and welfare bargaining at the local level in poor law studies, needs to be remedied in order to present an alternative view of pauper recipients.<sup>73</sup> This omission was also highlighted by Englander who felt that ‘a standing criticism of the current approach to poor law history is that it is concerned with policy rather than people, with what legislators and officials thought should happen rather than with the experiences of ordinary people.’<sup>74</sup> King, however, noted an indication in the 1990s of a sustained interest in the experience and tactics of the poor themselves, which he believed has begun to rectify this deficiency.<sup>75</sup>

The historiography of both the old and new poor laws is voluminous and complex and the debate on the poor laws continues to flourish. Historians have disagreed about the balance of factors involved in the reform of the old poor law that led to the formation of the new poor law. There is a consensus, however, that the central administration of the new poor law failed to enforce its strictures at many local levels at least until the 1850s. Indeed, the historiography of the new poor law frequently portrays the mid-nineteenth century as a turning point from which time the legislative measures and the spirit of the poor law began to be more commonly implemented.<sup>76</sup> Most historians agree that the new poor law was a flawed and cruel concept.<sup>77</sup> The assumption behind poor law reform was that poverty was a voluntary condition arising from indolence or improvidence. The legislation which narrowly focused on the able-bodied male, and women who bore illegitimate children, paid scant attention to other categories of pauper - the sick, the disabled, the elderly and women and children.<sup>78</sup> Under the 1834 legislation, women were regarded as ‘the appendages

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<sup>72</sup> Lees, *Solidarities*, pp. 151-76.

<sup>73</sup> *Ibid.*, p. 9. Lees excludes from this generalisation Lara Marks, ‘Medical Care for Pauper Mothers and their Infants: Poor Law Provision and Local Demand in East London, 1870-1929’, *Economic History Review*, 46 (1993), pp. 518-42.

<sup>74</sup> Englander, *Poverty and Poor Law Reform*, p. 90.

<sup>75</sup> King, *Poverty and Welfare*, p. 4.

<sup>76</sup> *Ibid.*, p. 14.

<sup>77</sup> For a more optimistic view see D. Roberts, ‘How Cruel was the Victorian Poor Law?’ *Historical Journal*, 6 (1963), pp. 97-107 and for a contrasting argument see U. Henriques, ‘How Cruel was the Victorian Poor Law?’ *Historical Journal*, 11 (1968), pp. 365-71.

<sup>78</sup> Kidd, *State, Society and the Poor*, p. 27.

of their husbands, and only single women were entitled to relief in their own right. In the 1840s the legislation began to tackle the problem of able-bodied women and mothers.’ However, many local unions continued to neglect the needs of women for childcare and ignored the economic difficulties faced by deserted wives and mothers.<sup>79</sup> Thus far from alleviating or preventing poverty, the new poor law rapidly became part of the problem of poverty.<sup>80</sup>

Marland observed that the new poor law ‘has been designated by historians as a distinct watershed in the provision of medical services for the poor, marking the beginning of an improved and widening range of facilities.’<sup>81</sup> This view has tended to assume that ‘however bad medical provision was during the first years of the new poor law administration, it marked the beginning of a period of improvement on the pre-1834 system.’<sup>82</sup> Indeed Flinn suggested that through the rapid appointment of medical officers by the newly-constituted boards of guardians, the district medical officer became the key figure of the medical service after 1842, and ‘there quickly emerged one of the more remarkable social developments of the Victorian period.’<sup>83</sup> Flinn regarded this ‘spontaneous development’ in medical relief provision as ‘an accident of history’, but he assumed that the ‘new flexibility and enhanced financial strength of the unions’ was responsible for ‘releasing the potential’.<sup>84</sup> However, he dispelled any idea that this transition progressed smoothly or willingly by his assertion that finance and ideology stood between the poor law medical service and efficiency, and in any case it was not until the late 1860s and early 1870s that conditions started to improve.<sup>85</sup>

In 1976 Fraser recorded that there had been a ‘comparative neglect’ of poor law medical services by social historians, which was surprising since the poor law medical service was ‘one of the most fully documented aspects of nineteenth-century social

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<sup>79</sup> Marks, ‘Medical care for Pauper Mothers’, pp. 518-542.

<sup>80</sup> King, *Poverty and Welfare*, p. 66.

<sup>81</sup> Marland, *Medicine and Society*, p. 70.

<sup>82</sup> *Ibid.*, p. 52.

<sup>83</sup> M.W. Flinn, ‘Medical Services under the New Poor Law’, in Fraser, *The New Poor Law*, pp. 48-9.

<sup>84</sup> *Ibid.*, p. 49.

<sup>85</sup> *Ibid.*, p. 53.

administration.’<sup>86</sup> However, national poor law medical services received detailed historical attention by Hodgkinson and Brand in the 1960s, Flinn in the 1970s and Crowther in the 1980s.<sup>87</sup> Marland asserted therefore that the development of the poor law medical service had already been fully described, although, she observed that the emphasis had generally been on the first thirty years after the Act, during which time, little improvement was made.<sup>88</sup> Hodgkinson’s study is regarded as authoritative and comprehensive. It is extremely detailed and its sheer bulk (400,000 words in eighteen chapters over 700 pages) can make it difficult ‘to see the wood for the trees.’<sup>89</sup> The extent of this work may account for the scarcity of studies of poor law medical history, as it may seem that little can be added, even though the study ceases at 1871. This assumption could also account for the lack of debate over poor law medical services, especially for the later period.

Several historians have identified the 1867 Metropolitan Poor Law Act as the ‘high water mark of reform’,<sup>90</sup> when infirmaries were separated from workhouses and the poor law medical service was set ‘on the road that was to lead, hesitatingly but inevitably, to Bevan’s National Health Service of the 1940s.’<sup>91</sup> These historians have regarded the new poor law as the forerunner to the modern welfare state, and poor law medical services as the origin of the National Health Service.<sup>92</sup> They have argued that, despite its deterrent philosophy and intention, the poor law gradually became a progressive source for the modern welfare state. Crowther was less certain of a clear progression. She surmised that, ‘Perhaps the National Health Service did originate in the poor law, but the path between was tortuous, and in the later nineteenth century it often seemed to be turning backwards.’<sup>93</sup> Historians now recognise that a much greater awareness is needed of the widespread complexities and ambiguities and those earlier

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<sup>86</sup> Fraser, *The New Poor Law*, p. 196.

<sup>87</sup> Brand, *Doctors and the State*; Hodgkinson, *Origins*; Flinn, ‘Medical Services’; Crowther, *Workhouse System*.

<sup>88</sup> Marland, *Medicine and Society*, pp. 52-3.

<sup>89</sup> Fraser, *The New Poor Law*, p. 197.

<sup>90</sup> Hodgkinson, *Origins*, p. 687.

<sup>91</sup> Flinn, ‘Medical Services’, p. 66.

<sup>92</sup> Hodgkinson, *Origins*; Flinn, ‘Medical Services’; Crowther, *The Workhouse System*.

<sup>93</sup> Crowther, ‘Paupers or Patients?’, p. 34.



studies are viewed as too simplistic by their assumption that 'history marched to a pre-ordained end by a transition from a harsh, punitive poor law to a benign welfare state.'<sup>94</sup>

Recent research by Elizabeth Hurren has placed more importance than earlier studies on the impact of the crusade against outdoor relief.<sup>95</sup> In the late 1860s the government became extremely concerned about the increase of out-door relief payments and, additionally, the unsystematic distribution of charitable funds to the poor. A circular issued by the government in 1869 reiterated the centrality of the deterrent workhouse and called for unions to apply the principle of less eligibility embodied in the 1834 Act much more strictly.<sup>96</sup> The circular also called for a more effective distinction between poor relief and charity. In the same year, the Charity Organisation Society (hereafter COS) was formed. The COS sought greater control and co-ordination of charity for the deserving poor and, moreover, wanted to encourage greater self-reliance among the poor which would, in turn, decrease the amount of public assistance given.<sup>97</sup> Consequently, during the 1870s and 1880s poor law policy increased the emphasis on in-door relief and the requirements for out-door relief were applied more rigorously. All categories of paupers were affected by the reduction of out-door relief, particularly women and the sick. A number of unions drastically curtailed out-door relief, however, the strict restriction of out-door relief was not applied universally. Indeed, Humphries has stated that 'from the mid 1870s around 90 per cent of poor law unions largely disregarded further LGB exhortations to reduce out-

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<sup>94</sup> Daunton, *Charity, Self-Interest and Welfare*, p. 1.

<sup>95</sup> E. T. Hurren, *The 'Bury-al Board': Poverty, Politics and Poor Relief in the Brixworth Union, Northamptonshire, c.1870-1900*, Ph.D. Thesis, University of Leicester, 2000; E.T. Hurren, 'A Pauper Dead-House: The Expansion of the Cambridge Anatomical Teaching School under the Late-Victorian Poor Law, 1870-1914', *Medical History*, 48 (2004); E.T. Hurren, 'Poor Law versus Public Health: Diphtheria, Sanitary Reform, and the "Crusade" Against Outdoor Relief, 1870-1900', *Social History of Medicine*, 18 (2005); E..T. Hurren, *Protesting about Pauperism: Poverty, Politics and Poor Relief in Late-Victorian England, 1870-1900* (Woodbridge, 2007). Hurren, *Protesting about Pauperism*, p. 3, has noted that the historiography on the 'crusade' is limited in comparison to the vast literature on the mid-Victorian poor law.

<sup>96</sup> The circular became known as the Goschen Minute after George Goschen who drew it up and who became the president of the PLB in 1868.

<sup>97</sup> K.D.M. Snell, *Parish and Belonging: Community, Identity and Welfare in England and Wales, 1700-1950* (Cambridge, 2006), p. 262-3.

door relief dramatically.’<sup>98</sup> According to Hurren, the crusade has tended ‘to be discussed in connection with the expansion of workhouse services’ when ‘in fact it was the outdoor paupers, the majority of the labouring poor, who bore the brunt of the *crusade*’s severe socio-economic rationale.’<sup>99</sup> Williams, declared the short-term reduction of out-door paupers from 1871 to 1876 of 33 per cent was ‘a brilliant short-run success’, yet he noted that the ‘reductions in the total number of out-door paupers did not continue after 1876.’<sup>100</sup>

Overall, the consensus among historians is that the new poor law system created ambivalence towards the sick, not least among the doctors who treated them and in many ways acted as disciplinarians on behalf of the system. Nevertheless, Loudon has contended that while the new poor law was intended to ‘make life unpleasant for the able-bodied pauper, it was never intended that the conditions for the sick, the aged, and the infirm should be any harsher than they had been previously.’<sup>101</sup> Stewart and King have more recently speculated whether the purpose of the new poor law was simply to turn entitlement and relief provision into administrative questions to reduce pauperism, as suggested by Driver, or whether there was ‘a subtle sub-text in which the poor law was intended to address long-term underlying causes of poverty through programmes of education and health care?’<sup>102</sup> If the issue was to tackle causes rather than the symptoms of poverty, as Stewart and King have suggested, the question arises as to how successful were poor law medical services? It would appear that some historians believe they were successful, if only for the hesitant introduction of state hospital provision. By contrast, the development of the welfare state has been regarded by other historians as a reaction to the inadequacies and cruelty of the poor laws.

Whatever view is taken, the stigma of pauperism and the spectre of the workhouse remained long in the British cultural psyche. The workhouse became a

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<sup>98</sup> R. Humphreys, *Sin, Organized Charity and the Poor Law in Victorian England* (Basingstoke, 1995), p. 29.

<sup>99</sup> Hurren, *Protesting about Pauperism*, pp. 3-5.

<sup>100</sup> Williams, *From Pauperism to Poverty*, pp. 102-3.

<sup>101</sup> Loudon, *Medical Care*, p. 236.

<sup>102</sup> Stewart and King, ‘Death in Llantrisant’, p. 69.

familiar feature of the new poor law, even though it only ever accommodated a minority of paupers.<sup>103</sup> The historiography on the workhouse system and on individual workhouses continues to grow.<sup>104</sup> Driver has suggested that the history of the new poor law was to a large extent a history of power relations and for the most part it shows the powerlessness of the paupers themselves.<sup>105</sup> He argued that the history of workhouse policy is a history of struggles and that historians have focused overwhelmingly on the strife between central and local authorities, so that other conflicts and controversies have frequently been neglected.

Despite the centrality of the workhouse to the new poor law which has engendered considerable historical interest in their organisation, administration and living conditions, it is remarkable how little is known about the inmates they accommodated.<sup>106</sup> For example, there is still a lack of understanding of how imbeciles were treated in the workhouse.<sup>107</sup> This study aims to redress the balance by addressing in depth a number of important issues that have been raised in other broad-ranging studies of the workhouse, not least the developments that occurred in the balance of power between the guardians and medical officers. Furthermore, where significant, the implications of the crusade against out-door relief upon the attitudes and actions of the Leicester union towards the provision of medical services to both in-door and out-door paupers will be noted.

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<sup>103</sup> Kidd, *State, Society and the Poor*, p. 34.

<sup>104</sup> Crowther, *Workhouse System*; A. Digby, *Pauper Palaces* (1978); S. Fowler, *The Workhouse: the People, the Places, the Life behind Doors* (Richmond, 2007); M. Higgs, *Life in the Victorian & Edwardian Workhouse* (Stroud, 2007); N. Longmate, *The Workhouse* (1974); T. May, *The Victorian Workhouse* (Princes Risborough, 1997); A. Reid, *The Union Workhouse: A Study Guide for Local Historians and Teachers* (1994, Chichester, 1998); P. Wood, *Poverty and the Workhouse in Victorian Britain* (Stroud, 1991).

<sup>105</sup> Driver, *Power and Pauperism*, p. 165.

<sup>106</sup> N. Goose, 'Workhouse Populations in the Mid-Nineteenth Century: The Case of Hertfordshire', *Local Population Studies*, 62 (1999), p. 52; Crompton, *Workhouse Children*, p. viii.

<sup>107</sup> E. Miller, 'The Role of the Poor Law in the Care of the Insane in the Nineteenth Century', *History and Philosophy of Psychology*, 8 (2006), p. 22.

## Summary

Studies in both the social history of medicine and poor law history have become diverse and wide-ranging. Historians acknowledge that there is a need for more local studies that use a wide variety of sources, to put forward new interpretations of the interactive nature of medicine as well as the experiences of the recipients of the poor law system, which can lead to greater understanding of the relationship between medicine, history and society.<sup>108</sup> It would appear, in the light of the new approaches to the history of the poor law outlined above, that this has not yet been followed by local studies of poor law medicine. In particular, little research has been carried out specifically on the experiences of poor law practitioners and paupers. This study, which is undertaken with the benefit of substantial recent research on the new poor law, aims to add to previous research by providing a detailed study of one union over an extended period and to take forward this debate by providing fresh insights to the history of poor law medicine.

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<sup>108</sup> Marland, *Medicine and Society*, p. 1.

## **Chapter 2**

### **Medical relief and Leicester**

#### **Introduction**

This chapter describes the context within which the study is set. The first section explains the national framework for poor law medical services by summarising the Poor Law Amendment Act of 1834 and the changes made to the provision of medical relief from the old to the new poor law. The general situation of poor law medical officers is also elucidated. The second part describes the economic situation of Leicester, its existing healthcare provision and the circumstances of the union and its workhouse.

#### **The Poor Law Amendment Act, 1834**

The Poor Law Amendment Act of 1834, which became known as the ‘new poor law’, has been extensively researched and there is a substantial and complex literature on this subject.<sup>1</sup> This study does not intend therefore to describe in great detail the intricate background to the Act or its workings, which are explained elsewhere. Nevertheless, some brief details are necessary to explain the underlying philosophy of the Act and its intended practice, which inevitably affected the provision of medical services within the poor law system.

There were wide variations in medical provision for the poor both before and after the 1834 Poor Law Amendment Act. However, attitudes towards poverty changed during the late eighteenth to early nineteenth-century from a comparatively sympathetic attitude towards the poor to a hardened, condemnatory attitude that highly stigmatised the state of pauperism. Put simply, the underlying reasons for this change of attitude derived from the rapidly expanding and increasingly urbanised population, which created ever greater demands on social and economic resources, while at the same time changes in the social and environmental structure,

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<sup>1</sup> See Chapter 1, footnote 62.

regional unemployment, and a lack of health care caused greater instances of poverty and reliance upon state help. Political economy became a powerful force and the attitudes of those in power who equated pauperism with indolence, vice and crime produced social policy determining that only those who were destitute and in 'genuine' need should benefit from poor relief.<sup>2</sup> Historians agree that the Poor Law Amendment Act was primarily intended to reduce the expenditure of the poor rates on subsidies to able-bodied, under-employed agricultural labourers. A strong deterrent was considered essential to prevent abuse of the system. Any relief that was provided should therefore be at a lower rate than the earnings of the lowest paid labourer. In other words, conditions for paupers had to be worse than those of independent labourers. It was on this principle of 'less eligibility' that the new system theoretically was to operate. In principle 'able-bodied' paupers were to be refused out-door relief and in order to receive relief, the entire family had to enter the workhouse.<sup>3</sup> The aim of the 'workhouse test' was to ensure that only the truly destitute would apply for relief and accept the stigma of being 'pauperised'.

Following the Act, about 15,000 parishes in England and Wales were gradually amalgamated into over 600 larger administrative poor law unions. Each union was managed by Boards of Guardians who were elected annually by ratepayers on the basis of property ownership. A clerk and treasurer were appointed to the union and relieving officers were employed for districts to evaluate and authorise applications for poor and medical relief. District medical officers were employed to attend the sick in receipt of out-door medical relief. New workhouses were built to house those in receipt of poor relief. Workhouse employees included a master and matron to run the workhouse, a workhouse chaplain, schoolmaster or mistress, and sometimes a workhouse medical officer to work solely within the workhouse.

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<sup>2</sup> Loudon, *Medical Care*, p. 236.

<sup>3</sup> See Crowther, *Workhouse System*, Chapter 1, 'From the Old Poor Law to the New', and Driver, *Power and Pauperism*, Chapter 1, 'Policing society: government, discipline and social policy', as well as literature on the new poor law referred to above.

## Medical relief under the old poor law

The aged, infirm, orphans, widows and sick were accepted as valid recipients of relief under the old poor law, although the unemployed were more doubtful claimants. Medical care was always part of the relief provided and local physicians were appointed to attend the sick in their homes.<sup>4</sup> Surgeons were paid separately for visits, medicines, surgical procedures and midwifery services.<sup>5</sup> By the late eighteenth century and early nineteenth-century, a rudimentary poor law medical service had developed as many parishes began to appoint medical officers to attend the sick of the parish.<sup>6</sup> In some urban parishes an infirmary was also provided either as a ward in the workhouse or as a separate building.<sup>7</sup>

Digby concluded that the overwhelming impression to be gained from surviving medical bills for treatment and from contracts for the employment of parish surgeons is of a considerable array of medical services before 1834.<sup>8</sup> Hence there was considerable disparity in the provision of medical services across the country to the poor and any relief that was given was on a small scale.<sup>9</sup> As Loudon pointed out, the main advantage of the old parish system of medical relief for both medical practitioners and patients was that they did not despise this work as it was paid at the same level as private practice. In addition, the parish surgeon was a familiar local doctor, which would have made him generally careful in his treatment of the poor.<sup>10</sup> Loudon suggested that under the old system by the mid-eighteenth century poor law medical appointments were not only numerous, but relatively well paid in terms of the amount of work involved.<sup>11</sup> In general, good relationships between parochial officers and medical practitioners contrasted with those found after the passing of the Poor Law Amendment Act. Previously poor law medicine could be considered to be relatively generous and effective, relative to its period's norms; and, indeed, the old poor law was reformed because it was considered both

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<sup>4</sup> R. White, *Social Change and the Development of the Nursing Profession: A Study of the Poor Law Nursing Service 1848-1948* (1978), p. 5.

<sup>5</sup> Loudon, *Medical Care*, p. 231.

<sup>6</sup> Flinn, 'Medical Services', p. 46.

<sup>7</sup> *Ibid.*, p. 47.

<sup>8</sup> Digby, *Making a Medical Living*, p. 224.

<sup>9</sup> Hodgkinson, *Origins*, p. 8.

<sup>10</sup> Loudon, *Medical Care*, p. 232.

<sup>11</sup> *Ibid.*, p. 228.

expensive and to encourage indolence.<sup>12</sup> Conversely, Crowther suggested that the reputation of the earlier parish surgeon appeared low because parish vestries employed the lowest bidder and, as long as he didn't order too many 'extras' or refuse to attend patients, he could do as he wished.<sup>13</sup> Loudon agreed that this may sometimes have been true but he believed the evidence pointed largely in the 'opposite direction.'<sup>14</sup> However, Loudon confirmed that levels of payment to parish surgeons varied widely and deteriorated during the early nineteenth century as parishes changed to paying annual salaries rather than payment per case. Furthermore, as the medical profession became increasingly overcrowded, appointments were frequently offered to the surgeon who put forward the lowest bid, regardless of his skills, experience or qualifications.<sup>15</sup> He argued that even before 1834, the general trend of the poor law medical service was of a worsening service.

### **Medical relief under the new poor law**

The poor law was the main source of medical help for the poorest in the population. Although the number of voluntary hospitals grew dramatically during the first half of the nineteenth century, they were funded through charity and subscribers intended that the hospitals should only treat the 'deserving' poor.<sup>16</sup> Voluntary hospital patients received free treatment, but had to obtain an admission ticket from a lay benefactor who decided if the person was a 'deserving' case and whether the condition was suitable for treatment. Accordingly, voluntary hospitals excluded socially 'undeserving' cases as well as the more 'difficult' conditions, which included sick children, pregnant women, fever cases, lunatics and incurable conditions.<sup>17</sup> Charitable public dispensaries had also been established to provide medical relief for the 'deserving' poor, but assistance was generally refused to those who could receive poor relief. It was not until the 1850s that poor law dispensaries

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<sup>12</sup> Bartrip, *Mirror of Medicine*, p. 51. See also Lane, *A Social History of Medicine*, Chapter 3 'Medical care under the old and the new poor law'.

<sup>13</sup> Crowther, 'Paupers or Patients?', p. 36.

<sup>14</sup> Loudon, *Medical Care*, p. 232.

<sup>15</sup> *Ibid.*, pp. 234-5.

<sup>16</sup> Brunton, *Medicine Transformed*, p. 37.

<sup>17</sup> L. Granshaw, 'The rise of the modern hospital in Britain', in Andrew Wear (ed.), *Medicine in Society: Historical Essays* (Cambridge, 1992), p. 202.



began to be set up, although they did not become widespread, being limited to London and the large towns.<sup>18</sup> The Leicester union did not establish its own dispensary, although much later (in 1912) arrangements were made with the local provident dispensary to dispense drugs prescribed by the district medical officers.<sup>19</sup>

Poor law legislation intended that the sick and infirm would continue to receive outdoor medical relief as before. However, in practice it was often difficult to distinguish between the healthy and the sick because a primary cause of poverty was the inability to work due to sickness. A fundamental concern of the poor law authorities was that malingerers might be encouraged by the provision of medical aid and relief at home in contrast to punishment in an institution for the able-bodied. Therefore in order to protect the less-eligibility principle, it was essential to apply the workhouse test to any doubtful cases.<sup>20</sup>

Nearly three-quarters of cases of mid-nineteenth century pauperism concerned sickness.<sup>21</sup> Yet, despite the seemingly obvious connection between sickness and poverty, there was no explicit provision for medical relief in the Poor Law Act of 1834. A House of Commons Select Committee enquired into the operation of the Act in 1838, but decided not to recommend any legislation by Parliament on medical relief, even though the Poor Law Commissioners noted that, ‘much dissatisfaction continued to prevail amongst many members of the medical profession.’<sup>22</sup> Indeed, medical practitioners continually complained to *The Lancet* and the *British Medical Journal* about their low salaries, difficult working conditions and their dislike of poor law control over the medical treatment of paupers. Upon pressure from the medical profession, the Commissioners issued regulations and guidance to the unions in an attempt to standardise the operation of medical relief, in a General Medical Order in an *Official Circular* in April 1842 and

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<sup>18</sup> Hodgkinson, *Origins*, pp. 205, 314.

<sup>19</sup> See Chapter 4, below.

<sup>20</sup> B. Abel-Smith, *The Hospitals, 1800-1948: A Study in Social Administration in England and Wales* (1964), pp. 46-7.

<sup>21</sup> Digby, *Pauper Palaces*, p. 166.

<sup>22</sup> *Official Circulars of Public Documents and Information: Directed by the Poor Law Commissioners to be Printed, Chiefly for the Use of the Members and Permanent Officers of Boards of Guardians, under the Poor Law Amendment Act*, Vol. II (12 April, 1842), p. 248. (The editions used here, initially published in 1840-51, were the New York, 1970 reprint editions, bound as two volumes for the initial vols. I-VI, and vols. VII-X. These are hereafter cited as *Official Circulars*.)

a General Consolidated Order in 1847. However, unions were not compelled to implement this guidance. The regular enquiries that appeared in the *Official Circulars* on, for example, qualifications for medical officers and payment of fees for treatment, imply that uncertainty and inequity in the operation of medical relief continued for many years.

### **Poor law medical officers**

There was no clear regulation in the Poor Law Amendment Act for the provision of medical officers. Appointments were made by each Board of Guardians as it thought fit. Although professionally qualified, medical officers were subservient to the guardians. Initially medical officer appointments were made under a system of tender on an annual basis. Under the General Medical Order, 1842 the system of offering medical officers' appointments by tender was abolished. The Commissioners stated that 'the competition of the candidates should turn upon their respective characters and skill, and not on the sum at which they may be severally willing to undertake the office.'<sup>23</sup> In practice though, many guardians operated on whatever principles they thought fit,<sup>24</sup> and either ignored this regulation, or, judging by their continual enquiries in the *Official Circulars*, remained ostensibly ignorant of the regulations.

Under the Medical Act of 1858, public appointments were confined only to those on the Medical Register. Practitioners could register on the basis of a single qualification in either medicine or surgery and it was not until the Act of 1886 that qualifications in medicine, surgery, and obstetrics were required.<sup>25</sup> Yet, under the 1842 General Medical Order, poor law medical officers were required to be qualified in both medicine and surgery. This meant that poor law medical officers were often better trained than some of their medical colleagues in private practice who may have had only one qualification. It is curious that a double qualification was considered necessary for treating paupers yet this stipulation did not confer a higher status nor was it rewarded by a standard scale of remuneration. Medical

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<sup>23</sup> *Official Circulars*, vol. II (12 April, 1842), p. 248.

<sup>24</sup> Abel-Smith, *The Hospitals*, p. 47.

<sup>25</sup> Digby, *Evolution of British General Practice*, p. 38.

officers were required to employ a substitute, who could be called upon in their absence, yet it was not necessary for the stand-in to have the double qualification: it was merely sufficient that he was legally qualified to practise medicine.<sup>26</sup> There was no uniform system of medical education and qualification until later in the century. It is apparent that for some time knowledge and understanding as to the necessary qualifications for medical officers remained somewhat confused as regular enquiries were made to the Commissioners and to *The Lancet* and *BMJ* for clarification on whether the qualifications possessed by applicants for medical officer posts were sufficient.<sup>27</sup>

The duties of workhouse and district medical officer were combined in some unions, but larger unions generally separated the responsibilities. Salaries varied widely and medical officers were usually expected to provide medicine and dressings as part of their own costs. Some medical officers received what might have been considered a reasonable salary while others were extremely inadequately paid. In their Report on the Poor Law Amendment Act, the Commissioners expressed the opinion that ‘the remuneration of medical officers should be such as to ensure proper attention and the best medicines.’<sup>28</sup> They recognised the advantages of a system of a fixed annual salary and separate payment for specific cases for medical officers. Yet the wide differences between the circumstances of different unions led the Commissioners to believe that it was impossible to prescribe the mode of payment. However, they did set a recommended scale of payment for certain surgical and obstetrical services in Article 10 of the General Medical Order, 1842, which fees were to be paid in addition to the annual salary. These payments were limited to operations on the out-door poor and did not include operations undertaken in the workhouse. The Commissioners considered that ‘as a general rule, the medical officer’s remuneration for his attendance in all surgical cases not mentioned in Article [10] of the [General] Medical Order, must be considered as included in his fixed salary.’ But they were of the opinion that if the Board of

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<sup>26</sup> *Official Circulars*, vol III (28 May, 1848), p 86.

<sup>27</sup> During most of the period studied here medical officers were male; women did not gain access to formal medical training until the late nineteenth century.

<sup>28</sup> Report on the Poor Law Amendment Act, p.25, cited in *Official Circulars*, vol. II (12 April, 1842), p. 249.

Guardians believed that the medical officer was fairly entitled to some extra remuneration, it would be justified in paying it.<sup>29</sup>

By 1844 there were some 2,800 district medical officers in post.<sup>30</sup> Their average salary in 1844 was £69 per annum, which Loudon concluded was much lower than that of a former parish surgeon as the average union surgeon had four to five times as many patients to care for on the same salary.<sup>31</sup> Persistent complaints in *The Lancet* and the *BMJ* focused on the high workload and low salaries of poor law medical officers. *The Lancet* claimed that medical officer had ‘two or three times the number of people under their charge as they can do justice to.’<sup>32</sup>

Despite low salaries and heavy workloads, competition for posts was often high. Digby found that local doctors who were building up a practice were keen to become known through holding a public office, and well-established doctors would take a local post, however low-paid, rather than see a stranger take it and begin to build up a competing practice.<sup>33</sup> Conversely, Loudon suggested that established practitioners often shunned such posts, but he agreed that they were an important source of income for a young new practitioner or for those whose income from private practice proved inadequate. Flinn’s view was that no doctor could have been expected to live entirely on the ‘meagre stipend’ of the poor law medical service and he concluded that practice within the poor law was only possible in combination with a private practice.<sup>34</sup> This situation doubtless contributed to the further detriment of the sick poor.<sup>35</sup> In fact, most medical officers were employed on a part-time basis. The Nottingham union was unusual by its insistence that its medical officers worked full-time and were prohibited from taking on private practice, even though some medical officers disliked and challenged this ban.<sup>36</sup>

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<sup>29</sup> *Official Circulars*, vol IV (29 February, 1844), p. 44.

<sup>30</sup> Flinn, ‘Medical Services’, pp. 48-49

<sup>31</sup> Loudon, *Medical Care*, p. 239.

<sup>32</sup> *The Lancet*, 1 July 1865, p. 20.

<sup>33</sup> Digby, *Making a Medical Living*, p. 50.

<sup>34</sup> Flinn, ‘Medical Services’, p. 50.

<sup>35</sup> Stewart and King, ‘Death in Llantrisant’, p. 70.

<sup>36</sup> E.C. Bosworth, *Public Healthcare in Nottingham, 1750-1911*, unpublished Ph.D. Thesis, University of Nottingham, 1998, pp. 209, 237.

The new poor law provided a more uniform system of medicine than the old poor law, but from the viewpoint of medical officers there were worsening terms and some deterioration in the quality of care given to outdoor paupers.<sup>37</sup> The General Medical Order, 1842 stipulated that the maximum population in a district with one medical officer should be 15,000 and the limit of such districts should be 15,000 acres. In a district containing almost exclusively a poor population, even the limit of 15,000 persons could be too large for one medical officer, especially if the district consisted partly of a town and partly of rural parishes.<sup>38</sup>

Medical officers were required to give medical help and treat any paupers who were referred by the union's relieving officer, whose duty it was to determine entitlement to relief.<sup>39</sup> The Board of Guardians prepared six-monthly lists of all the long-term aged and infirm in receipt of relief in each district. Each person on the list received a ticket to enable them to apply for medical assistance without the need for a medical order from the relieving officer. The medical officer was obliged to attend a patient with a ticket, but if he thought the patient had called him on 'frivolous' grounds he was expected to report such an instance to the guardians who would remove the pauper's tickets. That person could no longer receive medical treatment unless it was exceptionally urgent. Medical officers were required to keep weekly returns to show when visits or attendances had taken place.

Compulsory vaccination against smallpox was introduced in the Vaccination Act of 1853 and the administration of the Vaccination Act was carried out by the Board of Guardians. Workhouse medical officers vaccinated infants in the workhouse and district medical officers were appointed as public vaccinators to vaccinate all infants throughout the union before they reached three months. They were paid 1s 6d for each successful vaccination. The 1867 Vaccination Act tightened up the regulations and obliged medical officers to keep a record of all vaccination cases.<sup>40</sup> The Leicester guardians had an ambivalent attitude towards

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<sup>37</sup> Digby, *Making a Medical Living*, p. 244.

<sup>38</sup> *Official Circulars*, vol. II (12 April, 1842), p. 249.

<sup>39</sup> Flinn, 'Medical Services', p. 49.

<sup>40</sup> Smith, *The People's Health*, pp. 161-2, noted the opposition of the medical profession and the public to this state intervention and the linking of vaccination with the poor law.

compulsory vaccination and many opposed the principle.<sup>41</sup> As Rimmington pointed out, for the working class vaccination was linked to the administration of the poor law which was always disliked and feared.<sup>42</sup> The role of the medical officer therefore gradually became extended by the accumulated practice of treating non-pauper patients for accidents or childbirth and through the use of the poor law medical service to administer vaccinations.<sup>43</sup>

## Leicester

Leicester, the capital of the rural county of Leicestershire, evolved from a market town to an industrial city during the nineteenth century. Politically, Leicester was strongly radical throughout most of this period. From 1836 the new Liberal Corporation was made up of radicals and religious non-conformists. The town's hosiery, boot, shoe and allied elastic web industries expanded rapidly from that time encouraging much immigration into the town. Like Nottingham, Hull and Bradford, Leicester experienced rapid major population growth, as shown in Table 2.1 below.<sup>44</sup>

**Table 2.1**  
**Population growth in Leicester, 1851-1921**

<b>1851</b>	60,584
<b>1861</b>	68,053
<b>1871</b>	95,220
<b>1881</b>	122,351
<b>1891</b>	174,624
<b>1901</b>	211,600
<b>1911</b>	227,200
<b>1921</b>	234,200

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<sup>41</sup> For a detailed, if partisan, contemporary account of the vaccination question in Leicester see J.T. Biggs, *Leicester: Sanitation versus Vaccination* (1912). A useful consideration of the 'Leicester method' of dealing with smallpox is provided by S.M.F. Fraser, 'Leicester and Smallpox: The Leicester Method', *Medical History*, 23 (1980).

<sup>42</sup> G.T. Rimmington, 'Treatment of the Sick Poor in Leicester: North Evington Poor Law Infirmary, 1905-1930', *Midland History*, 24 (2004), pp. 92-106.

<sup>43</sup> Fraser, *The New Poor Law in the Nineteenth Century*, p. 6.

<sup>44</sup> Rimmington, 'Treatment of the Sick Poor', p. 93.

In 1871 the Registrar General noticed how rapidly the population of Leicester had increased within the past ten years and asked the guardians for their observations on this.<sup>45</sup> The clerk replied that a strike at Northampton in 1861 had caused the removal of a significant portion of its shoe trade to Leicester. In addition the depression in Coventry had brought in a large number of ribbon weavers who were absorbed into the elastic trade. He added that before 1861 the principal manufacture of Leicester had been hosiery, but since that time new trades had been introduced. The shoe trade had encouraged sewing-machine and nail makers and other trades had developed in connection with the elastic trade. The clerk remarked that there had also been a large immigration from other places which was continuing.<sup>46</sup> In his reports of the 1870s, the workhouse medical officer regularly commented on the rising population of Leicester and, consequently, the increasing numbers of sick people admitted to the workhouse. However, many more people received out-door relief. For example, 565 paupers were in the workhouse on 1 July 1875, while those in receipt of out-door relief numbered 2,353.<sup>47</sup> Nevertheless, increased numbers of both categories strained the resources of the union medical service.

The Midland Counties Railway service opened in Leicester in 1840. This undoubtedly helped the expansion of Leicester's industries and brought more people into the town. Both the station and the workhouse were built very close to each other, within a short space of time, on sites which were then on the edge of the town. As the railway service developed the south and south-east suburbs of the town expanded.<sup>48</sup> St Margaret's parish became the most populated area of the town. In 1801 a third of the town's inhabitants lived there, and by 1851 two-thirds.<sup>49</sup> The suburbs developed and grew during the second half of the century and in 1891 the municipal boundaries were extended by the Leicester Extension Act by which the parishes of Aylestone, Knighton, Belgrave, North Evington and West Humberstone were included. This increased the population figures of the town by 42 per cent

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<sup>45</sup> Leicestershire Record Office (hereafter LRO), G/12/57d/14, 7 Nov 1871.

<sup>46</sup> LRO, G/12/57b/4, 9 Nov 1871.

<sup>47</sup> LRO, G/12/57d/16. For a detailed discussion of the preponderance of out-relief under the new poor law see Snell, *Parish and Belonging*, pp. 207-338.

<sup>48</sup> A. T. Patterson, *Radical Leicester: A History of Leicester, 1780-1850* (Leicester, 1954), p. 365.

<sup>49</sup> R.H. Evans, 'Leicester and Leicestershire, 1835-1971', in N. Pye (ed.) *Leicester and its Region* (Leicester, 1972), p. 291.

over the 1881 total.<sup>50</sup> As will be seen, this had the effect of increasing the numbers of sick in the workhouse and eventually led to the decision to build a new workhouse infirmary at North Evington.

## Industry

Until the mid-century, hosiery was the town's major industry. It was an easy trade to enter as some of its work required little skill and no capital.<sup>51</sup> Families carried out framework knitting as a cottage-industry either in their own home or in a workshop using rented frames. Yarn was unwound by hand to be used to knit the stocking on the frame and the garment was stitched up by hand. Reliance by families upon the hosiery industry meant that Leicester suffered severe unemployment in the general economic depression that affected the trade in the 1840s. The resultant poverty meant that by the early 1850s it was necessary to rebuild and expand the town's workhouse. Leicester's prosperity fluctuated during the 1850s with severe winters that caused great hardship and illness. However, the growth of Leicester accelerated from the 1850s and from the 1860s its industries generally thrived and there followed three decades of economic prosperity.

The hosiery industry was slow to transfer from home-working to factories. It was not until the 1860s that the factory system of steam-powered machines gradually took over production. This was due to the easy availability of cheap labour, coupled with the profits that could be made from hiring out frames.<sup>52</sup> Hosiery was the largest single source of employment in 1851 in Leicester. By 1861 although the hosiery trade still dominated, the boot and shoe manufacturing industry that started in the early 1850s grew and in the 1870s it took over as the major industry. By 1891 hosiery and footwear production employed 62.5 per cent of workers in Leicester. Other industries in Leicester were branches of hosiery such as glove-making, elastic-web manufacture and engineering.<sup>53</sup> As Evans noted, the introduction of the factory system not only increased prosperity but changed the nature of the labour force. As domestic man-powered stocking frames were

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<sup>50</sup> M. Elliott, *Victorian Leicester* (1979), p. 151.

<sup>51</sup> *Ibid.*, p. 21.

<sup>52</sup> Patterson, *Radical Leicester*, p. 381.

<sup>53</sup> Elliott, *Victorian Leicester*, p. 23.



replaced by steam-powered machines in factories the demand for female labour increased in the hosiery industry. At the same time, the footwear and engineering industries created a demand for male labour.<sup>54</sup>

## Health

Despite the economic growth and increasing prosperity of the town, there were periods of unemployment and many people suffered poverty and ill-health. Hosiery work was carried out for long hours in ill-ventilated and overcrowded slum houses with inadequate communal sanitary facilities, and this was hardly conducive to good health. In 1848 Leicester was reported to be one of the unhealthiest of large English towns.<sup>55</sup> Its reputation for ill-health and a high mortality rate, particularly for infants, was maintained for many years. Bad trade and severe winters such as in 1878-9 resulted in large numbers of labourers being out of work and increased ill-health.<sup>56</sup> Consequently admissions to the workhouse rose at these times.

The growing population required rapid house building. The professional classes migrated towards the edge of the town and the central districts became filled with crowded properties, including back-to-back houses built during the period 1850-60.<sup>57</sup> The town was not equipped to provide adequate drainage and sanitation and illnesses resulted from problems with the water supply and drainage. Leicester was low-lying and the River Soar regularly flooded parts of the town. Private wells that were frequently contaminated provided the water supply up to the mid-nineteenth century. Piped water and a sewage system were not provided until the mid 1850s.<sup>58</sup> However, that system was ill-constructed and it was not until the 1890s that the water carriage of sewage was finally introduced throughout Leicester after a decade of rising deaths and agitation by sanitarians.<sup>59</sup>

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<sup>54</sup> Evans, 'Leicester and Leicestershire', p. 291.

<sup>55</sup> *Ibid.*, p. 294.

<sup>56</sup> J. Storey, Town Clerk of Leicester, *Historical Sketch of Some of the Principal Works and Undertakings of the Council of the Borough of Leicester* (Leicester, 1895), p. 78. One of the largest occupations for male inmates entering the Leicester workhouse was found to be that of 'labourer.'

<sup>57</sup> For a detailed analysis of the social geography of poverty in Leicester see Page, *Poverty in Leicester, 1881-1911*, pp. 99-130.

<sup>58</sup> Evans, 'Leicester and Leicestershire', pp. 293-4.

<sup>59</sup> Smith, *The People's Health*, p. 227.

In an effort to deal with matters of public health, two Sanitary Medical Officers were appointed by the county's Board of Health in 1846 under the Nuisances Removal Act and one, Dr Buck, continued as Leicester Corporation's Medical Officer of Health following the Public Health Act of 1848. The post was part-time until 1885. Following Dr Buck's resignation, John Moore, who was also the workhouse medical officer, became the next MOH until his death in 1867.<sup>60</sup> However, as Wohl pointed out, the role of an MOH required specialised knowledge and training beyond the qualifications necessary for general practice. At that time preventive medicine and sanitary science were not compulsory subjects in most medical schools and such officers were unlikely to be able to deal adequately with complex matters of public health.<sup>61</sup>

During much of the latter half of the nineteenth century Leicester was noted for its chronic annual incidence of diarrhoea which affected babies and young children in particular. Wohl recorded that Leicester's inefficient and rudimentary excrement removal was certainly a contributing factor to infant deaths.<sup>62</sup> The Leicester Board of Health tried to reduce the number of deaths for many years but the infant mortality rate remained high until the early twentieth century.<sup>63</sup> Harrison noted five diseases and disabilities that accounted for most infant deaths in Leicester during that period. These were summer diarrhoea, convulsions, lung diseases, atrophy/debility and premature births. Infants also died from whooping cough, scarlet fever and diphtheria.<sup>64</sup> Later chapters in this thesis discuss the illnesses and diseases suffered by children in the workhouse.

Leicester was also noted for its unusual attitude to smallpox and vaccination.<sup>65</sup> As Elliott stated, 'in the matter of smallpox, the people of Leicester

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<sup>60</sup> Moore was recorded as being 'zealous, able and thoroughly efficient' by A.P. Stewart in *Medical and Legal Aspects of Sanitary Reform* (1867, Leicester 1969), p. 42

<sup>61</sup> A. Wohl, *Endangered Lives: Public Health in Victorian Britain* (1983), pp. 183-4.

<sup>62</sup> *Ibid.*, p. 29.

<sup>63</sup> S. Aucott, *Mothercraft and Maternity: Leicester's Maternity and Infant Welfare Services, 1900 to 1948* (Leicester, 1997), p. 10.

<sup>64</sup> C. Harrison, *In Sickness and Health: A History of Leicester's Health and Ill-health, 1900-1950* (Leicester, 1998), p. 9.

<sup>65</sup> E.R. Frizelle, and B.J.L. Moss, 'The development of medicine, health and the social services', in Pye, *Leicester and its Regions*, p. 557

seem to have courted notoriety and deliberately flouted medical orthodoxy.’<sup>66</sup> Leicester suffered a severe outbreak in 1871-1872 with 3,000 cases and 358 deaths.<sup>67</sup> However, the influence of the Leicester Anti-Vaccination League which was formed in 1869 led to a drop from 94 per cent of children vaccinated in 1867 to only 1.3 per cent vaccinated by 1897.<sup>68</sup> Suspicious of vaccination, fearing that it spread rather than prevented disease, many working-class parents disobeyed the compulsory vaccination laws.<sup>69</sup> Dr. Johnson (who was an assistant medical officer of health for Leicester) developed a system of compulsory notification and isolation of smallpox victims in the fever hospital together with the vaccination and quarantine of their families and contacts. This helped to prevent the spread of the disease and encouraged a belief that mass compulsory vaccination was unnecessary.<sup>70</sup>

Poor law medical services provided treatment for both in-door and out-door paupers, but there were other institutions where the non-pauper sick could obtain some medical care. Many of these institutions were provided by a mixture of charitable and voluntary bodies.<sup>71</sup> Table 2.2 below shows the range and chronology of institutions that provided some form of healthcare in Leicester. This list is by no means exhaustive and it does not include other sources of medical care such as midwives, nurses, surgeons, physicians and chemists/druggists, who were listed in trade directories, or quacks and suppliers of alternative medicine, or the several convalescent homes and almshouses. Medical clubs and Friendly Societies also contracted with local doctors to provide medical treatment for working men who subscribed to those institutions, but this entitlement did not extend to members’ wives, children or female dependents.<sup>72</sup>

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<sup>66</sup> Elliott, *Victorian Leicester*, p. 93.

<sup>67</sup> B. Lancaster, *Radicalism, Cooperation and Socialism: Leicester Working-Class Politics, 1860-1906* (Leicester, 1987), p. 82.

<sup>68</sup> Biggs, *Leicester: Sanitation versus Vaccination*, p. 79.

<sup>69</sup> As initially lymph from the arm of a healthy child who had been vaccinated the previous week was used to perform a vaccination, parents’ fears seem understandable. *The Times*, 30 Oct 1884, p. 4, reported that out of 4,819 children born at Leicester in 1883, only 1,732 had been vaccinated.

<sup>70</sup> Biggs, *Leicester: Sanitation versus Vaccination*, pp. 462-3; Lancaster, *Radicalism, Cooperation and Socialism*, pp. 82-3; Frizelle and Moss, ‘The development of medicine, health and the social services,’ in Pye, *Leicester and its Regions*, p. 558

<sup>71</sup> Harrison, *In Sickness and in Health*, p. 61.

<sup>72</sup> O. Davies, ‘Female Healers in nineteenth-century England’, in N. Goose, (ed.), *Women's Work in Industrial England: Regional and Local Perspectives* (Hatfield, 2007), pp. 230-1.

**Table 2.2 The main institutions providing medical care in Leicester before the National Health Service.<sup>73</sup>**

Institution	Date	Provider/ Status	Patients/Services
Wyggeston's Hospital	1513 1867- Rebuilt on new site.	Charity	Almshouses founded after the grant of Royal Letters Patent from Henry VIII to William Wyggeston, a wool merchant and mayor of Leicester, for the care of 12 poor men and 12 poor women.
Trinity Hospital	1320-	Charity	Almshouses for 50 poor and infirm people founded by the third Earl of Lancaster and Leicester. It was rebuilt in 1776 and again in 1901-2. Finally the old hospital was sold and a new hospital was built on a new site and opened in 1995.
Leicester General Infirmary	1771-	Voluntary/ charity	General and insane wards. Separate fever and children's hospitals. Re-named the Leicester Royal Infirmary in 1912 and later became a NHS hospital.
Leicester Provident Dispensary (became Leicester & Leicestershire Provident Society)	1833  1862	Charity  Voluntary	Originally a charitable institution providing gratuitous medical relief to the poor. In 1862 it converted into a provident dispensary. Its aim was to place medical assistance within the reach of the working classes who did not receive relief from the union but who could not usually afford to pay for private medical advice. Patients could attend the dispensary for treatment, be visited in their own homes if too ill to attend, or attend the medical officers' own residence or surgery.
Leicestershire & Rutland County Lunatic Asylum	1837-1908	Charity/Poor Law/Private	Private, charity and pauper patients
	1914-1919	Military Hospital	War Office

<sup>73</sup> The information for this table was gathered from a variety of primary local records including Board of Governors of Leicester Provident Dispensary, *Leicester Provident Dispensary: Its History, Prospects, Present Position and Requirements* (Leicester, 1877); *Wright's Directory of Leicester, 1889-90* and secondary sources such as Harrison, *In Sickness and in Health*, and Pye, *Leicester and its Region*.

<b>Institution</b>	<b>Date</b>	<b>Provider/ Status</b>	<b>Patients/Services</b>
Leicester Union Workhouse  The workhouse continued to house the poor and aged poor under public assistance and the workhouse became known as Hillcrest Geriatric Hospital in 1955. The building was demolished 1977.	1836-1975	State/Poor Law	Insane and sick wards from 1840s. Children's sick wards provided 1867. Separate fever wards. Separate infirmary 1885.
North Evington Poor Law Infirmary	1905-1915	State/Poor Law	Sick paupers transferred from workhouse 1905 until 1915 when it was taken over as a war hospital when most paupers were returned to the workhouse. TB patients were transferred to Groby Road Sanatorium.
North Evington War Hospital	1915-1919	War Office	Wounded and sick soldiers.
North Evington Infirmary	1919-1930		North Evington Infirmary continued as a poor law hospital until 1930. It then became the City General Hospital under local government until it became a NHS hospital in 1948.
St Johns & Bents Hospital	1860	Charity	For 11 poor widows
Leicester Borough Asylum Became Towers Hospital	1869-2005	Corporation	Poor law and private patients
Institution for Trained Nurses	1865	Charity	To provide district nurses for the poor.
Leicester Borough Fever Hospital	1871-1900	Corporation	Temporary building of corrugated iron built on Freake's Ground. Used until the permanent isolation hospital was built at Groby Road in 1900.

<b>Institution</b>	<b>Date</b>	<b>Provider/ Status</b>	<b>Patients/Services</b>
Countesthorpe Cottage Homes	1884-1974	State/Poor Law	Children moved here from workhouse. A separate cottage provided as an infirmary for 20 children.
The People's Dispensary	1889- late 1930s	Voluntary	Established by Rev. A.A. Isaacs and Dr Bryan. Supported by subscriptions of the poor and working-classes and by fund-raising. Provided doctors and medicine.
Groby Road Isolation Hospital	1900	Corporation	Local sanitary authority provision for public. Replaced fever hospital on Freake's Ground.
Groby Road Smallpox Hospital	1901	Corporation	Local sanitary authority provision for public.
Provident Dispensary Hospital later became John Faire Hospital	1903 1911-1947	Voluntary	Working class by subscription.
Bond Street Maternity Hospital	1905-1940	Voluntary	National Union of Women Workers raised money through public subscription for the training of midwives and lying-in of working-class women.
Groby Road Sanatorium	1914	Corporation	Local sanitary authority provision for public.
Westcotes Maternity Hospital	1923-1974	Corporation	Local authority public maternity hospital.
Fielding Johnson Hospital	1923-1947	Private	Private patients.

Voluntary hospitals were reluctant to admit paupers.<sup>74</sup> However, the Leicester union paid annual subscriptions to the General Infirmary in Leicester in order to send patients there, such as acute cases that could not be treated in the workhouse infirmary. In 1822 fever wards had been built at the General Infirmary and the union also subscribed to send fever patients there until the Borough Fever Hospital was built in 1871. Indeed, the town clerk recorded that the prevalence of scarlet fever in 1870 and 1871 and the fear of a smallpox epidemic led to the decision to erect corrugated iron buildings with five wards for 36 patients for cases of smallpox, scarlet fever, measles, erysipelas and cholera.<sup>75</sup> The hospital was extended in 1893 and a new isolation hospital and sanatorium was opened in the north-west of the town in 1900.

There were also general practitioners for those who could afford to pay. Harrison stated that there is little information about the provision of doctors in Leicester but he calculated that there were about 105 general practitioners in 1904.<sup>76</sup> Most doctors who worked for the union medical service had private practices as well as other public posts. Many doctors dispensed their own medicines but people could also obtain medicine at the Leicester Provident Dispensary.

### **Leicester union**

Leicester union was one of eleven unions formed from the parishes of Leicester and Leicestershire following the Poor Law Amendment Act, 1834.<sup>77</sup> In urban areas Boards of Guardians mostly consisted of shopkeepers, tradesmen or retired businessmen, while in rural areas guardians were mainly farmers. Guardians generally felt their duty was to serve the interests of their electorate by saving money on the rates rather than to provide for the needs of paupers.<sup>78</sup> In the early years of the Leicester union the central authority was frequently disparaging about

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<sup>74</sup> For more detailed discussions on voluntary hospitals in the nineteenth century see, for example, K. Waddington, *Charity and the London Hospitals, 1850-1898* (Woodbridge, 2000), and J. Woodward, *To Do the Sick No Harm: A Study of the British Voluntary Hospital System to 1975* (1974).

<sup>75</sup> Storey, *Historical Sketch*, pp. 58-63.

<sup>76</sup> Harrison, *In Sickness and in Health*, p. 61.

<sup>77</sup> The other unions formed in the county were Ashby, Barrow-on-Soar, Billesdon, Blaby, Hinckley, Loughborough, Lutterworth, Market Bosworth, Market Harborough, and Melton Mowbray.

<sup>78</sup> Abel-Smith, *The Hospitals*, p. 63.

the mainly Conservative guardians. Thompson felt that the evidence suggested that they were ‘of indifferent quality’. But the ascent of a mainly Liberal, non-conformist board brought in many guardians who took their responsibilities more seriously and compassionately.<sup>79</sup> Liberals were in the majority on the Leicester Board of Guardians throughout the period studied here. The forty-eight guardians were from a range of occupations including gentlemen, manufacturers, professional men and tradesmen.<sup>80</sup> The local newspapers that reported on the guardians’ weekly board meetings were also Liberal newspapers.<sup>81</sup>

The union was initially divided into two districts. District number one, St Margaret’s, was the largest. It covered the eastern half of the town and contained the highest population with the greatest concentration of poverty in some of the poorest housing. The high population resulted from immigration into the parish by young people in search of work bringing a high rate of natural increase and also from Irish immigration. The second district consisted of the other five parishes in the western half of the town. In 1843 the number of districts was increased to four – East St Margaret’s, West St Margaret’s, St Mary’s (including the workhouse) and the remaining four parishes. In 1853 the workhouse was made a separate district and in 1857 St Margaret’s was divided into three medical districts. For the major part of the period studied the union consisted of five districts in addition to the workhouse until a sixth district was added in 1909. A chronology of key events in relation to the Leicester union and workhouse is provided in Appendix 1.

This study has found that, unsurprisingly, the highest number of paupers admitted to the workhouse came from the parish of St Margaret’s. This concurs with the findings of an earlier study of the geographical perspective of poverty and admission to the workhouse in Leicester.<sup>82</sup> The occupations of the majority of

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<sup>79</sup> Rimmington, ‘Treatment of the Sick Poor in Leicester’, p. 94.

<sup>80</sup> Property-owning women could become guardians, although few did. The first woman guardian was appointed in 1875 at Kensington union. Female guardians did not appear on the board at Leicester until 1889 when Fanny Fullager, the daughter of a former medical officer, was elected in All Saints Parish. She served on the Board for fifteen years. By 1895 there were over 800 women guardians around the country and by 1907 there were six female guardians on the Leicester board.

<sup>81</sup> The Liberal newspapers were *The Leicester Chronicle*, *The Leicester Daily Post* and the *Leicester Daily Mercury*. The *Leicester Journal* and the *Leicester Herald* were Conservative newspapers.

<sup>82</sup> S.J. Page, ‘Late Victorian Pauperism and the Poor Law in Leicester’, *Transactions of Leicestershire Archaeological & Historical Society*, LX (1960), pp. 47-62; Page, ‘Pauperism and the



paupers admitted to the workhouse were ‘unskilled’, such as ‘labourer’ for males and ‘charwoman’ for females. Constraints of space do not permit a detailed discussion here of the causes of such poverty and subsequent admission to the workhouse.

### **Leicester union workhouse**

The Leicester Union workhouse was situated on Swain Street near the railway station. It was originally built in 1838 to accommodate 600 people on what was then the border of the town.<sup>83</sup> It was later rebuilt on the same site in 1851 to accommodate 1,000 inmates.<sup>84</sup> Figure 1 shows the front of the workhouse. The workhouse was built on seven acres of land, of which about two acres were garden ground.<sup>85</sup> An inspection report of 1878 graphically described the workhouse:

‘The workhouse is placed on an elevated site, is built up on three sides and is open to the Railway which adjoins it on the front ... The House consists of three distinct parts, separated from but placed in close proximity to each other, viz. the house proper in the centre, the infirmary behind, and the school in front... In the centre of the House are the administrative buildings, master and matron’s quarters, dining hall and chapel and some of the out offices attached to them. In the centre of this great block runs a long corridor, lighted from above by openings in the floors, and bounded by the backs of the wards which ventilate into them wherever there are free openings, which are however few ... and quite inadequate for the free introduction of fresh air. The water closets all open into the wards ... on the lower floor on both sides are day rooms for all classes of inmate in health with yards attached to them.’<sup>86</sup>

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Leicester Workhouse in 1881’, *Transactions of Leicestershire Archaeological & Historical Society*, LXIII (1989), pp. 85-95; Page, *Poverty in Leicester, 1881-1911*.

<sup>83</sup> For a detailed account of the building of the earlier workhouse see K. Thompson, ‘The Building of the Leicester Union Workhouse 1836-1839’, in D. Williams (ed.), *The Adaptation of Change: Essays upon the History of Nineteenth-Century Leicester and Leicestershire* (Leicester, 1980), pp. 60-76.

<sup>84</sup> The workhouse later became known as Hillcrest Hospital after 1955 and was used as a geriatric hospital until it was closed in 1974. The building was demolished in 1977.

<sup>85</sup> LRO, G/12/57d/19, 8 Aug 1879.

<sup>86</sup> The National Archives (hereafter TNA), MH12/6489, 18 Feb 1878.



Figure 1 Leicester union workhouse c.1870s  
©Record Office for Leicestershire, Leicester and Rutland

The inspector considered the construction of the workhouse and the workhouse infirmary to be ‘radically defective.’ There were many problems and changes made to the infirmary during the period studied which are explained in detail in Chapter 6. As Rimmington pointed out, when the workhouse was first erected, it was located in fairly spacious surroundings on the edge of the town, but by late Victorian times the situation had changed and it was hemmed in by the Midland Railway on the north side and by St Peter’s parish, whose population had grown rapidly to more than 20,000 in 1893, with the poorest houses around the workhouse itself.<sup>87</sup>

The numbers of workhouse inmates varied over the years but there was always a core staff. The 1881 census showed 36 members of staff, 873 inmates and 26 vagrants. The most influential members of staff were the clerk and the married couple of workhouse master and matron. After 1843 until the poor law system ceased, the union employed a succession of three competent clerks who each spent lengthy periods in office. During the period studied, four successive married couples took on the positions of workhouse master and matron. Mr Dickisson, formerly a relieving officer of the union for seven years, was appointed in 1853 and he and his wife remained in post until 1880. The Dickissons appear to have had a good relationship with the medical officer and to have run the workhouse satisfactorily. However, their successors, the Gardiners, were asked to resign by 1886 after charges of ‘petty tyranny’ and ‘misappropriation of wine and spirits’ ordered for the patients were made by the medical officer and nurses. They were replaced by the Lamberts who remained in post until 1907. The last workhouse master and matron of the Leicester union workhouse were Mr and Mrs Lovell. During their employment, the responsibility for the management of the workhouse infirmary was taken over wholly by medical staff.

## **Summary**

During the nineteenth and early twentieth centuries, the town of Leicester greatly increased in both size and population. Industries expanded and the town mainly prospered, although there were fluctuations. Yet Leicester was considered

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<sup>87</sup> Rimmington, ‘Treatment of the Sick Poor in Leicester’, p. 92.

to be an unhealthy town for much of the period and its limited provision of health care developed in a piecemeal way. Low wages, periods of unemployment, poor housing and sanitation, overcrowding, deficient diets and occupational hazards all contributed to the need for many of the poorest to obtain poor relief during periods of hardship. The remainder of this thesis will assess the extent to which the medical service of this industrially situated poor law union, with all its associated health problems, was able to cope with and alleviate the needs of the sick paupers of Leicester.

## Chapter 3

### Leicester union's medical officers - their status and administrative situation

#### Introduction

This chapter elucidates the situation of both the workhouse and district medical officers of the Leicester union. Primary sources on the daily work of the workhouse medical officer are more plentiful than those for the district medical officers, even though despite the intention of the new poor law, out-door relief took place on a large scale and a great amount of medical relief, either as part of general out-relief or as medical relief only, was administered in people's homes.<sup>1</sup> Snell has contended that one reason why documentation on out-door relief is less profuse is because the central authority had limited power over out-relief policy. In-door relief and its sources are therefore more accessible to research.<sup>2</sup> Snell's contention has been borne out in this study. It is also possible that the records made by district medical officers were not seen as important as the workhouse records and were unwittingly destroyed. However, there are frequent albeit less-detailed references to the work of district medical officers in the various letters and minute books. This has enabled sufficient information to be gleaned to provide a reasonably comprehensive picture of those local poor law doctors, the nature of their work and its development.<sup>3</sup> Before discussing that work, in order to

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<sup>1</sup> *The Minority Report of the Poor Law Commission, Part 1, The Break-Up of the Poor Law* (1909), p. 219, quoted the Poor Law Commission's findings that for the year's count of pauperism 'no fewer than 216,022 persons' received medical relief only.

<sup>2</sup> Snell, *Parish and Belonging*, pp. 208-10.

<sup>3</sup> For the sake of consistency and convenience all medical officers are referred to here as 'Dr' to indicate their professional medical qualification except in direct quotations from the primary records. Loudon, *Medical Care*, p. 203, noted that the title of the general practitioner was a difficult subject as it was considered bad taste for such doctors to refer to themselves as 'Dr', and it was therefore common for them to be addressed as 'Mr'. Crowther, *Workhouse System*, p. 156, similarly points out that the term 'doctor' was not widely used until the late nineteenth century. Inconsistencies in the use of either 'Mr' or 'Dr' were found in the earlier local records, but increasingly in the later nineteenth-century records the term 'Dr' was used, confirming Crowther's point. Medical officers were always male, at least until the late nineteenth and early twentieth century.

set the situation of the Leicester medical officers into context, a brief summary of the mid-century poor law medical system is given.

## **Mid-century poor law medical relief**

A variety of associations campaigned for the reform of poor law medical services, with some success in the 1850s and 1860s.<sup>4</sup> However, according to Crowther, the impulse for reform died down thereafter, mainly because ‘the concept of a state service did not attract members of a profession who continued to seek advancement through private practice.’<sup>5</sup> That reasoning may have applied to the Leicester medical officers. Certainly no evidence was found of their involvement in any associations that campaigned for reform apart from a workhouse medical officer in the 1850s who the guardians allegedly brought a charge against to force him to resign.<sup>6</sup> Furthermore, the majority of the medical officers of the Leicester union worked in private practice. This may have, as Crowther argued, diluted their interest in the poor law service.<sup>7</sup> However, individual medical officers endeavoured to obtain improvements in accommodation and medical treatment through their local boards of guardians, as is shown in this study.

The Report of the Select Committee on Poor Relief in 1864 stated that the 46 per cent increase in medical officer posts from 2,376 in 1840 to 3,479 in 1861 was substantial considering that the number of unions had only increased by five per cent. The report also noted that medical officers received extra fees for surgery, vaccinations, attending childbirths and for visiting lunatics, as well as receiving special gratuities for dealing with outbreaks of fever, or for lengthy attendances upon accident cases or cases of protracted illness. The Committee congratulated itself on the improvements that had already been made to the workloads and status of medical officers. It believed that ‘the

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<sup>4</sup> These associations included the Provincial Medical and Surgical Association (which later became the British Medical Association) and the Convention of Poor Law Medical officers, and later the Poor Law Medical Relief Association, led by Dr. Richard Griffin who was medical officer to the Weymouth Union. This body was active throughout the 1860s and by 1869 ‘had become a powerful body with support pledged by 89 Members of Parliament.’ Flinn, ‘Medical Services’, p. 60.

<sup>5</sup> Crowther, ‘Paupers or Patients?’, p. 34.

<sup>6</sup> Thompson, *Leicester Poor Law Union*, pp. 201-2.

<sup>7</sup> *Ibid.*, p. 42.

poor were never so promptly attended to or effectively relieved during sickness.’ The committee clearly felt that medical officers could not be allowed to work unfettered as the report stated that to grant the requests made by Dr Griffin would allow the ‘unchecked discretion’ of the medical officer, which would add greatly to the expenditure on poor relief and diminish the control and responsibility of the guardians.<sup>8</sup> No doubt influenced by the fact that there was no difficulty in getting medical officers, the Select Committee concluded that there were insufficient grounds for materially interfering with the present system. As a concession to medical officers, however, the Poor Law Board (hereafter PLB) recommended that cod-liver oil, quinine and other expensive medicines should in future be provided by the guardians.<sup>9</sup>

### **The Metropolitan Poor Law Act, 1867**

The combined pressures of adverse publicity in the mid-1860s that highlighted the dreadful conditions of many workhouses, together with campaigns by the medical journals, demands for improvements from medical officers and their associations and the influence of prominent individuals such as Florence Nightingale and Louisa Twining, all succeeded in generating legislation for reform through the Metropolitan Poor Law Act in 1867.<sup>10</sup> This important Act instigated the greater separation of medical from poor relief functions, which resulted in the beginnings of a state hospital

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<sup>8</sup> *Report from the Select Committee on Poor Relief*, PP 1864 (349), IX, p. 15. The Select Committee considered that the changes advocated by Griffin were of ‘an extensive character’.

<sup>9</sup> *Eighteenth Annual Report of the Poor Law Board, 1865-66*, PP 1866 (3700) XXXV, Appendix 1, p. 23. The Leicester guardians had a lengthy discussion in 1872 about whether all medicines required by the sick poor of the union should be provided and dispensed by the board. However, they decided to continue with the current system. It was not until 1878 that the Leicester guardians finally decided that they would provide cod-liver oil rather than the workhouse medical officer. It was kept in the stores by the workhouse master and given out to the sick inmates at the direction of the medical officer.

<sup>10</sup> Hodgkinson, *Origins*, p. 451; Flinn, ‘Medical Services’, pp. 60-6. *The Lancet* and the *BMJ* both strongly supported and campaigned for improvements in poor law medical services. The *BMJ* was keen to see better terms and conditions for medical officers and the journal was highly critical of the main objective of the poor law, which it saw as to diminish the rates rather than bring relief to the destitute. *The Lancet*, in particular, made a major contribution in 1865-6 when it appointed its own private ‘commission’ to investigate and report on the appalling state of workhouse infirmaries in London. Dr Edward Smith’s 1867 report on the metropolitan infirmaries and sick wards and later on the provincial workhouses also confirmed the deficiencies in workhouses and care of the sick. For a concise explanation of the developments that led to the Metropolitan Poor Law Act of 1867 see G. M. Ayers, *England’s First State Hospitals and the Metropolitan Asylums Board, 1867-1930* (1971), Chapter 1.

service for the whole population.<sup>11</sup> The Act required the PLB to amalgamate the medical services of all the metropolitan unions into a single unit or into a small number of large units.<sup>12</sup> The Metropolitan Asylums Board became the hospital authority for the treatment of typhus, smallpox and insanity for the whole of Greater London. A Common Poor Fund was set up and financed by all the member unions in proportion to their rateable values. This ensured that wealthier unions subsidised poorer unions who generally made heavier demands upon the service. The unions were grouped into 'sick asylum districts' to provide separate hospitals for the sick poor for all other forms of medical treatment.<sup>13</sup>

London led the way in developing hospitals separated from the workhouse. Trained nurses replaced pauper nurses. Consultants and resident and assistant medical officers were appointed and medicines were paid for by guardians. Provincial unions were much slower to separate infirmaries from workhouses. Although there was a parallel Act in 1868 to encourage provincial unions to create separate hospitals, no provision was made for the merging of provincial unions and there was no common poor fund across unions as a financial incentive. Conditions did not immediately improve for medical officers or patients after the passing of the Metropolitan Poor Law Act. Where workhouse infirmaries were extended or new infirmaries were built, there were correspondingly increased numbers of patients requiring care.

## **Leicester union's medical officers**

Tables 3.1 and 3.2 below provide details of all the medical officers, their age, salary and length of service, who were employed by the Leicester union during the period 1867 to 1914.<sup>14</sup> Crowther believed that the ages of provincial medical officers

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<sup>11</sup> Harris, *Origins of the British Welfare State*, p. 97.

<sup>12</sup> Flinn, 'Medical Services', p. 64.

<sup>13</sup> *Ibid.*; Wood, *Poverty and the Workhouse in Victorian Britain*, p. 134.

<sup>14</sup> The tables have been compiled from information extracted from the large range of books of the correspondence of the Central Authority to the Leicester guardians which are too numerous to list here. The relevant records can be found mentioned throughout this thesis under the reference of G/12/57d/1-55. The medical officers who worked at the North Evington Infirmary are shown in Chapter 9.



are unknown.<sup>15</sup> However, the tables show that the most common ages of the medical officers upon appointment were from 26 to 30, confirming that young practitioners took these posts as a means of gaining medical experience. There were usually several applicants for posts, generally by applicants within two or three years of qualifying.<sup>16</sup> The tables also show that many medical officers remained in post for a substantial number of years. These doctors often held other offices and as far as can be ascertained from the local trade directories and references made in various letters, all also worked locally as general practitioners. The view by some historians that holding a poor law medical post was detrimental to a doctor's career in private practice does not seem to be upheld by these examples.<sup>17</sup>

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<sup>15</sup> Crowther, *Workhouse System*, p. 174.

<sup>16</sup> LRO, G/12/8a/31, 2 Mar 1897. By 1897, a female doctor was among five applicants. She was not appointed but she did receive votes from some guardians.

<sup>17</sup> See the *Report from the Select Committee on Medical Relief to the Sick Poor*, PP 1844 (531) IX, for the debate on the merits or otherwise of medical officers holding a private practice and poor law appointment. E.C. Tufnell, a Poor Law Commissioner, considered that poor law medical officers received additional payment from the experience they acquired which brought them credit and private patients. However, Digby, *Making a Medical Living*, p. 50, thought this was less likely later in the century when class differentials seem to have sharpened.

**Table 3.1**  
**District medical officers appointed to the Leicester union**

District	Name	Date appointed	Age on appointment	Salary on appointment	Left post	Reason for leaving	Years in service
2	William Derrington	Aug 1845	Unknown	£60.00	Jul 1877	Probably to retire	32
2	Claude Douglas	Aug 1877	25	£80.00	Oct 1886	Resigned to take post at Leicester General Infirmary	9
2	Charles Lakin	Dec 1886	38	£80.00	Oct 1893	Resigned - district too large.	7
3	John Oliphant	Dec 1870	Unknown	£70.00	Feb 1890	Resigned	20
3	Henry Meadows	Mar 1872	25	£70.00	Mar 1888	Gave up poor law work.	16
3	F.W. Lewitt	Feb 1889	28	£80.00	Sept 1903	Voluntarily	14
3	Paul de C. Potter	Nov 1903	39	£90.00			
4	Joseph Denton	Mar 1856	Unknown	£70.00	Jun 1874	Retired	18
4	Edward Rawston Denton	Jun 1874	47	£80.00	Mar 1897	Retired	23
4	William Peake	Jan 1890	28	£80.00	1919	Transferred to District No. 4 in 1892. Resigned 1919	29
4	Thomas Shearer	Oct 1893	36	£90.00			
5	Mark Sharman	Apr 1888	26	£80.00	Jun 1889	Resigned – gave up practice and left Leicester.	1
5	William F. McAllister-Hewlings	Apr 1897	29	£90.00	Feb 1914	None given	17
5	Sannyasi Charan Roy	Feb 1914	40	£90.00	Jul 1915	Asked to resign for failing in duty. See Chapter 4.	1
6	Frank Fullager	Mar 1843	Unknown	Not known	Apr 1876	Died	33
6	William A. Cox-Hippisley	May 1876	29	£80.00	Feb 1889	Died	13
6	Albert Hindle	Feb 1889	28	£80.00	Sept 1894	Voluntarily resigned	5
6	Charles Coles	Oct 1894	30	£90.00	Oct 1897	Ill health	3
6	George Henry Crofts	Sep 1897	28	£90.00	Dec 1909	Cause not stated	12
6	J.A. Mearns	Nov 1909	30	£90.00			
6	E. H. Snoad	Mar 1892	61	£40.00	Mar 1897	New district – previously in Blaby union. Retired	
6	P.E. Snoad	Apr 1897	27	£90.00		Previously deputy to father	
7	G. Goldie Smith	Sep 1909	29	£90.00		New district formed	

**Table 3.2****Medical officers appointed to the Workhouse and Cottage Homes**

<b>Institution</b>	<b>Name</b>	<b>Date appointed</b>	<b>Age on appointment</b>	<b>Salary on appointment</b>	<b>Left post</b>	<b>Reason for leaving</b>	<b>Years in service</b>
<b>WH</b>	John Moore	Jan 1857	53	£65.00	Apr 1867	Ill health	10
<b>WH</b>	Julius St Thomas Clarke	Apr 1867	30	£80.00	Jun 1880	Took a post as surgeon at The Leicester General Infirmary voluntary hospital	13
<b>WH</b>	Clement Frederick Bryan	Jun 1880	29	£100.00	Mar 1914	Resigned Feb 1914 to take effect in July 1914 when Hadley was to become Medical Superintendent for the WH as well as NEI but Bryan died 29 Mar 1914. His son Douglas Bryan acted as interim MO until Hadley took over.	34
<b>CH</b>	Richard Steele	Oct 1884	29	£30.00	1906	Took a post abroad	25
<b>CH</b>	William Beresford	Nov 1906	51	£45.00			
<b>NEI</b>	Ernest Hadley	Jul 1914	39	£120.00	1940	Retired	26

WH = Workhouse    CH = Cottage Homes at Countesthorpe    NEI = North Evington Infirmary

Medical officers were notoriously low paid. However, unlike private practice, where patients might be reluctant to promptly pay a medical bill, the poor law salary was at least a regular and reliable contribution towards a doctor's overall income. The numbers of medical officers grew to 4,728 by 1906, showing that the salary was an important source of income for the general practitioner.<sup>18</sup> It also seems plausible that holding the post was a way of keeping competitors away. The example of Joseph Denton who was succeeded by his son Edward, who was by then aged 47, would appear to support this view. Furthermore, as Digby has pointed out, despite their low salaries, at least medical officers were rewarded for essential medical treatment of the poor. Otherwise they may have felt obliged to treat destitute emergency cases unpaid simply from altruism and adherence to the Hippocratic Oath.<sup>19</sup>

Dr Clarke was appointed on an annual salary of £80. This was soon increased to £100 as he acquired extra duties when a separate workhouse school was opened.<sup>20</sup> In 1874 he requested another increase in his salary as the enlargement of the workhouse infirmary had increased his duties. The guardians unanimously resolved to raise his salary by £20 a year indicating that a good relationship existed between the guardians and Dr Clarke and that they acknowledged his increased workload.<sup>21</sup> Nationally salaries varied widely. Dr Clarke's salary was certainly lower than that of the medical officer of Sheffield union who received £200 when the infirmary was separated from the workhouse in 1881. In fact, the assistant medical officer at Sheffield received £100.<sup>22</sup> However, the Sheffield infirmary was larger with 400 beds.<sup>23</sup>

Interestingly, Dr Bryan was appointed on a lower annual salary of £100. The guardians may have seized an opportunity to economise. Perhaps Dr Bryan was

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<sup>18</sup> Crowther, *Workhouse System*, p.136; Digby, *Making a Medical Living*, p. 119. Research on the general practices of the Leicester medical officers would be useful to discover how their union salaries compared to their income from private patients.

<sup>19</sup> *Ibid.*, pp. 119, 249.

<sup>20</sup> LRO, G/12/57d/12, 20 Oct 1868.

<sup>21</sup> LRO, G/12/57b/5, 9 Sept. 1874.

<sup>22</sup> TNA, MH9/15.

<sup>23</sup> L. Howsam, *Life in the Workhouse & Old Hospital at Fir Vale: The Story of the Northern General Hospital, Sheffield* (Sheffield, 2006), p. 9.

satisfied with the salary as he was younger and less experienced than Dr Clarke. He appeared to remain satisfied as it was ten years later before his salary was increased to £125 a year.<sup>24</sup> Six years later Dr Bryan wrote to the guardians to support his application for another increase. It is worth quoting his letter which shows how he chose to emphasise his economic value to the guardians:

‘Professional men do not work by time, but should be paid according to their opinions or advice, for which they have to undergo a long and expensive training, and which after years of experience becomes much more valuable. I am quite aware that a younger and more inexperienced man might do the work but I am certain that one who has been used to the work and had the courage of his opinion is a very great saving to the ratepayers, ... in the treatment of tramps alone I am able to detect imposture and malingering which one who had not been used to it could not possibly do as he would be afraid lest he should make a mistake ... the quick detection and isolation of infectious and contagious diseases is another great saving. Also the statistics of cures of acute diseases will bear any favourable comparison with other large institutions ... In conclusion I think that as the master and matron by their recent increase of salary must feel a greater interest in their duties, so it would be with the medical officer.’<sup>25</sup>

One guardian stated that an increase was justified as Dr Bryan was one of the oldest serving officers having been in post for sixteen years. Furthermore, he had not received an increase when the borough was extended, unlike all the other officers, and his duties were described as ‘exceedingly onerous’ with attendance on 300 beds. The guardians had discovered from the figures of twenty other similar unions to Leicester that the average annual expenditure per bed was 12s 6d, while in Leicester it was only 8s 3d. They concluded that even if Dr Bryan’s salary was increased to £150, the expenditure per bed would still only be 10s.<sup>26</sup> Another reason was for his attendance upon workhouse staff who became sick through contact with infected patients or who received injuries while on duty. The Local Government Board (hereafter LGB) disagreed. It argued that the cost of this type of medical attendance should not be charged upon the rates. However, it did agree that Dr Bryan’s salary should be raised

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<sup>24</sup> LRO, G/12/57d/30, 14 Jun 1890.

<sup>25</sup> LRO, G/12/57d/36, 30 Dec 1895.

<sup>26</sup> LRO, G/12/188/1, 29 Jan 1896.

to £140.<sup>27</sup> The guardians pointed out that nurses were liable to fall ill at any time in the course of their duties. Many lived a long distance from their home and they felt bound to supply them with medical treatment which Dr Bryan was quite willing to give for a suitable reimbursement.<sup>28</sup> The guardians often requested permission to give gratuities to the medical officer for such work. They therefore decided that it would be more straight-forward and economic to have this arrangement. Some months later the guardians asked the LGB to sanction the payment of a gratuity to Dr Bryan of £7 18s 6d for attendance upon Nurse Wilson when she contracted typhoid fever from infected patients in the infirmary.<sup>29</sup> They reminded the LGB that had it approved the earlier requested increase of salary, Dr Bryan would have foregone his charges for this attendance.<sup>30</sup> However, the LGB's adherence to the regulations was to Dr Bryan's advantage as he received more from gratuities paid for each officer treated than he would have from a £10 annual payment to cover all such cases.

In common with most other unions, all the Leicester workhouse and district medical officers were expected to supply medicines and medical appliances throughout the majority of the period, excluding surgical appliances such as trusses and artificial limbs.<sup>31</sup> When the North Evington infirmary was opened in 1905, however, the guardians supplied all medicines and appliances, although district medical officers were still required to provide inexpensive medicines. In 1903 the LGB had requested the guardians to reconsider the issue of paying for expensive medicines for the sick poor. When the guardians asked the LGB for guidance on which medicines came under that category, it replied that it was a matter for arrangement between the guardians and their medical officers. However, it provided a list of medicines that another board of guardians had recently resolved to class as 'expensive'. The guardians evidently

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<sup>27</sup> LRO, G/12/57d/36, 6 Oct 1896.

<sup>28</sup> LRO, G/12/57b/10, 15 Apr 1896.

<sup>29</sup> In 1871 the Poor Law Board was replaced by a department of the Local Government Board.

<sup>30</sup> *Ibid.*, 21 Dec 1896. Later records show that Dr Bryan treated various workhouse staff for injuries they sustained on duty, for example, one officer fell down a well and severely injured his shoulders. Dr Bryan received one guinea for treating him. LRO, G/12/57b/12, 17 Jul 1905.

<sup>31</sup> Nottingham guardians exceptionally funded all drugs.

acquiesced, as later forms of appointment for district medical officers noted that payment for expensive medicines was not required.<sup>32</sup>

### **The workhouse medical officers**

According to a PLB report on the workhouse in 1867, the medical officer Dr John Moore considered that cases did as well at the infirmary as they did at the general hospital and the arrangements at the infirmary were good.<sup>33</sup> Dr Moore seems to have been a somewhat deficient workhouse medical officer. He visited the infirmary daily except Sunday, but he spent just forty-five minutes there.<sup>34</sup> In November 1866, for example, there were sixty-eight patients on his books. Forty-five minutes seems a brief visit for that number of patients, although possibly not all required daily attention. He was also frequently absent due to his own poor health. Eventually he was asked to resign after a patient died from gangrene. He had been unable to set her broken leg because of his failing health and had simply left it.<sup>35</sup> His successor was his deputy, Julius St. Thomas Clarke.

Dr Clarke resided at 37 London Road close to the workhouse. According to his obituary in *The Lancet*, Clarke became an eminent surgeon.<sup>36</sup> The *Leicester Guardian* recorded that ‘throughout the whole of his medical career he took the most earnest interest in the science of medicine and its daily development.’<sup>37</sup> He was born in Leicester, began his medical education at the Leicester Infirmary and trained at Guy’s Hospital in London where he gained a gold medal in anatomy and physiology at the University of London and also gold in clinical surgery at Guy’s. The *Leicester Guardian* also praised his ‘energy and indomitable will power’ which were apparent in

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<sup>32</sup> LRO, G/12/57d/43, 27 Oct, 11 Nov, 4 Dec 1903; G/12/57d/49, 29 Sep, 7 Dec 1909.

<sup>33</sup> TNA, MH32/67, 15 Apr 1867. The medical officers frequently referred to the general sick patients as ‘cases’ rather than ‘patients’. This confirms the view of historians that nineteenth-century medical practitioners began to focus on the sick body rather than on the individual.

<sup>34</sup> Hodgkinson, *Origins*, p. 352 noted that the 1860 Consolidated Orders Respecting Medical Relief (Article 207) stated that doctors were to make a personal daily visit to the workhouse and/or workhouse infirmary.

<sup>35</sup> Thompson, *Leicester Poor Law Union*, p. 202.

<sup>36</sup> *The Lancet*, 31 Aug 1901, pp. 624-5.

<sup>37</sup> *The Leicester Guardian*, 10 Aug 1901.

his gaining the degree of Doctor of Medicine at the age of 55 and Master in Surgery two years later. The newspaper pointed out that he was ‘one of the very few men in England’ who held both of these degrees with that of the Fellowship of the Royal College of Surgeons.<sup>38</sup> Dr Clarke gained these qualifications after he left his union post, but his history shows that he was a better qualified, more professionally aware and ambitious doctor than Leicester’s previous workhouse medical officer. He was a very busy and successful man with many other public commitments in addition to his workhouse duties. These included a seat on the town council and duties as a magistrate. He was also an honorary medical officer to the Institution for the Blind and the Leicester Borough Asylum and medical officer to the Leicester Trained Nurses’ Institution.<sup>39</sup> When he was appointed a member of the Leicester General Infirmary in 1880, he resigned his workhouse post.<sup>40</sup>

Dr Clarke was replaced by Dr Clement Frederick Bryan who was also from Leicester. He too was a student at Guy’s Hospital which he entered at the age of 16. He became one of the youngest practitioners in England, being in full practice at the age of 22. Dr Bryan was 29 when he became the workhouse medical officer, where he remained in post for thirty-four years until his sudden death in 1914 at the age of 64. Like Clarke, Dr Bryan was actively involved in public duties. In addition to his post as workhouse medical officer (for which he was ‘a favourite with his pauper patients’ according to a local newspaper), he was a surgeon under the Factory Act and he was active in the establishment of the People’s Dispensary. He was honorary surgeon to the Leicester Volunteers and he was elected President of the Leicester Medical Society in 1894.<sup>41</sup> Dr Bryan was a town councillor for several years and he was described as an ‘ardent Liberal’. His death was reported under the sub-heading, ‘Sudden end to a

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<sup>38</sup> *Ibid.*

<sup>39</sup> E.R. Frizelle, *The Life and Times of the Royal Infirmary at Leicester: The Making of a Teaching Hospital, 1766-1980* (Leicester, 1988), p. 221.

<sup>40</sup> In October 1900 Dr Clarke was shot in the sacrum by a former patient of the asylum while crossing London Road. The patient had threatened to harm Clarke after he had certified him for his homicidal tendencies. Dr Clarke partially recovered but died ten months later aged 64.

<sup>41</sup> *The Wyvern*, 16 Oct 1896.



useful career' in a local newspaper indicating that he was well-recognised for his professional and public work.<sup>42</sup>

Neither of the medical officers resided at the workhouse, but they visited it daily to attend infirmary patients and any infirm inmates who were accommodated in the main workhouse. They visited the lunatics three times a week.<sup>43</sup> The workhouse medical officer was also called in for any emergencies. Detailed information about the time the doctors spent at the workhouse is lacking. It is apparent however, that they spent more time visiting the patients than Dr Moore. For example, one record showed that Dr Bryan spent a total of 49.5 hours at the workhouse during a period of 58 days, i.e. 1.25 hours per visit. His deputy was there for 134 hours, i.e. 2.5 hours per visit. Clearly, by that time the medical officer was entrusting the bulk of his workload to his deputy who was also his son. Indeed, Dr Bryan senior had only attended one midwifery case out of the past ten cases, while his son attended all ten cases.<sup>44</sup> Throughout the period studied, the medical officers had private practices and other commitments. The routine care and responsibility for the pauper patients therefore principally rested upon other unqualified workhouse infirmary staff.

## **Record-keeping**

Record-keeping was an essential requirement of all medical officers. However, a PLB circular in 1868 criticised the way medical officers reported to guardians. It revealed that reports were often simply verbal or written on loose papers which became lost or were unnoticed. The PLB assumed that if reports were entered into specific report books supplied by the guardians, they would be made 'with more deliberation and care than heretofore.'<sup>45</sup> The workhouse medical officer's report book for the

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<sup>42</sup> *The Leicester Daily Post*, 30 Mar 1915, p. 5.

<sup>43</sup> TNA, MH12/6490, 14 Jul 1879.

<sup>44</sup> LRO, G/12/95, Nov 1903.

<sup>45</sup> LRO, G/12/57d/12, 20 Apr 1868. The only surviving medical officer's report book for the Leicester union was kept by the medical officer from 1871 to 1881.

Leicester union disproved that supposition.<sup>46</sup> It contained pre-printed columns for dates, comments and recommendations for his completion. However, Dr Clarke ignored the columns and simply wrote his comments across them. Entries were inconsistently made and irregular; some were very brief, but many were lengthy and detailed. For example, there were fewer entries for 1873 and 1874 than for 1872. No entries were written for some months but there were several entries for other months. Only one entry was made in 1876. There were several in 1877 and 1878, but few in 1879. Nevertheless, the report book provides invaluable evidence of the work Dr Clarke carried out, the types of illnesses and diseases he encountered and the treatments given. Some tables were included showing the numbers of cases, types of illness, deaths and numbers cured. Inadequate record-keeping by medical officers was widespread. Smith noted that very few kept their books up to date, although he pointed out that Dr Clarke was an exception as he was commended in the early 1870s as one of the few officers who presented an annual report.<sup>47</sup> Four annual medical reports for 1870 to 1873 appeared in the report book. Unfortunately no other annual reports were found in the local records.

The workhouse medical report book confirms that there were continual problems of overcrowding in the infirmary wards. It illustrates the conditions patients experienced and the problems they presented. As a piece of primary evidence it is illuminating and by cross-referencing entries with the guardians' minute books and letters to and from the central authorities, a fuller picture emerges. But its inconsistencies are frustrating. Were the entries irregular because the officer did not have time or did not consider many situations important enough to enter? Were records kept elsewhere that have since been lost or destroyed? The answers remain elusive but using the information that is available provides scope for interpretation of the medical service provided by the Leicester union for over a decade.

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<sup>46</sup> LRO, G/12/94. The guardians' minutes simply recorded that the medical officer's report was received; rarely were any details provided.

<sup>47</sup> Smith, *The People's Health*, p. 386.

To compare the record-keeping of medical officers, two medical report books for the Barrow-on-Soar union were also examined. Differences were found in the layout and the information provided. The Barrow-on-Soar book had pre-printed double pages with sections for completion on defects and recommendations. It was dated from June 1868 to September 1890. However, there were large gaps between the entries. Only one or two notes for each year were made, with none for 1876. The LGB twice commented on the lack of half-yearly reports on the state of the workhouse. A later report book for 1908 to 1935 for this union had even more pre-printed columns for the medical officer to complete. This book largely contained lists of inmates rather than any detailed information. There were columns for the date of admission; date of examination; name of inmate; physical condition; fitness for employment; class for diet; and date of discharge. By 1910 the medical officer began to include the age of the inmate and from 1913 onwards the entries were made by his deputy. After the list of inmates there were over twenty-five pages with pre-printed boxes to enter details about diet, warmth, etc. Again, the entries were infrequent and generally very brief.<sup>48</sup>

District medical officers were required to keep weekly returns of medical attendances yet, as the 1909 *Minority Report* pointed out, there was little incentive as they were not asked for details of the results of their treatment and no medical statistics were kept of their work.<sup>49</sup> Similar points were raised in *The Lancet* many years earlier.<sup>50</sup> The journal advocated that district medical officers should be permitted to transmit summary statements of sickness to the central authorities rather than have information collected from them to be collated by the MOH. *The Lancet* believed that this would ensure that information was more promptly received by the central authorities. Moreover, it felt that the current system implied a criticism of the district medical officers' trustworthiness and competence.<sup>51</sup> Nonetheless, district medical

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<sup>48</sup> LRO, G/12/94/1 & 2, Barrow-on-Soar medical officer's report books, 1868-1890 & 1908-1935.

<sup>49</sup> PLC, *Minority Report*, pp. 218-9.

<sup>50</sup> *The Lancet*, 28 Jan 1860, p. 93. In a paper given by Dr. Milroy entitled 'Suggestions for utilizing the statistics of disease amongst the pauper poor', he argued that 'valuable data' could be obtained from the returns made by the medical officers which was never explored, thus wasting information about sickness 'amongst the very portion of the population, whose condition it is most important, for the public welfare, to ascertain.'

<sup>51</sup> *The Lancet*, 17 Feb 1872, p. 270.

officers carried out their work unsupervised and without the official inspections that were made of the workhouse medical service. Indeed, the *Minority Report* criticised this long-standing situation by stating:

‘The domiciliary medical treatment of the sick poor is entrusted, in England and Wales, to 3,713 district medical officers, averaging five or six for each Union, severally appointed for life or during good behaviour by the Boards of Guardians concerned. The [LGB] insists that the person appointed shall be legally qualified; that he shall reside within the district assigned to him and that he shall receive a permanent and personal appointment. Subject to these requirements, the selection of the district medical officer, the amount of his remuneration, and the detailed conditions of his appointment are left entirely to the discretion of the Guardians, who have usually, for this purpose, no expert advice at their command.’<sup>52</sup>

Unfortunately the district medical relief books of the Leicester union are not extant but to see a similar example, a district medical relief book for the Brackley district of Northampton Union was examined. It contained lists of weekly visits on patients with their name, age, residence, nature of disease, days attended and necessities ordered, together with the present state or termination of the case. Types of conditions that were recorded were ‘debility’; ‘great debility’; ‘senectus’(old age); ‘hernia’; ‘fractured fibula and partial dislocation of ankle’; ‘scarlatina’. This district medical officer recorded 33 home visits over four weeks; 13 surgery attendances; and 11 instances of medicines supplied without seeing the patient. The ‘necessaries’ given were generally meat with also occasionally porter or brandy. Comments on the state of cases ranged from ‘the same’; ‘unable to work’; ‘not so well’; ‘very poorly’; ‘as usual’; ‘little better’; ‘improving’; or ‘dead’.<sup>53</sup>

It is evident that, despite providing specific books for reports and directing that precise records be kept, medical officers did not adhere to these requirements and their record-keeping was imprecise and inconsistent. Busy medical officers clearly disliked spending time making notes. Dr Bryan’s lax record-keeping was questioned several

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<sup>52</sup> PLC, *Minority Report*, pp. 214-5.

<sup>53</sup> Northamptonshire Record Office, PL1/415, District No 3. Medical Relief Book 1869-1872.

times.<sup>54</sup> For example, he was asked for a copy of a report he sent to the LGB on a baby's death. His response was that he was unable to supply a copy, 'as I never keep copies of my correspondence with them.'<sup>55</sup> In 1912 a district auditor found that the columns in the medical relief book for the dates of admission and discharge of patients, the diet and extras ordered, and the state of each case were all entered by a pauper. There were no records of Dr Bryan attending more than six of the 101 cases in the book. One patient was found to have received one egg and one chop daily for five years, apparently without the medical officer having seen him once in six months. The auditor wryly remarked that the original order for extras 'appears to have been lost in the mists of antiquity.'<sup>56</sup> Dr Bryan may have visited the patients of course, but delegated the paperwork to an unreliable pauper. This could account for the absence of entries in the column on the 'nature of the disease', although they may have been long-standing cases and he did not feel it necessary repeatedly to state the illness. Possibly he did not visit the cases, although he was noted by the LGB to be conscientious. However, by 1912 he was ageing. In 1903 he had mentioned that his health was not good and he was suffering from colitis.<sup>57</sup>

## **Working relations**

Since it was the guardians who chose and appointed medical officers, subject to the approval of the LGB, they were generally complementary about the performance of the officers they had chosen. This was particularly noticeable when the LGB enquired why doctors were appointed who were not resident in their district. The guardians usually explained that there was no other medical man in the district and the appointed medical officer lived a very short distance away. However, when the LGB questioned why they wanted to re-appoint Henry Meadows when there was by then another medical man resident in the district, the guardians replied that they wanted to retain him

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<sup>54</sup> LRO, G/12/8a/22, 6 Jan 1885. The guardians' minutes recorded that he had to attend a board meeting 'in reference to his medical books not being kept up properly.'

<sup>55</sup> LRO, G/12/95, 17 Jan 1903.

<sup>56</sup> LRO, G/12/57D/52, 11 Mar 1912.

<sup>57</sup> LRO, G/12/95, 20 Jan 1903. He also mentioned that he looked through the medical relief book each week and signed it at the bottom of each page. G/12 /57d/51, 3 Sep 1911.

as he had ‘performed his duties satisfactorily and without inconvenience to the poor.’<sup>58</sup> The records show that a reasonable working relationship generally appeared to exist between the guardians and the medical officers and between the medical officer and other workhouse staff, although there were some exceptions which are described below. The tone of writing in Dr Clarke’s report books indicates a respectful, professional relationship. However, the contemporary style of writing was formal and reflected standard practice. The way the working relationships were conducted can only be interpreted through these writings. What was actually spoken or thought unfortunately cannot usually be ascertained. Some examples can be found of other roles the medical officer played within the workhouse. For instance, Dr Clarke arranged the distribution of tea and tobacco to the sick inmates as well as a tea and entertainment for the children, imbeciles and other inmates. His wife also attended the entertainment.<sup>59</sup> Dr Clarke also presided over a presentation made to Mr Dickisson, the workhouse master for his twenty-six years of service.<sup>60</sup> The reports of these events infer that Dr Clarke’s involvement in these special occasions conferred a benevolent significance.

One of Dr Clarke’s reports acknowledged with thanks the co-operation he had ‘always received’ from Mr and Mrs. Dickisson.<sup>61</sup> In a later report he noted that Mrs. Lance, the school matron, had ‘in every instance been most anxious to co-operate in my wishes.’ Similarly, he praised the unvarying attention that the master and matron had paid to the sick and their wishes that he expressed on their behalf.<sup>62</sup> It may, of course, have been judicious or simply customary to include these comments and they should be interpreted with caution. The guardians appear to have been satisfied with Dr Clarke’s work judging by the thanks of the board for his ‘very satisfactory and able report.’<sup>63</sup> Furthermore, as mentioned above, the guardians readily acceded to his request for increases in his salary.

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<sup>58</sup> If the district medical officer lived even a few yards outside his district he could not be given a permanent appointment and initially he had to be reappointed every year. This was later extended to every three years.

<sup>59</sup> LRO, G/12/94, newspaper cutting on ‘Christmas Day at the Workhouse’ in 1871.

<sup>60</sup> *Ibid.*, 1880 undated newspaper cutting.

<sup>61</sup> *Ibid.*, 16 Nov 1872.

<sup>62</sup> *Ibid.*, 1873 Medical Officer’s Annual Report.

<sup>63</sup> LRO, G/12/8a/14, 13 Feb 1872.

Dr Clarke's attitude towards the patients seemed to be professional and relatively caring given the circumstances. As Crowther pointed out, poor law medical officers experienced divided loyalties between the ethics of their profession and the deterrent ethos of the poor law. Medical officers were responsible for classifying inmates, thus determining their diet and workload. They also decided whether inmates were fit for any punishment to be administered if this was stipulated.<sup>64</sup> In 1881 an angry ratepayer wrote to the LGB complaining about the use of solitary confinement as a punishment. He had learned of the recent punishment of a woman for burning her boots, for which, he wrote, she had 'suffered' eight hours in a totally dark room, known as "The Black Hole", 'where not even a ray of light can penetrate and where there is nothing but a brick floor upon which an imprisoned inmate can rest.'<sup>65</sup> The guardians retorted that the place of punishment was erected for that purpose when the workhouse was built. They enthusiastically stated that 'it stands two feet at least above the ground, it is warmed with hot air pipes and is well ventilated and clean, but it is certainly perfectly dark when the doors are closed.'<sup>66</sup> As a further endorsement, the medical officer's report was shown in which he stated that he had thoroughly examined the dark room and he was 'of the opinion that it is well suited for the purpose being perfectly dry, warm and well ventilated.'<sup>67</sup> He did not comment on its appropriateness for the confinement of imbeciles and insane patients which also occurred. It can easily be imagined that any inmates who were so confined received an unpleasant and frightening experience which was no doubt the officials' intention.<sup>68</sup>

The medical officer was also responsible for approving allowances of alcohol that were given to inmates who worked in the workhouse. An inspector criticised the amount of ale given in 1879 which he considered amounted to 4½ gallons daily: a

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<sup>64</sup> Crowther, 'Paupers or Patients?', pp. 47-8. Unfortunately the punishment book of the Leicester union is not extant.

<sup>65</sup> LRO, G/12/57d/21 7 Mar 1881.

<sup>66</sup> LRO, G/12/57b/6, 9 Mar 1881.

<sup>67</sup> *Ibid.*, 1 Jan 1881.

<sup>68</sup> C. Shaw, *When I was a Child* (1903, Wakefield, 1969), pp.112-3, described witnessing a fellow child inmate being punished by a flogging with a birch rod. The child was then taken away for the night. Shaw surmised that 'he was thrust into some "black hole" or lonely room, to add to his sufferings.'

‘lavish use of beer.’<sup>69</sup> Dr Clarke replied that the only way to reduce the ale list would be to take the younger men and women off the list and give it ‘only to old people who do the more unpleasant work.’ He emphasised that the ale was not for medical purposes but for work such as washing up, and attending the itch, vagrant and receiving wards. The master prepared the list and the medical officer signed it. Dr Clarke did not make recommendations as to who received the allowance but he believed that the ale was fairly earned and it was useful for retaining the pauper nurses. However, he was anxious that it should be accounted for under ‘work done’ rather than under ‘medicine’. He stated that he had ceased using ale as a medical stimulant some years ago and instead used wine or spirits ‘at very careful amount with satisfactory results.’<sup>70</sup>

Frustration can sometimes be detected in Dr Clarke’s reports as the guardians were slow to take up his recommendations. Overcrowding in the infirmary was a constant problem, especially as numbers of long-term chronic and infirm patients increased. No records were found of complaints by patients about their treatment by either of the workhouse doctors. Generally Dr Bryan also appeared to have a reasonable relationship with the guardians. However, it is noticeable that over the years, he became more forthright in expressing his opinion to the guardians. The occasions when disputes arose that were significant enough to be recorded concerned either conflicts between Dr Bryan and the nurses or criticism and interference by the guardians over medical matters. One such instance concerned a treatment for scarlet fever. The guardians were keen to try out a hydropathic treatment recommended by a Mr Pickering, who claimed to cure scarlet fever in five days by means of hot baths, and they asked Dr Bryan for his advice.<sup>71</sup> Dr Bryan took their suggestion as an insult to his medical professionalism, making it clear that he greatly resented lay guardians involving themselves in medical issues, by stating:

‘Having been a medical officer to the workhouse for over sixteen years, and without a single death from scarlet-fever, I cannot allow any interference with

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<sup>69</sup> TNA, MH12/6490, 27 Jun 1879, 13 Jan 1880.

<sup>70</sup> LRO, G/12/94, 8 Sep 1879.

<sup>71</sup> LRO, G/12/57b/10, 11 Feb 1897.



my medical treatment of the patients as I, and I alone, am responsible and best able to judge what treatment is the best for those under my care.'

He summarily dismissed the suggested treatment as a 'nostrum' brought out by an 'ignorant man.'<sup>72</sup> The dispute was reported in a local newspaper which brought it to the attention of the LGB. Its inspector, Mr Stevens, plainly supported Dr Bryan as shown by his comment written alongside the newspaper cutting:

'Dr Bryan is a very experienced man and I think there is a great too much "gas" in the Leicester Board room and with the *Daily Post* ... the medical officer holds his own with the guardians. This [matter] requires no further attention.'

Dr Bryan brought the debate to a conclusion simply by declining to argue the question with anyone outside the medical profession. The guardians were unhappy with his reaction but did not pursue it further.<sup>73</sup> Dr Bryan's hostile reaction implies a distrust of 'alternative' medicine but also shows his resentment of any consideration of other medical practices. However, it is clear that he was confident enough of his position to assert his medical authority. As Crowther observed, guardians could ignore their workhouse doctor in 1870, but by the early twentieth century they would have hesitated.<sup>74</sup>

### **The medical officers' public roles**

All medical officers inevitably became involved in issues concerning public health, if only because they were required to report patients with notifiable diseases to the local MOH.<sup>75</sup> Dr Clarke drew the guardians' attention to what he called 'cases of filth and neglect' that were sent by the police to the workhouse in a public cab. He

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<sup>72</sup> TNA, MH12/6507, snippet from *Leicester Daily Post*, 17 Feb 1897.

<sup>73</sup> See R. Price, 'Hydropathy in England, 1840-70', *Medical History*, (25) 1981, pp. 269-280 for more information on this subject.

<sup>74</sup> Crowther, *Workhouse System*, p. 173.

<sup>75</sup> Wohl, *Endangered Lives*, p. 137 noted that the Leicester Corporation Act 1879 made notification of smallpox to the local MOH compulsory. Before that the local MOH had encouraged such notification. The Infectious Diseases (Notification) Act of 1889 made notification of infectious diseases such as smallpox, typhus and scarlet fever compulsory in London but optional in the rest of England.

wanted to impress upon the police the ‘disagreeableness’ of using public vehicles to transport ‘filthy’ people who were infested with lice. He had reported this matter to the corporation, but without result, and he hoped the guardians would have more influence. He offered a practical solution by suggesting that easily-cleaned vehicles could be kept at the workhouse and the police station for this purpose.<sup>76</sup> His report demonstrated his desire to prevent the spread of disease but frustration because his suggestion had been ignored. He believed that the guardians might have more influence and power than he alone possessed. In a later entry he complained that the police brought ‘urgent’ cases to the workhouse who were simply ‘under the influence of drink’ and should have instead been detained in the police cells to be seen by the police medical officer.<sup>77</sup> Dr Clarke also presented a paper to the sanitary authority on the problems of the sewage system in Leicester.<sup>78</sup> Similarly, in 1901 Dr Bryan gave a public lecture on the ‘horrors and dangers’ of diphtheria, after five diphtheria patients had been transferred from the workhouse to the borough infectious hospital.<sup>79</sup>

The workhouse medical officer performed few vaccinations but the district medical officers who were appointed as public vaccinators for East and West Leicester carried out many more. For example, a return for one year showed the total number of vaccinations performed was 991.<sup>80</sup> A union vaccination officer was also appointed to ensure children were presented for vaccination and to prosecute those parents who refused to comply,<sup>81</sup> of which there were sufficient to cause comment in *The Times*.<sup>82</sup>

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<sup>76</sup> LRO, G/12/94, 12 Jun 1875.

<sup>77</sup> *Ibid.*, 17 May 1880.

<sup>78</sup> LRO, Pamphlet Vol. 62, paper read by Dr Clark before the Sanitary Sub-Committee, 27 August 1872.

<sup>79</sup> *The Leicester Guardian*, 14 Sep 1901; LRO, G/12/8a/36, 16 Jul 1901.

<sup>80</sup> LRO, G/12/57d/25, 29 Sep 1884. Dr Bryan only performed 11 vaccinations that year and 30 vaccinations the following year.

<sup>81</sup> TNA, MH9/10, William Maskell was appointed vaccination officer in 1868. He was paid 6s per case. He stayed in post until 1898 when the authority for vaccinations was passed from the guardians to the LGB.

<sup>82</sup> *The Times*, 12 Nov 1880, reported that ‘Leicester which for some time past has enjoyed the unenviable notoriety of being the most unhealthy large town in England, is also in the position of having by far the largest proportion of unvaccinated children, and this has led to a difficulty between the Board of Guardians and the LGB. The parents of more than 1,200 children are waiting to be summoned, and this number is being added to at the rate of about 400 per quarter. The vaccination officer is totally unable to deal with this large number of arrears, and the LGB have requested the Board of Guardians to appoint an additional officer, intimating at the same time that if they did not do so the LGB have the power to appoint one for them.’

One district medical officer was the borough analyst for several years.<sup>83</sup> Several other medical officers also acted as dispensary surgeons for the Leicester Provident Dispensary, including Claude Douglas.<sup>84</sup> However, he resigned that and his district medical officer post when he became an assistant surgeon at the Leicester General Infirmary in 1886. Nine of the poor law medical officers were also president of the Leicester Medical Society at various times.<sup>85</sup>

When Dr Bryan stood as a Liberal candidate in Leicester in 1896, a local newspaper described him as a ‘staunch Liberal, thoroughly in sympathy with the working classes.’<sup>86</sup> He was also instrumental in the establishment of the People’s Dispensary in 1889 and he helped the organisation by organising fund-raising events. It is interesting that he was involved with that dispensary rather than the much larger and older Leicester Provident Dispensary which had thirteen branches by 1903, with a panel of thirty-five doctors, seven midwives and four nurses to serve over 48,000 subscribing members.<sup>87</sup>

## Summary

This chapter has shown that from 1867 Leicester’s paupers benefited to some extent from the appointment of young, ambitious, well-qualified and long-serving medical officers. The two workhouse medical officers were well known locally and did not appear to suffer professionally from their association with the low status medical service. This is a view that differs from the general impression conveyed in the

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<sup>83</sup> TNA, MH12/6490, 16 Jan 1879. Dr. Meadows was appointed public analyst in 1879 on a salary of £80 a year, although he had to provide a laboratory and chemicals and pay to the borough fund all fees received by him for analyses made in the public capacity. Despite having an extensive private practice, Dr Meadows was described as having discharged his duties ‘satisfactorily’ by the borough council. However, in 1885 his position was terminated when a new MOH was appointed to also act as public analyst and police surgeon. TNA, MH12/6494, 30 Sep 1885.

<sup>84</sup> Board of Governors of Leicester Provident Dispensary, *Leicester Provident Dispensary: Its History, Prospects, Present Position and Requirements* (Leicester, 1877), p. 9, listed four of the Provident Dispensary’s medical officers who were also district medical officers for the union. They were Edward Denton, John Oliphant, Henry Meadows, and William Cox-Hippisley.

<sup>85</sup> Leicester Medical Society, *The Library Catalogue and a History of the Library* (Leicester, 1990), p. vi.

<sup>86</sup> *The Wyvern*, 16 Oct 1896, p. 403.

<sup>87</sup> Harrison, *In Sickness and in Health*, p. 69. As shown in Chapter 4, in 1912 the guardians arranged for medicines to be dispensed by the Provident Dispensary.

historiography.<sup>88</sup> The next chapter explores their medical service in greater detail. A combined summary of the significance of the medical officers' status and administrative situation and the medical care given by them will be provided at the end of Chapter 4.

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<sup>88</sup> Digby, *Making a Medical Living*, p. 120, noted that 'during the nineteenth century there was an increasing variety in the opportunities for making a medical income from salaried appointments, whether private or public, full- or part-time.' Further research may reveal that many such medical officers held other local public offices due to holding a double qualification. For example, Lane, *A Social History of Medicine*, p. 64, noted that the medical officer at Coventry workhouse, Charles Iliffe, also served as local MOH, coroner, councillor, alderman. W.G. Grace was also a union medical officer near Bristol.

## Chapter 4

### Leicester union's medical officers – their work

#### Introduction

The duties of workhouse medical officers stipulated in the General Consolidated Order, 1847, were to: examine every case on admission; classify children, the sick and insane as to diet and treatment; perform vaccinations; treat patients medically and surgically; report defects in sanitary arrangements and nursing; report overcrowding in the workhouse and infirmary; and to keep records of attendances and returns of sickness and deaths. District medical officers were required to attend and supply medicines to patients with orders for medical relief and to keep records for inspection.

Historians have emphasised the lack of incentive for poor law medical officers arising from the unrewarding salaries and tedious medical practice. Indeed, the *Minority Report* bluntly stated that the majority of cases the district medical officer had to attend were:

‘of the most disheartening kind – largely old people, with chronic complaints, or persons of more than the average degree of ignorance, carelessness, intemperance, and above all, grinding poverty, with the drawbacks of bad housing, the poorest kind of clothing, [and] insufficient and unsuitable food.’<sup>1</sup>

This description could equally apply to the medical cases found in the workhouse as many patients were elderly and suffered from chronic conditions. However, acute cases were treated and a medical officer of the Halifax union believed that while the wards of a workhouse hospital, ‘do not afford such an interesting class of acute cases’ as those of the voluntary hospitals, there were a ‘most varied selection of obscure and complicated cases’, which came into the

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<sup>1</sup> PLC, *Minority Report*, p. 217

workhouse ‘after passing through the hands of the private practitioner, the club-doctor, the infirmary or dispensary surgeon and the out-door poor law medical officer.’<sup>2</sup> This chapter discusses the variety of cases dealt with by the medical officers.

## **Workloads and districts**

Without consistent and accurate records it is difficult to calculate the exact workloads of the Leicester medical officers. However, data is provided below showing the probable numbers of both in-door and out-door sick. Rough estimates can be made of the in-door sick from those recorded as not-able-bodied in the admission returns. Even if very cursory examinations were made of every inmate on admission, a high number of admissions at any one time and a large workhouse population would result in a heavy workload, particularly if the majority of inmates were old, infirm and ailing. To discover how many paupers were classified as in need of medical attention, and the numbers and types of cases treated, samples of 100 admissions for the years 1879, 1889 and 1899 were taken from the Admission and Discharge Registers. This number did not necessarily equate to 100 individuals as some people were admitted more than once. The prime intention was to check how each inmate’s medical condition was recorded in the ‘Observations’ column. Unfortunately that information was found to be insufficiently explanatory and inconsistently entered. For example, the term ‘illness’ was occasionally entered but the condition was not specified. Comments such as ‘itch’ or ‘bad leg’ or ‘debility’ were sporadically entered. These inconsistencies were not unique to Leicester. Admission Registers for Barrow-on-Soar and Ashby-de-la-Zouch unions were also examined where the ‘observations’ were equally inconsistent, showing that an accurate analysis cannot be made of the health of people admitted and the illnesses and injuries that medical officers would encounter. A study of Devon pauper lunatic asylums similarly noted that general rather than precise labels were used for

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<sup>2</sup> T.M.Dolan., ‘Some Remarks on Workhouse Hospitals with Illustrative Cases’, paper read at Leeds & West Riding Medico-Chirurgical Society, 1879, p.4, viewed at the British Library. Dolan regretted that medical officers were not allowed to use deceased patients for medical investigation in order to advance medical science. However, post-mortems were permitted to be carried out in workhouses under the direction of the coroner to discover the cause of death in cases of sudden or unexplained deaths.

admissions, with ‘destitution’ covering the vast majority and ‘illness’ covering acute and chronic conditions.<sup>3</sup>

Table 4.1 below shows the total number of paupers receiving in-door relief recorded in the half-yearly returns over a number of years. Imbeciles, vagrants and all in-door children were included in the overall total. However, from late 1884 fewer children were in the workhouse, apart from infants and babies under two years old and newly-admitted children undergoing a period of quarantine. Furthermore, imbeciles were not necessarily classed as not-able-bodied and vagrants were not examined by the medical officer on admission or classified as infirm or able-bodied.<sup>4</sup> The total numbers of inmates who were not-able-bodied has been calculated by counting those who were so recorded together with other inmates who were recorded as suffering from ill-health or temporarily disabled. Inmates who were not-able-bodied would have required medical attendance on several occasions which gives a good indication of the numbers of inmates the medical officer attended despite the inadequacy of medical recordings.

The percentage of those in the workhouse who were sick and disabled (whether physically, mentally or temporarily) is also shown, giving further insight into the condition of those in the workhouse and the probable workload of the medical staff. This does not take account of those who were considered able-bodied but who became sick while in the workhouse and were admitted to the infirmary, or those who required medical attention in the main workhouse. Nor does it take into account those who were elderly but were still classed as able-bodied. Occasional references were made by the medical officer to the number of patients he had under

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<sup>3</sup> R. Adair, B. Forsythe, and J. Melling, ‘A Danger to the Public? Disposing of Pauper Lunatics in late-Victorian and Edwardian England: Plympton St. Mary Union and the Devon County Asylum, 1867-1914’, *Medical History*, 42 (1998), p.8.

<sup>4</sup> Vagrants were kept strictly apart from other workhouse inmates, except those who were given rest and medical treatment in the receiving wards or were sufficiently sick to be sent to the infirmary. The casual wards provided rudimentary accommodation for sleeping and working. Vagrants were expected to work for their food and accommodation. The medical officer did not usually encounter them unless they were ill. On admission an officer inspected each vagrant and called the medical officer if ‘suspicious spots’ were noticed or the vagrant complained of illness. But the lay officers’ abilities to detect infectious diseases or illness were patently unreliable and vagrants complained that officers sometimes ignored their requests for medical attention.

his care. For example, in 1880, he noted that he had had 300 patients under his care for most of the winter.<sup>5</sup>

**Table 4.1**

**Figures taken from half-yearly returns for 1<sup>st</sup> January 1870-1910 in five-yearly intervals showing the total number of inmates in the workhouse under the various categories.<sup>6</sup>**

<b>Category</b>	<b>1870</b>	<b>1875</b>	<b>1880</b>	<b>1885</b>	<b>1890</b>	<b>1895<sup>7</sup></b>	<b>1900</b>	<b>1905</b>	<b>1910*</b>
A-B Males	138	45	116	45	27	0	4	0	5
A-B Females	110	66	118	61	64	0	4	0	5
Children under 16	273	210	343	186	264	285	246	337	435
N-A-B Males	155	155	240	204	311	519	586	758	937
N-A-B Females	77	88	126	111	142	293	311	380	437
Lunatics Male	48	56	40	40	49	30	24	25	32
Lunatics Female	25	40	45	53	54	38	35	27	24
Lunatic Children under 16	5	4	0	3	3	4	5	1	0
Vagrants	10	14	15	31	35	90	41	133	110
<b>Workhouse total</b>	<b>841</b>	<b>678</b>	<b>1043</b>	<b>734</b>	<b>949</b>	<b>1259</b>	<b>1256</b>	<b>1661</b>	<b>1985</b>
N-A-B & Lunatics as percentage of workhouse total	<b>37%</b>	<b>51%</b>	<b>44%</b>	<b>56%</b>	<b>59%</b>	<b>70%</b>	<b>77%</b>	<b>72%</b>	<b>72%</b>

\* The figures for N-A-B inmates for 1910 include patients in the North Evington Infirmary and all inmates in the workhouse who were old and infirm and were classified as N-A-B.

Table 4.2 shows the numbers in receipt of out-door relief and those who were identified as not-able-bodied, including able-bodied males relieved on account of temporary sickness, who would have been attended by a district medical officer on one or more occasions.

<sup>5</sup> TNA, MH12/6490, 24 Feb 1880.

<sup>6</sup> LRO, G/12/57d/16-55. The forms issued by the LGB for completion by local unions broke down these categories into a number of sub-categories, but for simplification here the figures have been amalgamated into larger categories. The forms also changed over time to give even greater specification in defining able-bodied adults as suffering from ill health or temporarily disabled. Where these figures were given they have been included here as non-able-bodied who were likely to require some medical attention.

<sup>7</sup> The totals that appear on the original form for 1895 were incorrectly added up; the correct figures appear here.



**Table 4.2**

**Figures taken from half-yearly returns for 1<sup>st</sup> January 1870-1910 in five-yearly intervals showing the total number of inmates in receipt of out-door relief under the various categories.<sup>8</sup>**

<b>Category</b>	<b>1870</b>	<b>1875</b>	<b>1880</b>	<b>1885</b>	<b>1890</b>	<b>1895</b>	<b>1900</b>	<b>1905</b>	<b>1910</b>
A-B Males	18	12	3	5	1	63	70	523	181
A-B Females	262	264	250	281	214	400	353	1174	923
Children under 16	638	727	711	884	690	1196	997	2368	1777
N-A-B Males,	288	252	207	228	255	413	506	681	668
N-A-B Females	452	432	401	516	540	758	962	912	925
Lunatics, Male	64	99	113	160	170	221	263	285	310
Lunatics, Female	98	131	142	177	193	249	312	334	353
Lunatics, Children under 16	2	4	2	2	2	4	5	7	10
Vagrants	0	0	0	0	21	0	0	0	0
<b>Out-door total</b>	<b>1822</b>	<b>1921</b>	<b>1829</b>	<b>2253</b>	<b>2086</b>	<b>3304</b>	<b>3468</b>	<b>6284</b>	<b>5147</b>
N-A-B males and females as percentage of total outdoor*	<b>41%</b>	<b>36%</b>	<b>33%</b>	<b>33%</b>	<b>33%</b>	<b>35%</b>	<b>42%</b>	<b>25%</b>	<b>31%</b>

\* Lunatics have been excluded as the majority were in the asylum

The above tables show that over a forty-year period the numbers in receipt of in-door and out-door relief and the numbers classed as not-able-bodied increased substantially. Moreover, the borough's extension in 1891 further increased the populations of districts, particularly in some of the very poor neighbourhoods. Consequently the medical officers' workloads became heavier. In recognition of this, the district medical officers' salaries were increased by £10 in 1893. However, Dr Lakin felt that the increase was 'disproportionate' [sic] when compared to the increase in his duties. He declared that unless his district was re-arranged he would resign. The guardians refused to comply. They were confident that he could easily be replaced, and they were correct as there were six applicants for his post.<sup>9</sup> The guardians tried unsuccessfully to get the LGB's consent to the increased salaries being retrospective from 1891. To compensate, the guardians gave the district medical officers a gratuity of £14 6s in recognition of their extra duties.<sup>10</sup>

<sup>8</sup> LRO, G/12/57d/16-55.

<sup>9</sup> LRO, G/12/57d/33, undated list of medical officer applicants for District 2. Of the six applicants, five were aged between 32 and 36; one candidate's age was not given. Their ages suggest that they were not newly-qualified but had yet to establish themselves in private practices.

<sup>10</sup> LRO, G/12/188/1, 27 Sep 1893.

When required to state the population of each district the guardians simply referred the LGB to the most recent census, suggesting that they did not possess accurate figures. However, in 1880 the LGB pointed out that the population of District 2 was 26,000. It reminded the guardians that the maximum population should not exceed 15,000. The guardians shrewdly responded that they were aware that this district exceeded the limit, but they felt that it could easily be worked by one medical officer, because

‘a large number of the poorer classes are now members of the Leicester Provident Dispensary, and by a small weekly payment they provide for themselves a doctor in case of need and thus have no occasion to apply to the poor law authorities for medical assistance.’<sup>11</sup>

In 1887 the guardians noticed from the number of orders for medical relief that there was an imbalance in the district medical officers’ workloads.<sup>12</sup> Rather than employ additional medical officers, the districts were rearranged to divide the work more equally. Two medical officers’ salaries were increased by £10 to put all medical officers on the same salary.<sup>13</sup> In 1903 a further rearrangement of the districts showed that there had been a high growth in medical orders during the previous sixteen years. In 1903 there were 51 permanent sick cases and 4,628 orders for medical relief for the six districts.<sup>14</sup> In 1909 the districts were rearranged yet again, leading Dr Shearer to complain that his district was ‘too large to be handled satisfactorily’. Dr Potter stated that the extension of his district made it difficult for the poor people living there to ‘come as far for medicine.’ The LGB remarked that some of the districts were ‘inconveniently large’, but did not ask for changes to be made.<sup>15</sup>

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<sup>11</sup> LRO, G/12/57b/6, 24 Mar 1880.

<sup>12</sup> The numbers of orders were: District 1: 306; District 2: 403; District 3: 321; District 4: 205; and District 5: 147; totalling 1,382.

<sup>13</sup> LRO, G/12/8a/23, 13 Dec 1887.

<sup>14</sup> LRO, G/12/57d/43, 28 Jan 1903.

<sup>15</sup> LRO, G/12/57d/49, 3 Aug, 19 Aug 1909.

## Medical and surgical cases

The few annual reports made by Dr Clarke that show the numbers of patients and types of conditions admitted into the workhouse and school infirmaries over a period of four years are provided in Tables 4.3 and 4.4 below.

**Table 4.3**  
**Annual report returns for 1870-1873 showing numbers of adult infirmary cases.**<sup>16</sup>

Category	1870	1871	1872	1873
Remaining in wards 31 <sup>st</sup> December	128	125	103	116
<b>Discharged</b>				
Cured medical and surgical cases	293	259	154	215
Cured lying-in women	41	46	39	47
Cured smallpox	0	1	1	0
Cured measles	8	0	7	10
Cured cutaneous cases	157	216	193	101
Infants of lying-women, pauper	147	144	108	137
Relieved	184	194	236	138
Died	103	92	91	115
<b>Totals</b>	<b>1061</b>	<b>1077</b>	<b>932</b>	<b>879</b>

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<sup>16</sup> LRO, G/12/94.

**Table 4.4**

**Annual report returns for 1870-1873 showing numbers of children in the school infirmary.**

<b>Category</b>	<b>1870</b>	<b>1871</b>	<b>1872</b>	<b>1873</b>
Remaining in the wards 31 <sup>st</sup> Dec	22	25	9	18
<b>Discharged</b>				
Cured medical and surgical cases	172	187	146	119
Cured, scarletina (measles and smallpox)	2	0	14	7
Cured, cutaneous cases	90	122	101	57
Relieved	16	21	47	21
Died	8	2	7	3
<b>Totals</b>	<b>310</b>	<b>357</b>	<b>324</b>	<b>225</b>

<b>Total cases in adult and school infirmaries</b>	<b>1371</b>	<b>1434</b>	<b>1256</b>	<b>1104</b>
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The tables show that most cases were medical, surgical or skin conditions. Dr Clarke noted that many of the cutaneous patients were vagrants, perhaps unsurprisingly due to their lifestyle.<sup>17</sup> During 1871 over 300 vagrants in ill health were allowed several days rest and medical treatment in the receiving ward, or if too ill were put in the infirmary. They were eventually discharged cured or relieved.<sup>18</sup> The weather also affected the number of acute patients. The severe cold in December 1871 resulted in over 40 admissions during two weeks, many of which had fractures or required minor operations and fifteen children were admitted suffering from severe frostbite. However, the milder winter of 1872 meant fewer acute patients were admitted, although the increase in chronic cases was ‘steadily progressive’.<sup>19</sup>

<sup>17</sup> In the 1870s approximately seventeen vagrants came into the workhouse each day.

<sup>18</sup> *Ibid.* Smith, *The People's Health*, p. 266 noted that the terms ‘cured’ meant the symptoms had largely ceased and the patient was restored to health, at least temporarily if not completely; ‘relieved’ meant mitigation of pain without restoration to well-being.

<sup>19</sup> LRO, G/12/94, Medical Officer's Annual Reports, 1871-2.

Dr Clarke also performed hernia operations, which contradicts Mackay's statement that surgery in 1905 would have been limited to incision and drainage of abscesses and amputations for gangrene. For example, although open surgery for bladder stones existed, he believed it is doubtful that it was used on the infirm poor.<sup>20</sup> Yet as early as 1874 Dr Clarke recommended that an inmate with a bladder stone should be sent to the voluntary hospital for an operation to remove the stone. He felt that this was necessary because 'considerable professional assistance would be necessary for the operation', and the infirmary was full (particularly with 'bad or dirty' cases).<sup>21</sup> He implied that he was capable of undertaking the operation, but that the overcrowded and dirty conditions of the infirmary presented risks, quite apart from the lack of time and necessary medical support. He also sent a deformed child to a London orthopaedic hospital for a limb amputation. He was unlikely to be able to undertake these operations without the professional support and equipment that was available in more specialised hospitals. These instances show that pauper patients occasionally received specialist medical treatment that was unavailable within the poor law medical service.

Dr Clarke also regularly undertook eye operations on workhouse patients with the assistance of a district medical officer, Dr Fullager. These included the removal of an eye-ball; the correction of squints, and removal of cataracts. Dr Clarke reported that special attention was paid to cases of eye disease sent into the union infirmary. His generous praise of Dr Fullager, quoted below, indicates that they had a good professional relationship, and also provides justification for the procedures.

'Two cases of double squint and one of single squint in the schools were operated on with considerable improvement. An old man ... also underwent, on two different occasions, the operation for cataract in each eye, the result being that he was enabled to read again and go about as usual. A young man ... was also operated on with much success for a severe affliction of the eyelids, and has been thereby enabled to earn his living. Several other operations on the eyelids and eyes have also been performed with varying benefit, and I believe the Board will join with me in an expression of thanks to Mr Fullager, not only for the unlimited time he has

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<sup>20</sup> E.H. MacKay, *The Palace on the Hill: Leicester General Hospital Centenary, 1905-2005* (Leicester, 2006), p. 23.

<sup>21</sup> LRO, G/12/94, 2 Mar 1874.

placed at my disposal in the matters, but also for the hearty co-operation he has shown in this work.<sup>22</sup>

However, Dr Clarke was somewhat less appreciative of the treatment given to a workhouse patient by the Nottingham Eye Infirmary to which the Leicester union subscribed three guineas annually when the guardians learned that several local people had received great benefit from treatment there. They wished to recommend cases where relief was sought due to the loss of sight or eye disease.<sup>23</sup> Dr Clarke was aggrieved to be asked to make up a prescription the patient had brought back from Nottingham. He declared that making up another surgeon's prescription would place him, 'in the position of a chemist and druggist.' He also claimed that the drugs prescribed would do the man more 'more harm than good.' The Nottingham surgeon had prescribed a 'liberal' diet for the patient, but in Dr Clarke's opinion, it was evident that 'the man could not take this', and he should instead be on the special diet and strengthening medicine that he had ordered for him. Dr Clarke disclaimed all responsibility for the course of treatment prescribed by the Nottingham doctor if the guardians decided that those remedies were appropriate. He was evidently annoyed that he had not been involved in the decision to send the patient to Nottingham and he clearly wanted to impress upon the guardians his own professional status and judgment.<sup>24</sup>

### **Skin-grafting operations**

Interestingly Dr Clarke noted several times that he had 'induced' some patients with ulcerated legs to 'voluntarily undergo a newly-introduced operation of skin-grafting'. He explained that the operation consisted of the 'transference to the ulcer of a number of small pieces of skin taken from other parts of the body.' Unfortunately he did not record how he persuaded the patients to agree to the

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<sup>22</sup> *Ibid.*, Medical Officer's Annual Report, 1873. Workhouse medical officers did not receive extra payments for surgery but payments were allowed for outdoor operations. It is not clear whether Dr Fullager received extra payments for surgery carried out with Dr Clarke who did not. Dr Fullager was the medical officer for District No. 5 until his death in April 1875. He was also an honorary surgeon of the Eye Infirmary in Leicester and was evidently experienced in eye surgery as the records show that in 1856 the PLB approved a payment of £2 2s to him for performing a successful cataract operation.

<sup>23</sup> TNA, MH12/6484, 25 July 1872.

<sup>24</sup> LRO, G/12/94, 15 Nov and 12 Dec 1871.

operation, but he hoped that this new treatment would more effectively cure the condition and prevent its recurrence. He operated on twenty-five patients in 1870-1 and he remarked that the progress of recovery had been 'remarkably accelerated with the prospect of recurrence of the ulceration greatly diminished.' In 1872 he reported that eight cases of extensive ulceration of the legs had been treated successfully by skin-grafting. Only two patients had returned in contrast to the continual recurrence of ulceration in patients treated 'under the old plan', leading Dr Clarke to confidently comment that 'this operation bids fair to be of signal benefit to those who from hardships, fatigue or constitutional causes become the subjects of ulceration.'<sup>25</sup> He clearly took note of developments in medical treatments, as it was only in 1870 that *The Lancet* first reported on this new method of skin transplantation to treat large ulcerated surfaces.<sup>26</sup> Following the journal's initial report, there were several other reports and letters from other surgeons on successful skin-grafting operations they had since carried out. Dr Clarke was obviously keen to try out a new medical procedure and it would seem he did so successfully. He was satisfied with the patients' recovery, but it is a matter of conjecture as to whether he was chiefly motivated by a professional interest in experimenting on his patients as the procedure was still in its infancy when he carried it out. It is not possible to discover what the patients thought and there were no other references to this procedure after 1873 which may mean that it became routine and unworthy of note or that it was discontinued.

### **Infectious diseases**

Conditions for sick paupers in workhouses were generally neither appropriate nor sufficient for the provision of adequate care. Overcrowding, unhygienic conditions and inadequate medical care patently inhibited recovery. The frequent admission of infected paupers could promote further cases of sickness and disease, particularly as paupers admitted into the workhouse were more often the elderly and chronically ill. Infectious diseases were difficult to control due to

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<sup>25</sup> LRO, G/12/94, Medical Officer's Annual Report, 1872

<sup>26</sup> 'The healing of wounds by transplantation', *The Lancet*, 9 Jul 1870, p. 62; 27 Aug 1870, p. 669; 19 Nov 1870, pp. 707-8. A surgeon, Mr. Pollock, decided to test the treatment in May 1870 at St. George's Hospital upon learning of the development of the procedure by M. Reverdin in Paris in 1869.

insufficient accommodation and staff.

## **Typhoid**

In 1895 the LGB criticised the admission of inmates carrying typhoid fever. Even worse, the cases were treated in a ward that could only be entered through the dayroom of the ordinary sick inmates. The LGB pointed out that these patients should have been sent to the borough fever hospital.<sup>27</sup> Nurses also risked infection and the medical officer reported that a wardswoman who nursed the typhoid fever patients had contracted it and died.<sup>28</sup> The guardians disputed that there were any cases of typhoid fever. However, the LGB sent a copy of the medical officer's letter in which he stated that a vagrant and two children with typhoid fever had been sent into the workhouse.<sup>29</sup> Dr Bryan later reported that a woman in the workhouse infirmary had died from typhoid fever and there were by then ten patients suffering from the fever; the female cases being 'very bad', although the male cases were 'doing well.'<sup>30</sup>

Two months later another nurse died from typhoid fever. Dr Bryan informed the LGB that he had made a strong request to the guardians on the 'immediate necessity of better accommodation for the treatment of typhoid cases'; furthermore, that there should be nurses solely for typhoid cases.<sup>31</sup> The guardians' solution was to use some nearby wooden buildings for fever cases. Once again, the LGB stressed that it was most undesirable that infectious disease cases should be treated on the workhouse premises, particularly at such a large workhouse as that of the Leicester union.<sup>32</sup> The LGB again informed the guardians that an inspector had reported that cases of typhoid fever admitted from outside were being treated in wards that had never been sanctioned for their accommodation. In an attempt to elicit a response from the guardians, the LGB sent a telegram stating that in determining the necessary relief of a destitute infectious person, they must have due

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<sup>27</sup> LRO, G/12/57d/188/1, 11 Dec 1895.

<sup>28</sup> LRO, G/12/57d/35, 1 Aug, 1895.

<sup>29</sup> *Ibid.*, 19 Sep 1895.

<sup>30</sup> *Ibid.*, 24 Oct 1895.

<sup>31</sup> *Ibid.*, 20 Dec 1895.

<sup>32</sup> *Ibid.*, 8 Oct 1895.



regard not only to that person's need but also to preventing the spread of disease.<sup>33</sup>

Isolation accommodation at the workhouse was inadequate but infectious paupers should not have been admitted in the first place. The medical officer evidently did not have the authority to ignore the guardians and send infected patients straight to the fever hospital. Nurses were required to attend infectious patients and general patients, thereby risking transmitting infection and contracting the disease themselves. The guardians did not act quickly enough or seem aware of the risks, especially as they initially denied that there were any infectious cases. They patently ignored both Dr Bryan and the LGB's advice. Hurren has argued that the policy of retrenchment that dominated the LGB's spending policies had a detrimental effect not only upon the relief of pauperism, but also upon public health issues.<sup>34</sup> It is not clear whether the Leicester guardians' reluctance to send patients to the fever hospital was due to the cost; nevertheless the guardians were evidently lax in their duties in this instance. There was also confusion as to what was regarded as a separate hospital for infectious cases. The guardians stated that there was a separate infirmary for sick paupers and a separate hospital for infectious cases at the workhouse. Yet the LGB commented that their inspector had been informed that the union had occasionally placed scarlet fever cases in the cottages in the workhouse grounds that were intended for elderly couples. The LGB considered the cottages to be 'totally unsuitable for workhouse infectious wards.'<sup>35</sup>

## **Smallpox**

Smallpox epidemics were much feared throughout the nineteenth century.<sup>36</sup> Leicester's population were wary of vaccination against smallpox, but vaccination could be enforced in the workhouse. When Leicester suffered a severe outbreak of smallpox in 1871-2 with about 3,000 cases and 358 deaths, there were few cases in the workhouse as shown in Tables 4.3 and 4.4. However, there were occasions when the disease was brought into the workhouse. When a vagrant was admitted in

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<sup>33</sup> *Ibid.*, 28 Dec 1895.

<sup>34</sup> Hurren, 'Poor Law versus Public Health'.

<sup>35</sup> LRO, G/12/57d/35, 20 Aug; 8 Oct 1895.

<sup>36</sup> Smith, *The People's Health*, pp. 156-7, noted that it became a disease of the poor as it became concentrated in crowded urban slums.

1880, the officer in charge recognised that he was diseased and kept him away from the other vagrants. The medical officer diagnosed smallpox and sent him to the borough fever hospital. The room in which he had slept was disinfected and the bedding burnt. The tramp had called at various unions on his travels showing how easily the disease could be spread.<sup>37</sup> The town clerk made enquiries as to his route. It appeared that during the course of eight days he had spent each night at a different workhouse. The clerk noted that the hospital medical attendant had stated that the disease must have been visible for at least four days and it should have been detected earlier.<sup>38</sup>

In 1871 Dr Clarke had recommended to the guardians that vagrants should be vaccinated but no action was taken.<sup>39</sup> If Dr Clarke's idea had been implemented, it is possible that other unions may have followed this example and the later outbreaks in 1892-3 and 1903-4 could have been prevented. The latter outbreak occurred in three places in the town including the workhouse, where it was brought in by an infected tramp who had walked from Yarmouth. This time the disease was not initially recognised and by the time he was diagnosed and moved to the isolation hospital, six other inmates had become infected. Fourteen other cases occurred in the workhouse.<sup>40</sup> Following this incident, Dr Bryan was instructed to attend the workhouse each evening during the prevalence of smallpox to examine the vagrants who had been admitted to the casual wards.<sup>41</sup> Unsurprisingly, this event caused much consternation. An alderman wrote to a local newspaper alleging neglect by two medical men, one of whom was Dr Bryan.<sup>42</sup> The LGB were informed that the tramp had been sent to the casual ward by Dr Bryan on 9 December. The tramp complained of illness on 16 December and Dr Bryan first diagnosed influenza. He did not see him again until 22 December when he recognised the symptoms of smallpox and sent him to the smallpox hospital.<sup>43</sup>

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<sup>37</sup> LRO, G/12/57b/6, 17 Mar 1880.

<sup>38</sup> LRO, G/12/57d/20, 12 Mar 1880. Vagrants were often suspected of carrying and spreading infectious diseases, hence strict segregation was enforced in workhouses.

<sup>39</sup> LRO, G/12/8a/14, 18 Apr 1871.

<sup>40</sup> Harrison, *In Sickness and in Health*, p. 49.

<sup>41</sup> LRO, G/12/95, 20 Jan 1903.

<sup>42</sup> *Ibid.*, undated and unnamed newspaper report in workhouse papers for 1903.

<sup>43</sup> LRO, G/12/95, undated letter in which the workhouse master stated the facts to the LGB.

No doubt stung by the publicity and criticism of workhouse practice, the guardians finally took action and resolved that special measures should be taken during the smallpox outbreak. Two workhouse wards were to be isolated with inmates taking their meals in the wards and their nurses and attendants were prohibited from other parts of the workhouse. Disinfecting lamps were to be placed around the workhouse. All communication with the town was stopped and no visitors were allowed except for dying relatives. No pregnant women were admitted; confinements would take place in patients' homes. No lunatic cases would be received or sent to the asylum. Every inmate was to be medically examined at least once daily and a printed statement of the symptoms of smallpox was to be supplied to every workhouse officer.<sup>44</sup>

## **Childbirth**

Contrary to poor law regulations and despite a controversy in 1856 when the parish midwife was accused of gross incompetence, Leicester union's medical officers only attended difficult childbirth cases, and the guardians continued to employ midwives for all childbirth cases for a payment of 5s a case. The LGB were either unaware or ignored this practice until 1872 when it noticed that the master had made payments to a midwife. The guardians were reminded that it was 'the duty of the medical officer to attend all midwifery cases in the workhouse' for which he got a 'special fee.'<sup>45</sup> However, the guardians insisted that the union had always employed midwives to attend women in labour and medical officers were only called in for difficult cases. Their justification was that the poor much preferred to have a midwife; it was more economical for the union, and that by using midwives the union was able to secure the services of a 'much superior class of medical man', as the guardians believed that the medical profession regarded midwifery as 'a laborious and unremunerative part of the profession.' They assured

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<sup>44</sup> *Ibid.*, Workhouse papers, 1903.

<sup>45</sup> LRO, G/12/57d/14, 16 Feb 1872. Under the General Consolidated Order 1847 a workhouse medical officer was entitled to a fee of between 10s and 20s for such an attendance. LRO, G/12/57d/18, 19 Feb 1878. In 1878 the guardians requested permission to pay Dr Clarke a fee of £2 for difficult cases of childbirth. The LGB pointed out that, according to Article 183 of the Order, this fee was only to be paid to district medical officers, although it added that if the guardians thought that there was a particularly special case which merited a gratuity in addition to the usual fee, the LGB would consider any such application.

the LGB that no midwives were appointed who did not possess a medical certificate of competency.<sup>46</sup> Dr Smith, however, pointed out that these arrangements differed 'greatly' and felt that the guardians should be required to ensure that medical officers attended all midwifery cases. He also disagreed with their view that a better class of medic would be attracted by the midwifery fees on offer.<sup>47</sup>

Undeterred, the guardians continued their practice. Dr Clarke attended only three cases in 1872 and two in 1873. He reported that the lying-in cases had otherwise 'as usual done well', indicating that he was untroubled by the situation and that the midwife was sufficiently skilled as there were only a few complicated cases that required his attendance. However, in the interests of economy, it seems probable that the midwife was instructed to call him only for extremely serious cases.

Following three deaths in 1874, Dr Clarke closed the lying-in wards for disinfection and ventilation as erysipelas was prevalent and he thought deaths were more 'prone to occur' when that 'complaint is rife', although he added that it was impossible to say if there was any infection connecting the three cases.<sup>48</sup> The lying-in wards at the workhouse infirmary were never properly separated from the other infirmary wards, a situation that was continually criticised by the LGB.<sup>49</sup> These circumstances were not unusual and risk of infection was not the only concern. At the Strand workhouse the female insane ward was immediately beneath the lying-in wards. Rogers observed that, when a 'troublesome or noisy lunatic' was in the ward, 'it must have been anything but a comfort to the lying-in women above.'<sup>50</sup>

In 1889 another midwife's competence was questioned following the death of a young woman three days after delivery. Dr Bryan refused to give a death

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<sup>46</sup> LRO, G/12/57b/5, 24 Feb 1872. Once again, in 1874, the guardians reiterated that since the formation of the union, it had been their practice to employ midwives for all parish cases. In support, they emphasised that all the lower and lower-middle classes were still attended by midwives and doctors were only called in for difficult and dangerous cases. LRO, G/12/57b/5, 24 Apr 1874.

<sup>47</sup> TNA, MH12/6484, 1 Mar 1872. Digby, *Making a Medical Living*, p. 269, noted that medical practitioners regarded midwifery with some ambivalence due to the time involved, but they valued the reliable income.

<sup>48</sup> LRO, G/12/94, 9 Nov 1874.

<sup>49</sup> It was not until 1906 that maternity wards were provided at the North Evington Infirmary.

<sup>50</sup> J. Rogers, *Reminiscences of a Workhouse Medical Officer*, (1889), p. 6.

certificate as he said he should have been sent for at the time of the birth and he reported the case to the coroner. An inquest was held at which the jury concluded that she had died 'from exhaustion consequent upon the whole of the afterbirth not having been removed at the proper time.'<sup>51</sup> The guardians accepted that the midwife, who had been employed by them for seven years, was 'very negligent' by not sending for the medical officer and she was immediately dismissed.<sup>52</sup> After this, the LGB insisted that Dr Bryan approve her replacement and that he should see all women who had been delivered and that he was responsible for their treatment.<sup>53</sup>

Information on out-door childbirth cases is scarce, although it has been estimated that 10 per cent of the total number of persons relieved nationally both inside and outside the workhouse were childbirth cases. The majority of these were out-door paupers delivered by midwives.<sup>54</sup> In 1895 the guardians decided to appoint a midwife to be solely responsible for parish midwifery cases. Miss Lily Masters, a fully-trained and certificated midwife, was duly appointed on a salary of £65. Her appointment caused considerable debate with the LGB. It would only sanction it on the understanding that in all cases she was under the direction and supervision of the medical officer who was to visit and remain responsible for all cases.<sup>55</sup> The guardians assured the LGB that she had been given strict instructions to call a medical officer 'in every case where necessary'. The LGB stipulated that when the relieving officer gave an order to the midwife, he must also give an order for the attendance of the district medical officer.<sup>56</sup> It pointed out that the duties of both relieving and district medical officers were clearly laid down in the General Consolidated Order and that the guardians should not override those regulations by issuing contrary instructions.<sup>57</sup>

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<sup>51</sup> TNA, MH12/6497, 26 Nov 1889.

<sup>52</sup> C. N. Wright, *Wright's Directory of Leicester, 1889-90* (1890), p. 270 included Mrs. Bettoney among the list of 19 midwives in Leicester. She was also a midwife for the Leicester Provident Dispensary. She evidently continued working as a midwife despite her dismissal from the union as her name still appeared in the 1894 directory.

<sup>53</sup> LRO, G/12/57d/30, 11 Jan 1890; 21 Jan 1890; 18 Mar 1890.

<sup>54</sup> *Lancet*, 20 Apr 1872, p. 564.

<sup>55</sup> LRO, G/12/57d/35, 15 Apr 1895.

<sup>56</sup> *Ibid.*, 2 Oct 1895. By 1915 the guardians proposed that female rather than male relieving officers should take details from applicants for maternity relief. G/12/57d/55, 16 Jun 1915.

<sup>57</sup> LRO, G/12/d/35, 19 Nov 1895.

Nonetheless, determined to stay in control, the guardians sent the LGB their resolution which stated that the guardians should have the discretionary power of appointing duly qualified midwives for attendance at childbirth in place of the district medical officer.<sup>58</sup> The disagreement was reported locally as an attempt by the guardians to appoint a better class of midwife than ever before which was thwarted by the LGB's insistence that she must not attend cases without a doctor.<sup>59</sup> Fortunately for the guardians, Miss Masters willingly accepted the post of 'midwife nurse' instead of 'certificated midwife', although one guardian thought they ought to have fought the LGB because 'they would have beaten them as they had in other things.'<sup>60</sup>

Relationships between Miss Masters and the district medical officers were strained,<sup>61</sup> causing the guardians to consider whether to appoint a single 'maternity doctor' to attend all cases instead of a midwife and relieve the district medical officers of this work. However, concerns were expressed during the guardians' debate on this proposal that this would deprive the doctors of their fees and place a hardship upon the poor who lived in the outlying parts of the union by having to come to a central place instead of getting help from medical men in their neighbourhoods. Some guardians questioned whether it would be possible to attract a doctor to devote all his time to this work. One guardian was suspicious that the board was hoping to appoint a 'lady doctor'. The LGB reiterated that it was the duty of district medical officers to attend all poor persons requiring medical treatment in their district. It felt that even if the regulations were amended to allow the appointment of a poor law maternity doctor, if he was allowed to continue in private practice as well, he would find it difficult to 'properly carry out his poor law duties.' The idea was abandoned.

The guardians' priority with economy seems apparent in their preference for midwives. The stipulation that district medical officers must attend childbirths led the guardians to reduce the fee for attendance on normal cases from £1 to 10s 6d.

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<sup>58</sup> TNA, MH12/6505, 20 Nov 1895.

<sup>59</sup> 'The Midwifery Question', *Leicestershire Daily Mercury*, 18 Dec 1895.

<sup>60</sup> His comment aptly illustrates the regular differences that occurred between central and local administration of the poor law and the desire of guardians for local autonomy.

<sup>61</sup> O. Moscucci *The Science of Woman: Gynaecology and Gender in England, 1800-1929* (Cambridge, 1990), p. 71, noted that some medical men feared competition from qualified midwives.

The district medical officers reluctantly agreed, but pointed out that this was inadequate considering the time, care and responsibility each case involved. The LGB also sanctioned claims by district medical officers for fees of one guinea for assistance by another doctor when chloroform was administered in difficult childbirth cases.<sup>62</sup> However, the LGB tried to impress upon the guardians that where anaesthesia was required for a serious operation, the patient should not be treated at home or in the workhouse but should be sent to a public hospital.<sup>63</sup>

Throughout, the guardians insisted that a fully-qualified certificated midwife was the most suitable person to attend normal maternity cases, and that a doctor was only needed in abnormal cases. They considered that this system had worked well and mothers had ‘expressed the fullest satisfaction’. The guardians complained, however, that since the decision of the LGB that a medical man must be in attendance, ‘Nurse Masters had scarcely had any employment.’ They claimed that their enquiries had found that

‘in the majority of cases the poor women have so great an objection to call in the aid of a medical man at such times that they either prefer the help of a neighbour or ignorant so-called midwife, to the presence of a doctor ... or they postpone sending for the doctor till it is too late for him to be present at the birth which necessitates the fee being paid for work which has not actually been done.’

The guardians were reluctant to continue paying a nurse as well as the district medical officers, and when Miss Masters resigned in May 1896, the guardians proposed to ‘select, when needed, respectable women, with sufficient knowledge of nursing to follow medical directions.’ Nevertheless, the guardians were confident that they had raised the standard of maternity nursing by employing a ‘well-trained superior midwife’ and that the LGB’s decision would again ‘lower the standard of maternity nursing among the poor’.<sup>64</sup> In 1897 the guardians noted that a saving of £25 had been made in the year since nurses had attended out-door relief confinement cases. Nonetheless, they repeated that they felt that the patients

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<sup>62</sup> LRO, G/12/57b/11, 8 Jan, 1901; 21 May, 13 Aug 1902, provide examples of many requests by district medical officers for such payments for urgent cases, for example of placenta praevia and induced labour.

<sup>63</sup> LRO, G/12/57d/34, 1 Nov 1894.

<sup>64</sup> LRO, G/12/57b/10, 18 May 1896.

did not now get the same amount of nursing cover as they had during Miss Masters' employment.<sup>65</sup> Ultimately the LGB had to change its position when the Midwives Act of 1902 had been in operation for some years. In 1907 it declared that guardians could appoint midwives for the in-door poor, providing that the midwife was certified and had passed the examination of the Central Midwives' Board.<sup>66</sup>

## Cases of neglect

Predictably the medical journals tended to emphasise the altruism and dedication of medical officers. When medical officers were accused of neglect and incompetence the journals usually blamed the poor law system. In a report of one such case *The Lancet* claimed that 'the pauper doctor is the scapegoat of the poor-law medical service'.<sup>67</sup> Thompson detailed some significant cases of neglect by several medical officers in the earlier years of the Leicester union, including the long-serving William Derrington who was accused of causing the death of a man through neglect. It transpired that it was actually his assistant who had been involved, although this was still 'neglect' as Derrington was supposed to discharge his duty personally.<sup>68</sup> Hodgkinson claimed that the number of medical officers dismissed after the late 1860s was negligible.<sup>69</sup> Yet, as Crowther noted, 'a dangerous amount of inefficiency could produce an official caution rather than dismissal'.<sup>70</sup> Confirming her assertion, this study has not found any cases of neglect that were prosecuted. Nevertheless, there were some cases of distinct irregularity concerning medical certificates, although surprisingly no discussion was found about these incidents in the guardians' minutes.

In 1857 the guardians found that in over half the cases in Derrington's district the certificates had been signed by his substitute. His excuse was that, 'the enormous amount of labour in [my] district renders it impossible for one person to

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<sup>65</sup> LRO, G/12/8a/32, 14 Nov 1897.

<sup>66</sup> LRO, G/12/57d/47, June 1907.

<sup>67</sup> *The Lancet*, 28 Aug 1869, p. 324.

<sup>68</sup> Thompson, *Leicester Poor Law Union*, pp. 200-3.

<sup>69</sup> Hodgkinson, *Origins*, p. 425.

<sup>70</sup> Crowther, *Workhouse System*, p. 174.



attend to all the cases.’<sup>71</sup> In another instance, a death certificate was presented to the Registrar who refused to accept it being aware that the district medical officer, Dr Cox-Hippisley, who had apparently signed it, was away in America. It transpired that the deceased child had been attended by an unqualified assistant who had completed a blank signed certificate left by the district medical officer for use in his absence. The guardians informed the LGB but merely stated that the medical officer had been informed of the heavy penalties he was liable to.<sup>72</sup>

The LGB usually praised Dr Bryan for being conscientious, despite his lax record-keeping, although occasional criticisms of his work appear in the records. For instance, Dr Steele complained that children who had been examined by Dr Bryan before their removal to the cottage homes were found to be very dirty, particularly on their legs and feet. Dr Bryan retorted that their arms had been clean when he examined them two days earlier but he did not examine their feet. His excuse for the cursory examination was that they were sent off to the cottage homes quickly as the room was required, otherwise he would have seen them before they left, but he also pointed out that he was only required to check for disease. He was instructed that in future he should examine all children within twenty-four hours before they were sent to the cottages. On another occasion, Dr Bryan was annoyed when the guardians ordered him to attend all children on the day they were admitted to the receiving homes. He declared that it was impossible for him to do so as some children were not admitted until the evening which was during his private surgery hours. Yet he added that for an extra fee of 5s a visit it might be possible for him to attend, although he was doubtful if that amount would cover his loss.<sup>73</sup>

An exceptionable accusation of ‘neglect’ against Dr Bryan occurred when an inquest jury added a rider to its verdict of ‘death from natural causes’ because the doctor did not see a dying person before leaving the workhouse. A newspaper report on the incident and Dr Bryan’s letter of explanation to the LGB revealed several mistakes made by workhouse staff including Dr Bryan. The circumstances were

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<sup>71</sup> LRO, G/12/8a/9, 15 Dec 1857.

<sup>72</sup> LRO, G/12/57b/6, 10 Oct 1883. A coroner’s inquest was held but unfortunately, the record of the inquest is not extant

<sup>73</sup> LRO, G/12/8g/1, 11 Oct 1909. LRO, G/12/8e/5, 8 Dec 1910. A district medical officer later agreed to attend the receiving home as well as the scattered homes for an extra £5 a year.

that a 66 year-old woman had been diagnosed by Dr Bryan on admission as suffering from a weak heart. Yet she was not sent into the infirmary until six weeks later when her breathing became worse. She died the following morning. Dr Bryan explained that he ordered that she should be sent to the infirmary at once and he expected to see her there when he went on his rounds thirty minutes later. The timing of the incident reveals the short time the doctor spent on his rounds in the infirmary. He ordered her admittance to the infirmary at 1.15 pm. She was actually sent there at 2.45 pm. Dr Bryan went to the infirmary about 1.45 pm and stayed there until 2.00 pm. He also visited the male and female imbecile wards and the old infirmary to see if there were any more cases of smallpox before he left at 3.00 pm. He stated that he forgot about the case until the next morning when he was informed that the woman was dead. Under the impression that he had seen the woman, he wrote out a certificate, which he later withdrew when he realised his mistake.

Several observations emerge here. First, that cases the doctor ordered to be sent to the infirmary were not immediately sent there. Second, that Dr Bryan did not immediately examine the woman or order any treatment as he thought he would shortly see her in the infirmary. Thirdly, that he very quickly forgot about this patient, which implies a failure on his part but also indicates that the large numbers of inmates encountered daily made this omission easily possible. In evidence the superintendent nurse said that it was not usual to send for Dr Bryan after he had been on his rounds unless the case was urgent. She had no idea the doctor had not seen the woman, nor did she consider the woman to be dangerously ill. She added that if she had telephoned Dr Bryan he would have been 'very angry'. After hearing the verdict Dr Bryan remarked in his defence that he had over 300 patients in the infirmary and also smallpox cases, as well as a number of inmates to see in the main workhouse. The jury withdrew the rider. It seems curious that Dr Bryan had forgotten about the case, yet without seeing the body he wrote on the certificate that the cause of death was 'syncope'. This invites speculation that this cause was routinely given to sudden deaths when an earlier diagnosis had been made of 'weak heart', without investigating the possibility of any other cause of death.

This incident caused conflict between Dr Bryan and the superintendent nurse who accused him of neglecting his duty by not seeing patients in the workhouse.

Unaware that she was referring to the recent case, Dr Bryan lost his temper and angry words were exchanged. He later recalled the case and telephoned the workhouse to stop the certificate being sent to the Registrar. He then reported the case to the coroner. Dr Bryan blamed the nurse for not sending for him although he admitted that he should have seen the patient before. His reasons for this neglect were that he wanted to 'save my steps' as he was feeling unwell and suffering from colitis. Furthermore, he complained that his workload was 'exceedingly heavy' and the guardians would only allow his deputy to help on Saturdays. Dr Bryan emphasised to the LGB that he had been in service for nearly 23 years without a complaint against him.<sup>74</sup> It was later reported that he wrote a conciliatory letter to the guardians stating that he hoped that 'by mutual consideration and forbearance, all further friction would be avoided' between himself and the master, matron and superintendent nurse. However, he added a veiled warning to the guardians that 'even an old horse, if too tightly reined, is liable to become fidgety and restive.' The friction had been caused partly by the incident of the woman's death, but mainly due to the doctor's resentment of the guardians' interference over lectures to the nurses.<sup>75</sup> The guardians felt that the doctor had defied them but they decided to accept his explanation and forgive him.<sup>76</sup>

Complaints were made about a district medical officer, Dr Sannyasi Charan Roy. He resigned his post at the newly-opened North Evington Infirmary within a month. Nevertheless, he was later appointed to replace Dr MacAllister-Hewlings whose deputy he had been for nine months. Several local doctors supported his application stating that he was a well-known and established practitioner in Leicester; he was well-qualified and he was popular with his patients, despite, as MacAllister-Hewlings pointed out, 'a good deal of opposition' he had 'naturally' met at first.<sup>77</sup> However, complaints were soon made about Dr Roy's conduct. On two occasions, he refused to immediately attend seriously ill patients in lodging houses even though relieving orders were produced. In the first incident the relieving officer called in emergency medical aid from another doctor who arrived

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<sup>74</sup> LRO, G/12/95, 1903 Scrapbook of workhouse papers contained an unnamed newspaper report of 16 Jan 1903 on the incident; 19 Jan 1903 account of workhouse committee's meeting with Nurse Roberts on her argument with Dr Bryan and Dr Bryan's letter to LGB 20 Jan 1903.

<sup>75</sup> See Chapter 5.

<sup>76</sup> LRO, G/12/95, *Leicester Daily Post*, 1 Apr 1903.

<sup>77</sup> LRO, G/12/57d/54, 25 Feb 1914.

quickly and stated that the woman was too ill to be moved and was in fact dying. When Dr Roy eventually arrived he argued with the landlady and left without seeing the patient even though he was aware that she was 'very ill'. The patient died during the night. Dr Roy also delayed attending upon the guardians to account for his failure. However, though not at all satisfied with his explanation, they simply reminded him of his duties and recorded that he had failed to carry them out.<sup>78</sup> On the second occasion, Dr Roy refused to attend the patient until later and the patient subsequently died after emergency admission to the workhouse. This time the guardians dismissed Dr Roy for failing in his duty.<sup>79</sup>

## Medical extras and medicines

Doctors recognised that illnesses could be caused by poor and inadequate nutrition, and they felt that food could be more beneficial to the patient than medicine, particularly if the poor relief given was insufficient. Medical officers could order 'medical' extras such as alcohol, meat, bread and milk which were financed from the poor rates unlike most medicines. This system was open to abuse.<sup>80</sup> Yet few disputes were found in the local records, which suggest that there was general agreement between the medical officers and the guardians over the quantity and type of medical extras recommended.<sup>81</sup> Occasionally explanations were requested. For example, Dr Denton was called in to assure the guardians that the large quantity of meat he had ordered was necessary. His explanation was accepted and he was informed that the guardians did not want to restrict his powers for ordering extras where these were medically necessary.<sup>82</sup> A complaint in 1894 noted that, although the total amount for medical extras was lower than in the previous year, the average costs of two district medical officers were considerably

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<sup>78</sup> LRO, G/12/8a/48, 3 Nov 1914.

<sup>79</sup> LRO, G/12/57d/55, 22 Jun, 30 Jun, 29 May, 8 Jul, 23 Jul 1915.

<sup>80</sup> *The Lancet*, 4 Nov 1871, p. 650-1. For example, a clergyman pointed out to the Carmarthen guardians the temptation posed to medical officers to order porter and mutton instead of giving cod-liver-oil or quinine at his own cost. He claimed that he tasted the medicine when he found the poor had insisted on having it and generally found it was a 'decoction of peppermint and water.'

<sup>81</sup> G/12/57b/5, 13 Dec 1876. The guardians saved £25 8s 2d during the half year ended 30 Sept 1876 by purchasing wines and spirits wholesale for the recipients of out-door medical relief. They reported that the arrangement had proved satisfactory, not only in a saving of expenditure but also because it enabled them to 'supply wine and spirits of a superior quality to the poor'.

<sup>82</sup> LRO, G/12/8a/23, 1 Jan, 5 Feb 1889.

higher than the others. One had given more brandy. He declined to respond but another district medical officer pointed out that it was misleading to take one period of six months to form an average and that during that period he had had several serious consumptive and cancerous cases in his district.<sup>83</sup> The differences in the numbers of orders made may have been due to disparities in the numbers of paupers in the districts, the types of illnesses treated, or the liberality of individual district medical officers.

Workhouse medical officers also ordered extras for their patients. Indeed, Dr Clarke thanked the guardians for ‘so liberally’ allowing him to order mutton chops and eggs, which he valued ‘far more than stimulants for broken down and debilitated constitutions.’<sup>84</sup> The doctors clearly believed that some foods had beneficial properties for patients’ conditions. Dr Bryan’s explanation to the district auditor perhaps sums up the view of most medical officers:

‘The extras are ordered when I think it necessary for the health of an inmate, probably because they require different food (such as in the case of the man who has had an egg daily for years) as he is a rheumatic subject. I have always been very careful in the ordering of extras, but amongst so many aged and those of a debilitated constitution, extras are obliged to be given, particularly to those who are unable to masticate or digest the ordinary diet.’<sup>85</sup>

The Medical Relief (Disqualifications Removal) Act of 1885 enabled sick people to obtain medical treatment from a poor law dispensary without incurring the status of ‘pauper’.<sup>86</sup> However, the Leicester union did not set up its own dispensary. When the district medical officers applied to the guardians in 1912 for increased salaries as the high price of drugs caused a large proportion of their salaries to be absorbed by dispensing medicines, rather than raise their salaries the guardians decided to make arrangements with the Leicester Provident Dispensary for it to supply all medicines for the out-door poor prescribed by the district medical officers for an annual payment of £150. The district medical officers were said to

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<sup>83</sup> LRO, G/12/188/1, 7 Nov 1894.

<sup>84</sup> LRO, G/12/94, Medical Officer’s Annual Report 1871.

<sup>85</sup> LRO, G/12/57b/13, 14 Sep 1911.

<sup>86</sup> Harris, *Origins of the British Welfare State*, p. 56.

approve of this arrangement.<sup>87</sup> However, the Pharmaceutical Society of Great Britain complained to the LGB that a ‘grave injustice would be done to the sick poor’ if the LGB sanctioned the proposed arrangement. The Society had checked the accounts of the guardians which showed that 3,000 out-door patients were treated in 1911 and they estimated that 30,000 prescriptions would be dispensed during the coming year.<sup>88</sup> The Society thought that £150 was insufficient to dispense the quantities of medicine prescribed and it feared that there would be a ‘practice of making some drugs go further in the preparation of medicines than they should go legitimately, and further than they were intended to by the prescriber.’ It was also concerned about the lack of medical or pharmacological supervision over unqualified branch dispensers. The LGB concurred that under its order of 1895, a definite qualification was required for poor law dispensers. Nevertheless it agreed to the arrangements being undertaken for an experimental period of one year. The Pharmaceutical Society warned that a completely independent enquiry would be necessary to judge whether the trial was satisfactory as it thought that it was unlikely that poor law patients would complain or that the dispensary would provide trustworthy information.<sup>89</sup>

## Summary

The workload expected of poor law medical officers was high and the range of cases dealt with was extensive, certainly in large urban unions and particularly as posts were generally part-time and doctors had private patients and other public commitments. Chapter 3 and this chapter have shown that the medical officers of the Leicester union were reasonably conscientious. The workhouse medical officers attended the workhouse regularly and tried to make improvements to the treatment and conditions of patients. Similarly, most of the district medical officers carried out their work satisfactorily, although the absence of detailed records impedes a categorical judgment. A lack of complaints may only signify that unless significant malpractice occurred, lesser incompetence or neglect was ignored. However, the low turnover and lengthy service of many medical officers indicates some level of

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<sup>87</sup> LRO, G/12/57b/13, 24 Apr 1912.

<sup>88</sup> LRO, G/12/57d/52, 2 May 1912.

<sup>89</sup> LRO, G/12/57d/52, 11 Jul 1912.

satisfaction on their part and at least provided familiarity and continuity of care for their patients. The strictures of the system clearly did not encourage medical officers to spend much time with patients or keep detailed records nor to provide expensive medicines, particularly for long-term patients. Relationships between the guardians and medical officers were relatively cordial, although it is clear that they often had different priorities. However, the system ensured that power over medical administration rested with the guardians. The subsequent chapters on workhouse nurses and different types of patients will also provide further insights into the work of the medical officers.

## Chapter 5

### Nursing in the workhouse infirmary

#### Introduction

Existing scholarly literature on poor law nursing is slight, despite its significance within nursing history.<sup>1</sup> The nurses of the Leicester workhouse had a major role in the daily care of pauper patients as the medical officers were non-resident and spent much less time in the sick wards than the nurses. This chapter discusses the developments in the provision of nurses at the workhouse until the new poor law infirmary was built. This chapter will increase the historiography on poor law nursing by providing a detailed insight into this union's handling of the nursing of sick paupers set within the context of the central administration of the poor law. Due to the paucity of local primary sources on outdoor relief, the main focus is necessarily on the nursing of adult patients in the workhouse.<sup>2</sup> The nursing of sick pauper children, imbeciles and epileptics is discussed in Chapters 7 and 8.

#### Pauper nurses

In the early nineteenth century before hospital reform, nurses generally did not undertake what later came to be regarded as standard nursing duties. No special

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<sup>1</sup> S. Cherry, *Medical Services and the Hospitals in Britain, 1860-1939* (Cambridge, 1996), p. 81. B. Abel-Smith, *A History of the Nursing Profession* (1960), p. 10, noted that while there were many detailed accounts of the operation of voluntary hospitals, there were few for poor law hospitals. This situation remains, apart from a useful and important contribution on poor law nursing by R. White, *Social Change and the Development of the Nursing Profession: A Study of the Poor Law Nursing Service 1848-1948* (1978). Poor law nursing received some attention in R. Dingwall, A.M. Rafferty and C. Webster (eds), *An Introduction to the Social History of Nursing* (1988); M.A. Crowther, *The Workhouse System*, pp. 165-167; 175-181; and S. Kirby, 'Diaspora, Dispute and Diffusion: Bringing Professional Values to the Punitive Culture of the Poor Law', *Nursing Inquiry*, 11 (2004), pp. 185-191. For nursing under the Old Poor Law see S. Williams, 'Caring for the Sick Poor: Poor Law Nurses in Bedfordshire, c. 1770-1834', in P. Lane, N. Raven, and K.D.M. Snell (eds), *Women, Work and Wages in England, 1600-1850* (Woodbridge, 2004).

<sup>2</sup> The LGB issued a General Order in 1892 authorising the appointment of district nurses to attend the sick at home if absolutely necessary, although it was felt better to nurse the sick in infirmaries. *The Minority Report*, p. 217 found that guardians had 'almost uniformly refused to do so' and only a small minority of unions paid a subscription to the local nursing association. Leicester guardians were among that small minority as they subscribed to the Leicester District Nursing Association. LRO, G/12/8a/40 recorded the renewal of the annual subscription of £50.



knowledge or aptitude was required. Their duties were more in the line of domestic service - providing basic care of patients and cleaning and washing. Indeed, the majority of hospital nurses at that time were drawn from the domestic service class.<sup>3</sup> The new poor law was not designed to treat the sick, therefore no stipulation was made for the provision of nurses for those who became sick in the workhouse or entered it because they were sick. The General Consolidated Order of 1847 set out the duties of workhouse nurses as being simply to attend the sick in the sick wards; to administer to them all medicines and medical applications according to the direction of the medical officer; to inform the medical officer of any defects observed in the arrangements in sick lying-in wards; and to take care that a light was kept at night in the sick wards. Workhouse nurses were therefore merely required to be sober and capable of reading and understanding the medical officer's instructions.<sup>4</sup> Despite the latter provisos, illiterate pauper nurses were sometimes used.<sup>5</sup>

The guiding principle was always economy. However, there were other reasons for the use of pauper nurses. Initially there was no existing supply of trained nurses to draw upon. Moreover, inmates who were considered able-bodied had to be given work to do and nursing was one task that could readily be allotted regardless of whether the inmate was suitable. The nursing of fellow inmates was regarded favourably by guardians as it did not compete with outside trades thereby avoiding indignation from those ratepayers who were in trade. Furthermore, the unpleasant nature of the work also discouraged inmates from staying in the workhouse.<sup>6</sup> Consequently, pauper nurses were usually those who could not leave the workhouse. They were commonly elderly, incapable and unsuitable for nursing duties. Indeed many were hardly in a better state than the patients. This situation was widespread in workhouses including Leicester where a medical officer in 1847 thought the pauper nurses were inadequate and untrustworthy.<sup>7</sup> These circumstances were readily confirmed by the workhouse reformers Louisa Twining

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<sup>3</sup> Abel-Smith, *History of the Nursing Profession*, pp. 2-9.

<sup>4</sup> Crowther, *Workhouse System*, p. 166.

<sup>5</sup> Bosworth, *Public Healthcare in Nottingham*, p. 262, recorded that two elderly pauper nurses at the Nottingham union were finally regarded as too decrepit to continue working in 1868 after twenty years as pauper nurses. 'They were both unable to read, even prescriptions.'

<sup>6</sup> Dingwall, *Social History of Nursing*, p. 12.

<sup>7</sup> Thompson, *Leicester Poor Law Union*, p. 205.

and Joseph Rogers as well as in *The Lancet* and *BMJ*.<sup>8</sup> Workhouse infirmaries became notorious for using unsuitable pauper nurses and rewarding them with extra rations, including alcohol, despite the central authority's disapproval. The Leicester union evidently carried out this 'accepted' practice as shown by the medical officer's suggestion that the male pauper nurses might have their ale for work done reduced from one to half a pint daily. Far from disapproving, he thought that it was fairly earned and had been useful for keeping the pauper nurses.<sup>9</sup> It is questionable whether a reduced supply of alcohol would have continued to retain the nurses.

Pauper nurses remained even when paid nurses were appointed. For many years the central authority vacillated on this point. By 1865 it recommended the discontinuance of pauper nurses. However, it failed to prohibit their use. In 1895 it again recommended that this practice cease but stipulated that any that were used should be clearly distinguished from paid qualified nurses; their services should be approved by the medical officer, and they should be under close supervision 'at all times' by paid officers.<sup>10</sup> It was not until 1897 that the use of paupers for any nursing duties was forbidden.<sup>11</sup> The sources for the Leicester union contain numerous letters and appointment and resignation forms due to the consistently high changes of nurses. Although scant information was found on the continued use of pauper nurses, as late as 1898 correspondence occurred between the guardians and the LGB about the inappropriate use and behaviour of inmates acting as *wardsmen* [sic] (i.e. attendants) in the infirmary, showing that the Leicester guardians still permitted this practice. The limited mention of pauper nurses perhaps instead shows that it was taken for granted that inmates worked in the sick wards. The

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<sup>8</sup> Louisa Twining formed the Ladies Workhouse Visiting Association and campaigned for improvements in workhouse treatment of the sick from the 1850s to the end of the century.

<sup>9</sup> LRO, G/12/94, 8 Sep 1879. Joseph Rogers confirmed that his pauper nurses 'were frequently under the influence of drink.' Their duties were rewarded by a pint of beer and a glass of gin for the 'more repulsive duties.' Rogers, *Reminiscences*, p. 9.

<sup>10</sup> LRO, G/12/57d/35, 29 Jan 1895. This circular was sent by the LGB following the Local Government Act 1894, to highlight points about workhouse administration to newly elected guardians as many had no previous experience of poor law administration. The circular stressed the serious responsibilities involved in the office of nurse and the high qualities required of such nurses. It further insisted these same qualities were also required of assistant nurses. Commenting upon this circular, *The Lancet* declared that despite the chronic nature of illnesses in pauper patients, there was no reason why they should not be treated as efficiently as hospital patients were. It called for more of the 'old spirit' of medieval bedehouses that were thought to have regarded sick paupers as objects of care rather than burdens on the rates. *The Lancet*, 2 Feb 1895, p. 298.

<sup>11</sup> Crowther, *Workhouse System*, p. 177.

performance of those who were paid for their work inevitably attracted more attention from the guardians.<sup>12</sup>

Pauper nursing in the early years of poor law administration should be viewed against the context of the primitive social conditions of the poor, the lack of medical knowledge and the state of general hospital nursing at that time. This early period predated general reforms in nursing and, as White has pointed out, the duties of workhouse nurses set out in 1847 were more responsible than those of the nurses at St Thomas's Hospital in 1857.<sup>13</sup> However, the deterrent ethos and political economy that pervaded the new poor law undoubtedly impeded an effective system of poor law nursing for many years. The remainder of the chapter will show the extent to which this ethos was adhered to at the Leicester union.

## **Paid nurses**

The Leicester guardians appointed two paid nurses in 1847 following pressure from the central authority when a coroner suggested that a pauper nurse be removed after an inmate died from an overdose of laudanum.<sup>14</sup> The paid nurses had no nursing experience and did not receive any professional training for many years.<sup>15</sup> Dr Smith's reports on the workhouse in 1867 and 1871 confirm that there continued to be two paid nurses for the sick cases of each sex in the infirmary, as well as what he described as a 'sort of pupil assistant' to each. The nurses were paid £17 per year, and an extra amount of 7s in lieu of board and rations. The assistant nurses were paid a small salary with board and lodging.<sup>16</sup> The paid nurses were obviously not qualified but could be considered to be reasonably paid at that

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<sup>12</sup> The use of the term 'nurse' hereafter refers to paid nurses.

<sup>13</sup> White, *Social Change*, pp. 8; 25-6. Jack Simmons, *Leicester Past and Present: Volume Two, Modern City, 1860-1974* (1974), p. 21, noted that none of the nurses in the Leicester voluntary infirmary were fully trained until 1862, when three were appointed from St. Thomas's Hospital where The Nightingale School of Nursing started in 1860.

<sup>14</sup> Thompson, *Leicester Poor Law Union*, pp. 204-5.

<sup>15</sup> Abel-Smith, *Nursing Profession*, p. 4, stated that there were hardly any paid nurses in workhouses until after the middle of the nineteenth century, which shows that the Leicester guardians were unusual in appointing two at that time.

<sup>16</sup> LRO, G/12/57d/12, 17 Apr 1867. One nurse's salary was increased to £20 per annum. She left the next year to take up a post at the Nottingham Union. TNA, MH9/15 shows that salaries paid to male nurses at the Sheffield union at that time were also £20 although its female nurses received £25.

time.<sup>17</sup> Dr Smith later recommended that with the imminent enlargement of the infirmary four more trained nurses would be necessary.<sup>18</sup> Yet he recognised the difficulty of obtaining trained nurses. In 1867 he had suggested that respectable, healthy, young or middle-aged women who found themselves in the workhouse due to desertion or widowhood could easily make efficient nurses and become paid officers instead of remaining pauperised.<sup>19</sup> Dr Smith recognised that inmates were often victims of circumstances rather than the dissolute and undeserving stereotypes that prevailed.

In contrast, Florence Nightingale believed it was highly unlikely that women of good character, suitable for training as nurses, could be found in workhouses. She wanted dedicated, reliable and respectable young women to enter nursing.<sup>20</sup> Ernest Hart went further and declared that nursing was an art ‘of no small difficulty’ and that without proper training even ‘persons of the better class’ were unfitted to perform the duties of a hospital nurse.<sup>21</sup> Recruits to Florence Nightingale’s nursing campaign were philanthropic, educated middle-class women, who were unlikely to be attracted to the hard conditions and low status of workhouse nursing.<sup>22</sup> Working-class women who wanted to become nurses could gain posts more easily in workhouses than in the voluntary hospitals. The Leicester union appeared to be somewhat ahead of trends in the late 1860s,<sup>23</sup> when its medical officer, Dr Clarke, recommended to the guardians that the workhouse infirmary might be a ‘desirable place for training nurses.’ Consequently the guardians advertised in the local newspapers for two nurses. They offered rations, lodging and a salary of £6 during

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<sup>17</sup> TNA, MH9/10, Sarah Brown who was appointed in August 1865 on a salary of £17 a year received £20 a year by April 1867. However in February 1868 she was called on to resign because of her ‘temper’. Abel-Smith, *Nursing Profession*, p. 14, found that the average salary paid to 53 nurses in 11 metropolitan workhouses was £20 18s in 1866, White, *Social Change*, p. 74, mentioned that the average salary of a poor law nurse in 1851 was £14; in 1870 it was between £20 and £30 per year, although salaries were subject to the approval of the central authority, it failed to set standardised salaries and always allowed local variation.

<sup>18</sup> TNA, MH32/67 15 Apr 1867, 21 Apr 1871.

<sup>19</sup> *Report of Doctor E. Smith on Forty-eight Provincial Workhouses in England and Wales*, LX (1867-8), p. 12.

<sup>20</sup> Bynum, *Science and the Practice of Medicine*, p. 188.

<sup>21</sup> E. Hart, ‘The Condition of our State Hospitals’, *The Fortnightly Review*, 3 Dec 1865, p. 223. Hart became editor of the *BMJ* in 1867 where he remained for thirty years. He had earlier worked as a medical journalist with *The Lancet*.

<sup>22</sup> Crowther, *Workhouse System*, p. 176.

<sup>23</sup> Thompson, *Leicester Poor Law Union*, p. 206.

training. When the nurses were sufficiently trained they would get a certificate of competency from the medical officer.<sup>24</sup>

The PLB was obviously aware of the difficulties of providing capable nurses for workhouse infirmaries and the problems that ensued when pauper inmates were used. Yet unlike its inspector Dr Smith, the PLB's attitude towards the training of nurses was ambivalent. It considered that such training in workhouses could not be considered as 'strictly within the object of the administration of the laws for the relief of the poor.'<sup>25</sup> Nevertheless it reluctantly sanctioned the proposed appointments at Leicester provided that the medical officer confirmed that assistant nurses were required and he was satisfied that those appointed were competent. Two assistant nurses were accordingly appointed in February 1868. Details of their training are lacking, but one assistant was promoted to nurse at the new workhouse school infirmary six months later. Her annual salary was doubled to £12. The other assistant left for a post at Blaby union seven months later.<sup>26</sup> In 1872 another nurse who had received training at the workhouse left for an appointment at Daventry workhouse. As was customary, the LGB asked the guardians for their opinion of her character and conduct. They stated that during her training period of fifteen months her conduct had been good. Furthermore, she had discharged her duties faithfully and the medical officer had certified her as a competent nurse. Without a curriculum of nursing skills to be attained, a good character and obedience were considered to be the important qualities that defined a nurses' suitability.

Despite taking on trainee nurses, pauper nurses still worked on the infirmary wards. At times there were insufficient suitable able-bodied inmates for this work which forced the use of convalescent patients as ward nurses who subsequently became ill again themselves.<sup>27</sup> Dr Clarke's reference to recovering patients as 'nurses' indicates that any form of attendance upon the sick was regarded as 'nursing'. Until the duties of nurses became more medically defined, poor law

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<sup>24</sup> LRO, G/12/57b/4, 23 Nov 1867. There was no standard curriculum, training or external examination at that time, therefore the medical officer's judgement as to the nurse's competence was relied upon.

<sup>25</sup> LRO, G/12/57d/12, 6 Jan 1868. Section 29 of the Metropolitan Poor Law Act allowed infirmaries to officially admit and train probationer nurses by 1873. Kirby, 'Diaspora', p. 188.

<sup>26</sup> LRO, G/12/57d/12, Aug, Sept 1868.

<sup>27</sup> LRO, G/12/57d/13, 1 Jul 1869.

nursing mainly comprised menial domestic tasks and the personal care of chronically sick patients in contrast to the more skilled nursing required for acute patients in the voluntary hospitals.

The Metropolitan Poor Act of 1867 began to improve matters with the introduction of trained and paid nurses and it probably had an influence on other areas.<sup>28</sup> By then, though the Leicester union had already begun to employ paid nurses, but their training, as for most workhouse nurses, was gained from experience in post rather than specific education. Dr Clarke agreed with Dr Smith's suggestion for training 'respectable' able-bodied female inmates as nurses, although he was disappointed that some of the women he identified as suitable preferred to return to their former occupations.<sup>29</sup> It is reasonable to speculate that Dr Clarke was aware of Dr Smith's suggestion for training inmates as nurses, as Dr Smith was the poor law inspector for the Leicester union at that time and undoubtedly would have talked to Dr Clarke about nursing provision. It is also probable that Dr Clarke was aware of *The Lancet's* 1866 enquiry that uncovered appalling conditions in many workhouse infirmaries, including insufficient nurses.

### **The calibre of nurses**

Two replacement assistant nurses appointed in 1871 were widows, aged 33 and 40. One had previously worked as a machinist and the other in domestic service.<sup>30</sup> To his dissatisfaction, the medical officer was excluded from the appointment of nurses. He was unimpressed by the low calibre of the appointed nurses and suggested that any candidate selected to be trained as a nurse should be tested by him as to her suitability for the office before her appointment was officially sanctioned. He emphasised that this was usual with all the nursing institutions with which he was 'conversant'.<sup>31</sup>

The following year he reported that the new nurse at the school infirmary was inadequate and showed no signs of improving. He further recommended that

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<sup>28</sup> Dingwall, *Social History of Nursing*, p. 63.

<sup>29</sup> LRO, G/12/94, Medical Officer's Annual Report, 1871

<sup>30</sup> TNA, MH12/6484, 5 Sep, 17 Oct 1871. They were appointed on an annual salary of £8.

<sup>31</sup> LRO, G/12/94, 1 Oct 1872.

no-one should be appointed who had not had one year of training in a hospital or infirmary. Furthermore, he felt that it would be an advantage to appoint women of middle-age, who had been married and had children.<sup>32</sup> However, the occupations and ages of successive nurses show that his advice went unheeded. Many years passed before nurses with prior training and experience were appointed. Evidence of training and qualification could not be a strict requirement in any case until the training and examination of nurses was generally established.<sup>33</sup> Testimonials from previous employees usually satisfied the guardians.<sup>34</sup>

Ten probationer nurses were trained at the infirmary in 1873. Two became superintendent nurses and one an assistant nurse.<sup>35</sup> The medical officer reported favourably on their 'attention and diligence' and on the 'general cleanliness of the wards'. A note of disappointment was sounded, however, when he added that since the autumn there had been no new women to train as nurses.<sup>36</sup> The nursing appointees were socially and educationally similar to the pauper inmates. As White stated, the only firm basis for distinguishing a poor law nurse from the pauper nurse was that she was paid and was therefore an employee and not a pauper and she presumably wished to be a nurse.<sup>37</sup> An inspection report in 1878 remarked that the infirmary nurses were 'untrained paupers with no special education.' Disapproval was expressed that an assistant nurse made up the medicines although she was not a qualified dispenser.<sup>38</sup> However, Dr Clarke informed the inspector that he considered the nursing staff was adequate. As the poor law inspector was a doctor, there was clearly a difference of professional opinion on that point.

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<sup>32</sup> *Ibid.*, 13 Nov 1873. Abel-Smith, *Nursing Profession*, p. 43, noted that one result of the 1865-6 *Lancet* enquiry was that the central authority advised guardians to employ paid nurses with one year's experience, although training wasn't mentioned.

<sup>33</sup> Dingwall, *Social History of Nursing*, p. 67. There was no nationally recognised examination and certification of general nurses until 1925.

<sup>34</sup> LRO, G/12/57d/23, 18 Oct 1883.

<sup>35</sup> There was no formal grading structure to judge the ability of the nurse. Promotions were made on the recommendation of the medical officer and agreement of the guardians.

<sup>36</sup> LRO, G/12/94, 1873 Medical Officer's Annual Report.

<sup>37</sup> White, *Social Change*, pp. 26-7.

<sup>38</sup> TNA, MH12/6489, 18 Feb 1878.

## Recruitment and retention

A high turnover of nurses was common. Many left because they did not like the work or to get married, while others used the training gained at one workhouse to move on to a higher position in another, or moved to a workhouse infirmary that provided training.<sup>39</sup> For example, an assistant nurse at Leicester moved on to become a nurse at Melton Mowbray workhouse.<sup>40</sup> Numerous other examples of nurses moving to different unions were found in the local sources. In each case the central authority wrote to the respective union to enquire as to the character and conduct of the applicant and the reason for her resignation. The guardians' reports were generally favourable but occasionally nurses were criticised for not being strong enough to perform their duties.<sup>41</sup> The guardians were also concerned about the moral character of paid nurses. They requested an assistant nurse to resign when they discovered that she was not the widow she claimed to be but a single woman with two illegitimate children.<sup>42</sup>

The recruitment of nurses was sometimes difficult and posts had to be re-advertised with an increased salary to attract applicants.<sup>43</sup> By 1881 a superintendent nurse was appointed on a salary of £30 a year plus board, lodging and washing and a general nurse was appointed on £25 a year.<sup>44</sup> The superintendent nurse's salary was later increased to £36 in 1882 as the guardians said she had given great satisfaction in the discharge of her duties.<sup>45</sup> In 1881 the guardians provided the six female nurses and imbeciles' attendants with uniforms; a move which received the sanction of the LGB after some deliberation.<sup>46</sup> The provision of uniforms and increased salaries signified a desire to distinguish nurses from pauper assistants, as well as an attitude that nursing was a female occupation as uniforms were not suggested for male nurses.

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<sup>39</sup> Digby, *Pauper Palaces*, p. 172, noted that the tedium of geriatric cases, social isolation and poor facilities also made it difficult for rural unions to recruit or retain good nurses.

<sup>40</sup> LRO, G/12/57d/14, 1 May 1874, 16 May 1872, 20 Mar 1875.

<sup>41</sup> Frizelle, *The Life and Times of the Royal Infirmary*, p. 316, also noted that 'too delicate' was quite a common reason for a probationer nurse leaving the Leicester General Infirmary.

<sup>42</sup> *Ibid.*, 21 Nov 1883.

<sup>43</sup> *Ibid.*, 9 Mar 1880.

<sup>44</sup> LRO, G/12/57d/21, 18 Jan 1881; LRO, G/12/57b/6, 18 Feb 1881.

<sup>45</sup> LRO, G/12/57b/6, 21 Jun 1882.

<sup>46</sup> *Ibid.*, 23 Aug 1881; G/12/57d/21, 7 Oct 1881.



Another contrast in the treatment of male and female nurses appeared in two appointments made in 1884. The female nurse had previously worked as a union nurse at Skipton union which she left to qualify and work as a district midwife. She had a certificate in midwifery and was a 39 year old widow with an independent child.<sup>47</sup> A few months later a male nurse was appointed. He was also 39, but single with no children. He was a soldier invalided out of the army after an accident. He obviously did not have any nursing qualifications but was presumably considered fit enough to nurse sick paupers. He was appointed on a higher salary of £25. No explanation was considered necessary for this decision as it was standard practice to pay women less than men.

## **Complaints**

Despite the continual changes of nurses, there were few records of complaints about their behaviour or their treatment of patients. This may not signify that they were all obedient and treated the patients well. It is likely that only major incidents that drew public attention or vociferous complaints by patients received the guardians' consideration. No doubt there were regular complaints by both staff and patients which were ignored. The following three instances evidently required some action by the guardians.

An unfortunate incident occurred in 1886 when a coffin was buried without a body. The entry in the guardians' minutes reveals an interesting insight into the duties undertaken by nurses and the guardians' attitude. The assistant attendant to the male imbeciles removed a coffin that should have contained a deceased child from the dead house without the required attendance of a nurse. The guardians excused his 'inadvertent behaviour' on the grounds that he was young and rather hurried by wishing to arrive at the cemetery on time. The superintendent nurse had apparently failed to make an entry in the coffin book or issue the tickets to be placed with the body and on the coffin identifying the body or even to see the coffin. The guardians felt that she was very much to blame and cautioned her. However, the nurse who should have placed the body in the coffin received the major censure.

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<sup>47</sup> LRO, G/12/57b/6, 5 May 1885 a testimonial for the nurse stated that she was in post for 15 months during which time she was 'steady and efficient and kind to the patients.'

The child had died under her charge; she had ordered the coffin and shroud but had failed to mention the matter to the nurse who took over when she went off duty. On her return she was apparently aware that the shroud had not been used, yet made no enquiries as to the whereabouts of the body until several hours later. The guardians felt there were no excuses for her behaviour and requested her immediate resignation.<sup>48</sup>

Another incident that occurred in 1902 revealed further discrepancies in the workhouse procedure when deaths occurred. A nurse found a mother in bed holding her month-old baby who had died. The nurse reported the death to the superintendent nurse and then washed and laid out the body. At the inquest the coroner questioned the nurse's actions. She stated that she did not think it was her duty to report to a doctor immediately in the case of a patient in the infirmary dying because 'it had not been done before.' Dr Bryan was not informed of the death until eight hours later while he was making his daily rounds. He stated that the death should have been reported to him immediately as the child had not been under medical treatment and, as the coroner stated, it was in the same position as an inmate when any sudden death would be immediately reported to the medical officer. As the baby had already been laid out, Dr Bryan was unable to say categorically the cause of death. The verdict of the inquest was 'accidental suffocation' as the mother and child had been in a single bed and the nurse had stated that a locker had been placed against the bed to support the mother and prevent her from falling out. It was therefore concluded that the mother had overlain and suffocated the baby. As a consequence the coroner recommended that in similar cases the doctor should be communicated with immediately and the LGB told the guardians that cots for infants should be placed beside the mother's bed in the infirmary.<sup>49</sup> The guardians quickly complied with these recommendations.<sup>50</sup>

In the third instance, a patient complained that she had slept in a wet bed

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<sup>48</sup> LRO, G/12/8a/22, 16, 23 Mar 1886. TNA, MH12/6494, 18 May 1886. A cutting from *The Standard* stuck into a LGB correspondence book reported that a dead body had been found at the workhouse, four days after its supposed interment, and the Home Secretary had ordered the exhumation of the coffin, which was found to be empty. An official noted in the margin that this was found to be due to the negligence of a nurse.

<sup>49</sup> LRO, G/12/95, 30 Dec 1902, 13 Jan; 16 Jan 1903.

<sup>50</sup> LRO, G/12/57b/11, 24 Feb 1903.

when she had upset a bed pan rather than ask for the sheets to be changed because she was frightened of the nurse. The guardians stated that there was no reason for the patient to be afraid of the nurse as she was a competent nurse who was highly regarded by the master and superintendent nurse. The nurse confirmed that she sometimes spoke sharply to patients when necessary but the guardians felt that it was the nurse's duty to be firm in the patient's interest and they decided that the incident was entirely the patient's fault.<sup>51</sup>

The above examples usefully illustrate the dynamics of the power relationships within the workhouse between the guardians, medical officer and nurses. The patient patently lacked any obvious power. Nurses were accountable to the master and matron rather than to the medical officer and the guardians did not include the medical officer when making decisions about matters concerning patients and nurses.

### **Sick and injured nurses**

Nursing sick and infectious patients obviously posed health risks to the nurses in addition to the unremittingly hard work. The ratio of nurses to patients was low and even more so when nurses themselves were frequently sick. At such times permission was occasionally given for temporary nurses to be employed. The medical officer was not required to treat sick nurses himself, although he made recommendations for their transfer to the general or fever hospital or the granting of convalescent leave. Temporary nurses were also appointed when there were outbreaks of infectious diseases.<sup>52</sup> Pauper wardsmen and women were used to help wash infirm patients and make their beds. In addition to illnesses acquired from overwork or infections,<sup>53</sup> nurses could receive injuries through their duties, such as slipping on the polished ward floors.<sup>54</sup>

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<sup>51</sup> LRO, G/12/95, 16 Feb 1903.

<sup>52</sup> LRO, G/12/57d/21, 28 Apr 1881. For example, upon an outbreak of measles and scarlet fever in the workhouse, the guardians appointed a temporary nurse for the children's infectious wards. She was paid 15 shillings a week.

<sup>53</sup> LRO, G/12/8a/31, 23 Feb 1897.

<sup>54</sup> LRO, G/12/8j/2., 23 Sept, 18 Nov 1909. Patients were also in danger from the highly polished floors at the new infirmary. At an inquest on one patient, the jury recommended that patients should be provided with slippers to prevent them slipping over. The guardians subsequently purchased three dozen pairs of slippers.

## Increased numbers of nurses

There were always fewer nurses for the high numbers of patients in workhouse infirmaries in comparison with the numbers in the voluntary hospitals.<sup>55</sup> Dr MacVail, who conducted an extensive survey of infirmaries, calculated that the ratio of beds to nurses was one to every 10.6 beds in poor law infirmaries. This compared with one to 2.7 in teaching hospitals, and one to 3.8 beds in voluntary hospitals.<sup>56</sup> The guardians acknowledged the insufficiency of nurses in 1886 when they recommended that the nursing staff be rearranged and increased from four to six nurses. Two assistant nurses were promoted to second nurses, one nurse was promoted as head nurse for the male patients, an additional head nurse was appointed to female patients and another two assistant nurses were appointed.<sup>57</sup> The newly-appointed assistant nurses soon left, both having been found not 'strong enough to perform their duties.' They were swiftly replaced by two women who had previously worked as nurses, one at a workhouse infirmary and one at a general hospital where she had been trained. It was unusual for a nurse from a voluntary hospital to elect to work in a workhouse infirmary.<sup>58</sup> Two additional assistant nurses were appointed which meant that the number of nurses had doubled during 1886.<sup>59</sup>

When Harriet Adcock, one of the head nurses, left to get married in 1887 her replacement was Margaret Roberts, who was married but separated from her husband, who was believed to have left the country. They had been master and matron of Burton-on-Trent workhouse for nine years, but she had to leave the post as her husband resigned and disappeared. She had previously worked as a nurse at two other workhouses.<sup>60</sup> Her experience of workhouse nursing evidently impressed the guardians as they waived the practice against employing married women as nurses and accepted that her young child would live elsewhere with 'friends.' Poor

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<sup>55</sup> White, *Social Change*, p. 82, stated that in 1913 poor law infirmaries had double the number of beds and just over half the number of nurses of the voluntary hospitals.

<sup>56</sup> PP 1909 (4835) xlii, 45-6, cited in Crowther, *Workhouse System*, pp. 169, 175.

<sup>57</sup> LRO, G/12/57d/26, 11 Jun 1886.

<sup>58</sup> Rimmington, 'Treatment of the Sick Poor in Leicester', p. 98, stated that 'Workhouse nursing did not attract 'ladies', still less those who had been trained in voluntary hospitals.'

<sup>59</sup> LRO, G/12/57d/26, 3 Aug, 6 Oct, 18 Oct 1886.

<sup>60</sup> LRO, G/12/57d/27, 12 Mar 1887.

law nurses were required to be single women or widows without ‘encumbrances’ as they had to live at the workhouse. However, the guardians began to accept those who had dependent children provided they lived elsewhere and were married women who were separated from their husbands.

The five nurses appointed in 1886 soon became dissatisfied with their conditions and they all resigned simultaneously the following year. Some moved on to other unions. Their reasons for leaving were not given but they were easily replaced, although the LGB raised some issues concerning their replacements. One assistant nurse claimed to have worked as a nurse at Nottingham General Hospital but when the LGB checked on her character, it transpired that she had left there more than a year before and had since worked at the Leicester General Infirmary. Despite being given this information, the LGB agreed to her appointment. This confirms that many poor law nurses were failed nurses from the voluntary hospitals and that the frequency with which nurses had to be replaced meant that guardians could not always be too particular about the character and skills of those appointed.

On occasions and when necessary, the LGB would allow duties to accrue to individuals who did not have had the appropriate qualifications. In 1889, Head Nurse Roberts was put in charge of both the female and male infirmaries when another nurse left. Similarly, in 1890 when the workhouse midwife was dismissed for negligence, Nurse Roberts took on midwifery duties. In both cases, additional payments were made in compensation for taking on the extra duties. However, it is important to note that Nurse Roberts was not qualified as a midwife but the LGB reluctantly sanctioned this appointment on the strict understanding that the medical officer would be called to attend any case that presented the slightest difficulty and that he was responsible for all cases.<sup>61</sup> Furthermore, the guardians were saving money by not employing replacement nurses. The 1890 return stated there were 270 beds in the workhouse infirmary and the average number of patients in the wards for October to November 1890 was respectively 194, 185 and 200. Nurse Roberts evidently had a considerable workload and heavy responsibilities,

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<sup>61</sup> LRO, G/12/57d/30, 11 Jan, 21 Jan, 18 Mar 1890. For more details of conflicting opinions between the guardians and the LGB on the issue of midwifery in the Leicester union see Chapters 3 and 6.

particularly as there were only seven paid nurses, of which only four had received training prior to their appointment.<sup>62</sup>

### Night nurses

Night-nursing at workhouse infirmaries was ‘conspicuous by its absence.’<sup>63</sup> It remained a controversial issue for many years, especially when deaths occurred at night.<sup>64</sup> For example, an inquest held into the death of a pauper at Chester workhouse found one trained nurse responsible for 160 beds distributed throughout two blocks.<sup>65</sup> Assistant day nurses at Leicester union had to take night duty one week in four. The regulations for nursing staff contained in the guardians’ minutes of the mid 1880s provide a good insight into their duties and conditions of service and show the limited amount of personal freedom allowed to nurses which no doubt accounted for difficulties in recruitment and retention of nurses.

1. There shall be a night nurse on duty in each infirmary from 10 pm until 8 am.
2. The three assistant nurses in each infirmary shall take night duty alternately for one week at a time.
3. An allowance of 2oz of tea and 1oz of coffee and 1lb of sugar per week be made to each nurse on night duty.
4. Each night nurse when off-duty shall rest in her bedroom for at least six consecutive hours.
5. The day nurses shall come on duty at 8 am in the summer and 8.30 am in the winter.
6. Nurses be allowed leave from the workhouse – one day each week from 2pm and also on every alternate Sunday. But no more than two nurses shall be absent from either male or female infirmary at any one time.
7. Nurses must report to the master and matron when taking leave and leave and return by the main workhouse gate.
8. The master and matron may grant special leave to stay out later than 10 pm or special leave under special circumstances in addition to the above leave.

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<sup>62</sup> *Return for each Workhouse, Infirmary and Sick Asylum in England and Wales of Number of Beds in Sick-Wards; Average Number of Sick, September to November 1891; Number of Paid Officers acting as Nurses*, LXVIII (1890-91), p. 12.

<sup>63</sup> Digby, *Making a Medical Living*, p. 246.

<sup>64</sup> Chapter 8 also discusses the problems that ensued with insufficient night nurses for the imbeciles and epileptics wards.

<sup>65</sup> *BMJ*, 21 Jul 1894, pp. 146-7. The journal suggested the death may have been caused by the ill treatment of the patient by a pauper wardsman while the nurse was in the other block.

9. Nurses expecting visitors should give previous notice to master so that visitors may not be kept waiting at the gate. No visitors can stay later than 10 pm.<sup>66</sup>

After five deaths occurred in the night in the winter of 1893, a guardian suggested that another night nurse should be appointed, but this suggestion was dismissed.<sup>67</sup> However, attitudes rapidly changed as the next year a night nurse was appointed,<sup>68</sup> and by 1898 it was proposed that two more probationer nurses would be employed specifically to assist the two night nurses as soon as the nurses' accommodation was completed. According to the LGB, the practice of placing nurses solely on night duty was unwise and had been discontinued in most poor law institutions. It recommended that night-nursing should be shared by nurses alternately for no more than four months at a time. The system at the Leicester union was for two nurses on permanent night duty with one probationer assisting for a month at a time.<sup>69</sup> The guardians felt that their experience of dividing night and day duty between the nursing staff had not been satisfactory and they preferred to continue with their system. On learning that the medical officer agreed with the guardians, the inspector decided that it was not necessary to press the point because of 'the ability and experience and attentiveness to duty that Dr Bryan ha[d] always shown'.<sup>70</sup> An infirmary inspection in December 1899 recorded that there were eight nurses, eight probationers and one night nurse. Two probationers spent a month at a time on night duty.

### **Experience and salaries**

Several nurses resigned in early 1894, leading one guardian to comment that this showed that they were not well paid. Nevertheless, the guardians took the opportunity to replace one nurse with a lower-paid probationer, despite her glowing testimonials from a surgeon, a vicar and an architect.<sup>71</sup> The guardians appointed her on £18 a year, although the nurse she was replacing had received £21. When a

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<sup>66</sup> LRO, G/12/8a/23, 2 Nov 1886.

<sup>67</sup> LRO, G/12/188/1, 25 Apr 1894.

<sup>68</sup> TNA, MH12/6505, 23 Dec 1895.

<sup>69</sup> TNA, MH12/6508 4 May 1898.

<sup>70</sup> *Ibid.*, 19 Jul 1898.

<sup>71</sup> LRO, G/12/57d/34, 17 Jan 1894.

second nurse was also appointed on £18, the LGB queried the reductions in salaries.<sup>72</sup> The guardians explained that the nurses had been paid on a progressive scale since 1890 and the starting salary for probationers was now £18, rising by £1 each year to £24.<sup>73</sup>

The majority of guardians complacently disagreed that the nurses were not well paid because there were always several applicants for any vacant posts.<sup>74</sup> This situation discouraged them from considering the benefits of retaining staff, quite apart from noticing whether the applications were made by suitable candidates. When the *BMJ* assessed some random advertisements for poor law nurses, it found that the ‘utmost licence’ was used in describing a nurse. It concluded that medical officers were not involved in the recruitment process which was conducted entirely by the guardians. The journal also noted the great diversity of salaries offered. The lowest salary was £16 per year and the highest £40. The journal believed it was obvious that by then nurses knew their value and that low salaries would only ‘catch failures or those who want to try out nursing.’ It felt that guardians should pay at least £25 to attract a nurse of good character with training and certificates and £30 if midwifery was also required.<sup>75</sup>

As Pickstone noted, by 1890, poor law infirmaries were judged by the nursing system, even more than the design of the building.<sup>76</sup> In 1894 the *BMJ* published a retrospective article on workhouse infirmary nursing in which it commented that although much had improved since 1865, many infirmaries were still unreformed. It concluded that the poor law system was at fault because any recommendations that were made were not enforceable and the old prejudice persisted that the trained nursing of sick paupers was an extravagance.<sup>77</sup> An interesting discussion took place among the Leicester guardians on a report by a committee of guardians that had been formed to consider the situation of the nurses and their salaries. The committee discovered from the national returns that nurses

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<sup>72</sup> *Ibid.*, 7 Nov 1894.

<sup>73</sup> LRO, G/12/57b/9, 5 Feb 1894.

<sup>74</sup> LRO, G/12/188/1, 23 Jan 1894.

<sup>75</sup> *BMJ*, 3 Nov 1894, pp. 1000-1.

<sup>76</sup> J.V. Pickstone, *Medicine and Industrial Society: A History of Hospital Development in Manchester and its Region, 1752-1946* (Manchester, 1985), p. 217.

<sup>77</sup> *BMJ*, 2 Jun 1894, p. 1197.



received higher salaries on a progressive scale in the majority of unions in comparison with the salaries paid by the Leicester union. The committee recommended that nurses with previous experience should be appointed on £22, rising by £2 annually, to a maximum of £26 and probationary nurses should receive £15 initially rising to a maximum of £22. Furthermore, probationers should wear a different uniform from the other nurses.<sup>78</sup> Following a lengthy discussion<sup>79</sup>, the guardians wrote to the LGB giving three reasons for revising the nurses' salaries:

1. The nurses are very much underpaid as compared with other unions of a similar size.
2. The nurses are constantly leaving to obtain more lucrative positions.
3. Paying higher salaries will induce them to stay for a longer period and by doing so there will be a more efficient staff of nurses.<sup>80</sup>

The guardians did not seem to consider that formal training and qualifications were necessary to prove a nurse's competence, and they clearly favoured experience over education. Moreover, they did not appear to seek the medical officer's opinion but felt themselves qualified to decide the matter. The Leicester guardians were not alone in their views. The *BMJ* commented that one of the great difficulties to introducing systematic nursing into workhouse infirmaries was that 'few guardians seem to understand or appreciate the fact that technical skill is required.'<sup>81</sup> However, by 1897 an advert for a day nurse in the workhouse infirmary stated that candidates must have had at least one year's experience in nursing in some workhouse infirmary. The salary offered was £23 per annum to increase to a maximum of £26. This included lodgings, washing, rations and uniform which were valued at £32 per annum, although deductions would be made under the Poor Law Officers' Superannuation Act, 1896. Applications were invited from single persons or widows without 'encumbrances', even though, as shown above, married women had previously been appointed.<sup>82</sup>

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<sup>78</sup> LRO, G/12/57d/34, 13 Apr 1894.

<sup>79</sup> LRO, G/12/188/1, 25 Apr 1894.

<sup>80</sup> LRO, G/12/57b/9, 24 Apr 1894.

<sup>81</sup> *BMJ*, 10 Mar 1894, p. 537.

<sup>82</sup> LRO, G/12/57d/37, 8 Apr 1897.

An 1896 LGB return stated that of the nine nurses at the Leicester workhouse, eight had previous training. The average period in office was 2 years 9 months. Nevertheless the workhouse infirmary received another adverse report in 1897 that pointed out that there were still too few nurses and the nursing was inefficient. The charge nurses had only received a year's training as probationers, although the inspector recommended that it was desirable that charge nurses should have three years training before being appointed.<sup>83</sup>

The titles given to nurses were often misleading. Some untrained appointees were called 'Nurse' or 'Assistant Nurse' rather than 'Probationer Nurse.' In a circular of 1897, the LGB stipulated that a superintendent nurse should be employed where there were three or more nurses or assistant nurses.<sup>84</sup> The Leicester workhouse had employed a superintendent nurse since 1881 who was under the medical direction of the medical officer but, like the other workhouse staff, she was under the administrative control of the workhouse master and matron who were not medically qualified. In separate workhouse infirmaries the matron had to be a trained nurse and had control over the nursing staff. The superintendent nurse was required to have spent three years at a training school for nurses, although if there were three nurses on the staff, one could be promoted if she fulfilled the training criterion. Training was permitted only where there was a superintendent nurse and a resident medical officer. Training requirements seem to have been loosely interpreted. The Leicester infirmary was not strictly separate from the workhouse, nor was the medical officer resident. It was only later that the North Evington infirmary was recognised by the LGB as a training institution for nurses. Meanwhile, the nurses were trained simply by working and picking up knowledge and experience along the way rather than by a structured training scheme. The LGB stressed that nurses were required to be experienced in the treatment of the sick, but it was additionally important they were of a respectable character with diligent and decorous habits.<sup>85</sup> Similarly, the training of Nightingale nurses also favoured caring skills acquired by example and experience over specialist knowledge.<sup>86</sup>

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<sup>83</sup> *Ibid.*, 29 Oct 1897.

<sup>84</sup> LGB, 6 Aug 1897, *General Order, Nursing of the Sick in Workhouses*.

<sup>85</sup> LRO, G/12/57d/35, 29 Jan 1895. LGB standard letter on workhouse administration.

<sup>86</sup> M. Rhodes, 'Women in medicine: Doctors and Nurses, 1850-1920' in Brunton, *Medicine Transformed*, p. 169.

Despite the increased numbers of nurses, problems still arose from the use of pauper assistants. When the LGB requested Dr Bryan to report on alleged mistreatment of patients by wardsmen in 1897, he informed the guardians that he had received new orders from the LGB with a request to certify the fitness of any pauper to perform the duties pertaining to that of wardsmen or woman. Dr Bryan declared that it was impossible for him to certify that the paupers were fit for any other work in the infirmary except for scrubbing, cleaning and taking messages. He emphasised that instead it was absolutely necessary that more nurses should be appointed to cope with the large increase in the numbers of sick paupers. He suggested that there should be one charge nurse and two probationers for each fifty beds and that there should be two probationer night nurses.<sup>87</sup> The guardians questioned Dr Bryan and he reiterated that he could not 'conscientiously' certify the fitness of paupers to attend the sick 'in the manner they do now.' He stated that he received constant complaints of their rough treatment of the patients and gave instances such as a boy sick with typhoid being hit on the head by a wardsmen and an old man with a 'fearful bruise and cut on the head by a wardsmen.' He also felt it was not 'fit and proper for the young nurses to be helped by wardsmen while washing the male patients' although he did not explain his objections. The nurses apparently needed assistance to lift the helpless male patients to wash them and had to use inmates as there were insufficient nurses. Dr Bryan stressed that 'the character of the sick is now greatly changed from what it was as we have many more acute cases to treat than formerly, which require much greater care.' He also protested against the wardsmen being allowed to attend the typhoid patients as he complained that 'when the patients cry out with hunger, they frequently feed them regardless of consequences.'<sup>88</sup>

This correspondence evidently had an effect upon the guardians as Dr Bryan reported in October 1898 that the wardsmen's work had 'nearly been done away with.'<sup>89</sup> An inspection in 1899 confirmed that no inmates then helped in the infirmary.<sup>90</sup> The guardians had instead appointed an additional charge nurse and two more probationers and had authorised the master to engage extra help when

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<sup>87</sup> TNA, MH12/6508, 13 Dec 1897.

<sup>88</sup> TNA, MH12/6508, 15 Jan 1898.

<sup>89</sup> *Ibid.*, 28 Oct 1898.

<sup>90</sup> TNA, MH12/6510, 14 Dec 1899.

‘pressure of cases’ required it.<sup>91</sup> Additional accommodation for the nurses was built at the workhouse during 1898 to enable more nurses and probationers to be employed. By May 1898 the nursing staff consisted of one superintendent nurse, nine nurses and three probationer nurses.

### **Probationer nurses**

Probationers were often young or were women who wanted to try nursing and gain experience but found it difficult to obtain posts in a voluntary hospital.<sup>92</sup> In 1900 three probationer appointments were approved by the LGB. Two of the probationers were aged 20 and 19 causing the LGB to remind the guardians that it was ‘undesirable’ that people younger than 21 should be appointed as probationers.<sup>93</sup> During 1901 a total of eight nurses were appointed to fill vacancies, several of whom were probationers. Only two had formerly been appointed as poor law nurses. Table 5.1 shows the previous occupations of some probationers appointed in 1901 and the reasons given on their application forms as to why they wanted to become nurses. None had prior experience of workhouse nursing.

**Table 5.1**

#### **Nursing applicants**<sup>94</sup>

<b>Name</b>	<b>Age</b>	<b>Previous post</b>	<b>Reason for application</b>
Mary Ann March	34	Father’s housekeeper	Desire to take up nursing
Julia Ann Greeley	24	Housemaid	Wants change
Eva Annie Langton	28	Waitress	No reason given
Martha Ellen Garner	25	Shop assistant	Desire to become a nurse
Ada Marriott	33	Hosiery mender	Because I take an interest in the poor
Winifred Anderson	22	Children’s nurse	To have training and better myself

<sup>91</sup> LRO, G/12/57b/10, 18 Jan 1898.

<sup>92</sup> Crowther, *Workhouse System*, p. 177, pointed out that although the workhouse training was not as thorough as in the voluntary hospitals, working-class girls had lower expectations and took these posts in preference to domestic service.

<sup>93</sup> LRO, G/12/57d/40, 13 Aug 1900. The LGB believed nursing was too heavy a labour for adolescent girls. Crowther, *Workhouse System*, p. 177

<sup>94</sup> LRO, G/12/57d/41, 22 Feb, 26 Mar, 30 Mar, 6 Jun, 16 Oct, 16 Nov, 1901; 1 Jan 1902.

The lack of experienced nurses and frequent changes of personnel no doubt had a detrimental effect on the quality of nursing the patients experienced, but because there were always applicants for posts, there was little reason for the LGB and the guardians to radically improve conditions both for patients and staff.

### **Nursing lectures**

By the beginning of the twentieth century lectures on medical nursing, bandaging, midwifery and ‘antiseptic measures of surgical work.’ were given to the nurses by the medical officer’s deputy, his son Dr Douglas Bryan. He was only allowed to give lectures; practical instruction had to be provided by his father.<sup>95</sup> Problems soon resulted in the lectures being suspended and a flurry of letters was exchanged between Dr Bryan and the guardians which were reported in a local newspaper. The intention of the lectures was evidently interpreted somewhat differently by the guardians and the medical officer and nurses. The guardians ruled that lectures were to be provided purely for ‘the efficient attention to the inmates’ and only allowed one charge nurse to take practical instruction in midwifery. Dr Bryan considered that this was unsatisfactory and that the lectures should permit all nurses to gain a certificate which would enable them to apply for posts as charge nurses at the impending new workhouse infirmary. He pointed out that under the existing training system, nurses who left the workhouse were not qualified to obtain posts elsewhere except as probationers. Furthermore, he felt that working for a certificate would help to retain nurses. He also thought that fortnightly lectures were insufficient. For nurses who wished to gain a London Obstetrical Society Certificate, lectures needed to be attended regularly and to include midwifery taught by a medical man or nurse who held a certificate and a position recognised by that society. He suggested that lectures on general nursing be held for two hours a week with practical instruction demonstrated on the ward, ‘when dressings are being

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<sup>95</sup> LRO, G/12/8a37, 24 Feb 1903. Rhodes, ‘Women in medicine’, p. 172, has noted that by the end of the nineteenth century, nurse education began to incorporate more theoretical and medical training designed by doctors.

done.’<sup>96</sup> It was probably no coincidence that a few days later Nurse Roberts resigned her midwifery duties citing as her reason the changes in arrangements for the nursing of maternity cases. As she was unqualified she was ineligible to teach the nurses, although she was allowed to act as midwifery nurse; consequently she may have felt undermined. Dr Bryan noted that she and three other nurses had been jealous when one nurse gained an LOS certificate. A certificated midwifery nurse was soon appointed in her place.<sup>97</sup>

To support his views, Dr Bryan sent the LGB a copy of an unsigned letter from thirteen nurses who wished to gain experience and nursing qualifications including midwifery and who currently felt excluded. The nurses were at pains to stress that they were grateful for the lectures, which they felt had enabled them to go about their work ‘with greater interest and confidence.’<sup>98</sup> Nevertheless, they wished to have the opportunity to work for a certificate. The guardians naturally wanted to know which nurses had signed the letter. Dr Bryan was reluctant to give their names, as he had intimated that they were going to resign if matters did not change, but he later relented.

The problem lay not only with the desire of the nurses and Dr Bryan to enhance their training with midwifery instruction, but also with the guardians, who were apprehensive that the lecturers might adversely influence the nurses regarding their duties or management. The guardians made clear that they were more interested in maintaining the efficient management of the workhouse than retaining or encouraging nurses to qualify and advance in their profession, in a dismissive remark scrawled in the margin of a letter - ‘Qualification of midwifery nursing will not be required at the workhouse infirmary.’ They further stated that, ‘It must be understood that lecturing does not establish any official position in the house or infirmary nor convey any right to interfere in the arrangement of the house or

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<sup>96</sup> LRO, G/12/95, 5 Jan 1903.

<sup>97</sup> *Ibid.*, 12 Jan 1903. Nurse Roberts requested that the £10 she received as a midwife should be added to her salary as superintendent nurse as her duties had ‘greatly increased’ since her appointment in 1887. In fact her salary was subsequently increased to £50 while the new midwife received £30 a year. LRO, G/12/57d/43, 11 Mar 1903.

<sup>98</sup> LRO, G/12/95, 20 Jan 1903. Dr Bryan stated that they had shown their appreciation of his son’s lectures by presenting him with a handsome silver card case and cigar and tobacco stand.

infirmiry.<sup>99</sup> Tensions increased between the lay managers, the experienced medical officer and the nascent nursing professionals when the guardians ruled that lectures could be attended by any lady guardians who wanted to observe. Dr Bryan resented their attitude and interference in medical matters and insisted that it was not the custom for anyone outside the medical profession to attend a lecture given to nurses in institutions.<sup>100</sup>

### **The new infirmary**

In 1905 Nurse Roberts resigned.<sup>101</sup> The guardians decided not to replace her as the new infirmary was soon to be completed. The workhouse patients would be transferred there and new medical officers and nurses were to be appointed. In the interim the workhouse matron was given temporary control of the infirmary. Despite her lack of nursing qualifications or experience, the LGB agreed to her taking over the responsibility, for which she received a gratuity of £50.<sup>102</sup> When the new infirmary opened, some patients remained at the workhouse, notably the itch and venereal cases and initially the imbeciles and epileptics.<sup>103</sup> Dr Bryan continued his post there and two new charge nurses and probationers were appointed to carry out any nursing required at the workhouse.<sup>104</sup> Another probationer was retained at the workhouse as an ambulance attendant to accompany patients who were transferred between infirmaries.<sup>105</sup> The master was permitted to engage temporary nurses if necessary until the patients were removed and some new nurses were appointed for later transferral to the new infirmary. In contrast to the workhouse, nurses at the new infirmary were under the management of the trained hospital

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<sup>99</sup> LRO, G/12/95, 23 Feb 1903.

<sup>100</sup> *Ibid.*, 5 Jan 1903.

<sup>101</sup> LRO, G/12/57d/52, 3 Oct 1912, showed that Margaret Roberts retired at the age of 56 and received an annual superannuation allowance of £57 from 5 Jan 1905. Her total period of service was 33 years. The allowance was calculated on the value of an average annual salary and emoluments of £103 12s and was awarded on the grounds that she had 'permanent infirmity of body'.

<sup>102</sup> LRO, G/12/57b/12, 12 Jan, 25 Jan, 1905; 4 Mar 1906.

<sup>103</sup> LRO, G12/8a/40, 6 & 20 Mar 1906. Attendants were used for the itch and VD cases, until nurses were appointed following the LGB's recommendation.

<sup>104</sup> LRO, G/12/57d/45, 10 Apr, 17 May, 10 Jul 1905.

<sup>105</sup> LRO, G/12/8a/40, 17 Oct 1905.

matron, thus moving away from the control of the workhouse matron who represented the old order.<sup>106</sup>

## Summary

This chapter has shown that improvements were made to the nursing of paupers during this period. Pauper nurses were no longer used, numbers of nurses increased and training and experience were becoming recognised as essential. However, the turnover of nurses remained high, indicating that conditions were unsatisfactory for nurses and retention was unimportant to the guardians. Nevertheless, Dr Bryan endeavoured to improve working conditions for the nurses. Both he and some of the later nurses showed more progressive expectations of the role of nursing, training and patient care than the guardians and they were prepared to act together in their professional interests against the guardians, thereby challenging the guardians' power and authority. However, until nursing was taken out of the workhouse into the hospital and came under the auspices of medical professionals, nurses continued to be supervised by lay authorities in an incongruous environment that benefited neither them nor their patients. Chapter 9 will show some of the changes that were made to workhouse nursing in the new hospital environment of the North Evington Infirmary.

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<sup>106</sup> White, *Social Change*, pp. 88-9.



## **Chapter 6**

### **The conditions and treatment of workhouse patients**

#### **Introduction**

Workhouse sick wards were originally intended for able-bodied inmates who became ill. Yet increasingly the destitute sick were admitted to the workhouse if there was no one to look after them or their homes were unsuitable for their recovery and outdoor relief was inadequate.<sup>1</sup> Admitting sick paupers to a workhouse was also more convenient and economical both for the district medical and relieving officers.<sup>2</sup> This chapter presents a wide-ranging assessment of the medical treatment of the workhouse patients and the conditions they experienced. The first section focuses on the infirmary accommodation and patients' living conditions because the physical environment and daily life are important features that exemplify the way patients were treated. The second section explores the treatment of disabled, aged and venereal patients and provides examples of patients' complaints about their treatment. This section also discusses the numbers and causes of deaths in the workhouse, including suicides, and describes supplementary medical services that were provided for patients.

#### **Infirmary accommodation and living conditions**

Anxious to avoid increasing financial demands on the ratepayers, guardians were reluctant to provide sufficiently for the daily medical care of the sick in the workhouse, or to spend money on suitable buildings and equipment. Wherever possible old buildings were used for infirmaries; if unavoidable, spending on new buildings was kept to an absolute minimum.<sup>3</sup> This was true of the many additions and alterations made to the Leicester workhouse during the period studied as the

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<sup>1</sup> Hodgkinson, *Origins*, p. 451

<sup>2</sup> Abel-Smith, *The Hospitals*, p. 48.

<sup>3</sup> Flinn, 'Medical Services', p. 55.

guardians attempted to cope with rising numbers, changing needs and different types of patients.<sup>4</sup>

An official PLB circular of 1868 attempted to standardise accommodation. It recommended that the sick should occupy a separate building. In larger workhouses both sexes should be divided into the ordinary sick, lying-in women, itch, dirty, offensive and venereal cases, fever and smallpox cases, and children.<sup>5</sup> Dr Smith's report on provincial workhouses in 1867 showed that Leicester's partly complied with these recommendations. There was a separate infirmary for both sexes, and an unattached building for fever and smallpox cases. There were also individual wards for itch, incontinent cases and female venereal patients. Lying-in women were placed in the infirmary and there were two large lunacy wards in the main workhouse.<sup>6</sup> The infirmary, although described as 'separate', was actually very close to the workhouse. The infirmary site was described by an LGB architect as being of 'considerable elevation', directly 'overlooking the engine sheds and sidings of the railway'.<sup>7</sup>

In 1866 a PLB inspector had considered the provision for the sick and infectious at Leicester workhouse to be 'sufficient'.<sup>8</sup> However, the infirmary's poor ventilation was persistently criticised.<sup>9</sup> Wards were constructed side-by-side with external windows on one side only; consequently little fresh air circulated throughout the wards.<sup>10</sup> The building was heated by hot air flues fired by furnaces underneath the ground floor. Brick floors contributed greatly to the cold conditions. In 1873 the medical officer recommended board flooring for the smallpox and fever wards which were being erected in the male infirmary. He considered it to be superior for 'comfort, warmth and appearance', but also it could be 'efficiently and

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<sup>4</sup> This refers to the 1851 workhouse, for a discussion of the earlier workhouse see Thompson, 'The Building of the Leicester Union Workhouse' in Williams, (ed.), *Adaptation of Change*.

<sup>5</sup> PLB 21<sup>st</sup> Annual Report (1869), pp. 47-8

<sup>6</sup> TNA, MH32/67, 15 Apr 1867.

<sup>7</sup> LRO, G/12/57d/19, 8 Aug 1879.

<sup>8</sup> TNA, MH32/67, 6 Jul 1866.

<sup>9</sup> The contemporary belief was that disease was caused by miasma. i.e. foul air caused by poisonous vapours from stagnant water or sewage.

<sup>10</sup> TNA, MH32/67, 15 Apr 1867. H. Richardson, (ed.), *English Hospitals, 1660-1948: A Survey of their Architecture and Design* (Swindon, 1998), p. 60, noted that the recommendations that wards should have opposing windows made by Samuel Kempthorne, a workhouse designer, were almost universally ignored.

thoroughly disinfected and cleaned.’ Conversely, he thought the itch ward flooring was not of any consequence to ‘matter much which is chosen for it.’<sup>11</sup> This was a surprising comment considering that itch was a contagious skin infection, transmitted particularly in crowded and unhygienic places and obviously required efficient disinfection. Contemporary attitudes towards ‘itch’ mirrored those towards venereal disease.

In 1871 Dr Smith recommended that the infirmary accommodation should be improved, particularly for smallpox cases. He thought it was pointless to enlarge the existing infirmary as the guardians intended, as it had originally been built on a ‘defective plan’ on a restricted site. He suggested that the Midland Railway Company might buy the land for £6,000-£8,000. A new infirmary could then be built with the profit. He recommended that detached wards should be provided in any new building for infectious and fever cases with separate itch and venereal wards to keep those patients apart from the general sick.<sup>12</sup> Dr Smith had previously called for the isolation of venereal paupers, ‘not so much for the treatment of their disease, as for the separation of persons who carry evidences of profligacy with them, and who are unfit to mix with ordinary cases’.<sup>13</sup> Overcrowding in workhouse infirmaries made it impossible to maintain segregation as was evident at Leicester. Dr Clarke repeatedly mentioned this problem. In 1872 he declared there was a pressing need for additional wards as the female venereal ward had practically become abolished, which had forced him to put those cases in the same ward with the ‘offensive general cases’ as there was no other ward at his disposal.<sup>14</sup> His remarks confirm the contemporary attitude that female venereal cases were identified as carrying an offensive, dirty disease which should be segregated from ‘ordinary’ cases of sickness.

The guardians accordingly attempted to sell the infirmary land to the railway company who offered £4,000 for the land and buildings. This offer was declined as

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<sup>11</sup> LRO, G/12/94, 1 Dec 1873. It seems Dr Clarke’s remarks were not applied to the brick flooring of the imbecile wards. These were regularly criticised by the VCL as a danger to epileptics.

<sup>12</sup> TNA, MH32/67, 21 Apr 1871.

<sup>13</sup> *Report of Doctor E. Smith on Forty-eight Provincial Workhouses in England and Wales*, LX (1867-8), p. 7.

<sup>14</sup> LRO, G/12/94, 16 Nov 1872.

they had hoped to get £10,000.<sup>15</sup> Instead they decided to extend the infirmary. Protracted negotiations took place between the central authority and the guardians. The new borough fever hospital had recently opened and the guardians assumed that smallpox patients could in future be sent there; consequently the two existing ten-bed fever rooms could be used to accommodate other sick cases. The LGB disagreed and ruled that separate fever accommodation should still be provided.

The guardians seemed uncertain of the requirements for workhouse infirmaries as they requested copies of the circular on workhouse construction.<sup>16</sup> But they either paid the stipulations little regard or were determined to follow their own ideas as the LGB architect was highly critical of their plans which he stated were not in accordance with instructions and were ‘on every point at variance with the Board’s usual requirements.’<sup>17</sup> He particularly criticised the inadequate proposals for ventilation and declared that the plans were ‘thoroughly opposed to modern sanitary principles’, and urged that a new infirmary be built.<sup>18</sup> Undeterred, the guardians requested approval for the proposed alterations at an estimated cost of £1,000. Unsurprisingly, the LGB refused. Subsequent proposals were still inadequate, leading the architect to conclude that the guardians had ignored his suggestions and were solely ‘governed with a desire to preserve uniformity with the adjoining old building.’<sup>19</sup> He was adamant that the same rule should be applied at Leicester that had been ‘enforced’ on many other unions, that ‘all new sick wards must have external windows on their opposite sides.’<sup>20</sup> After lengthy negotiations, approval was finally given for the alterations to be undertaken.<sup>21</sup>

The guardians claimed that Dr Clarke approved of the plans, although he later stated that the alterations would still not provide sufficient accommodation for female patients.<sup>22</sup> He complained that the lack of space resulted in general sick and incontinent cases being put into wards intended for infectious patients who then had

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<sup>15</sup> LRO, G/12/8a/14, 17 Oct 1871. They also expected the company to build a wall and erect a seven foot high fence.

<sup>16</sup> LRO, G/12/57b/5, 29 Nov 1871.

<sup>17</sup> TNA, MH12/6484, Architect’s notes, 1871-72.

<sup>18</sup> *Ibid.*

<sup>19</sup> *Ibid.*

<sup>20</sup> *Ibid.*, 5 Jul 1872.

<sup>21</sup> *Ibid.*, 26 Sep 1872.

<sup>22</sup> LRO, G/12/94, 16 Nov 1872.

to be put into other wards. Suspicious cases that required isolation until a positive diagnosis was made were placed in a ward close to the entrances to two other wards. The infectious ward only contained two beds which were plainly insufficient. Patients were regularly transferred between wards to try to manage situations as they arose. On one occasion, for instance, two female smallpox patients were put into the male infectious ward. Dr Clarke suggested that the solution was to build yet another storey over the new wards, or to provide accommodation for infectious cases elsewhere in the infirmary grounds. He felt certain that these problems would continue, particularly if there was a bad winter as the number of 'chronic, permanent and bedridden female cases' which occupied 'a bed for months or years had doubled over the past four years leaving little accommodation for acute cases.' He warned that the continuous increase of chronic cases would outgrow the extra accommodation and he recommended that there should be separate wards where the 'dirty' cases of each sex could be put by themselves.<sup>23</sup>

Despite his reservations, Dr Clarke congratulated the guardians on the new infirmary wing and on the 'excellent' new wards that provided greater width, length, light and ventilation.<sup>24</sup> Nevertheless, by early 1875 he reported that the female accommodation was insufficient. Patients who were 'scarcely fit' had to be discharged to make room for others who were more 'urgently ill'. All the female wards were occupied with beds so close together that there was little air space. Furthermore, all the wards opened out onto a common vestibule which, he remarked, was bad for the sick and 'likely to engender disease at special seasons' especially when such a large number of bad or dirty cases were admitted. In Dr Clarke's opinion it was high time that the lying-in wards were 'quite disconnected' from the general sick wards. He believed that the current erysipelas outbreak had shown how essential it was to separate the lying-in wards from the main infirmary as four women had died of puerperal fever in the past four months. He pleaded for

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<sup>23</sup> *Ibid.*, 29 Jul 1872. He explained that by 'dirty' he meant cases that through 'increasing age, infirmity or imbecility, the control over the bowels and bladder is lost, hence they smell very offensively and are intolerable to others. He clearly wanted to make the guardians aware of the situation by being explicit but, perhaps mindful of his position, he added an apology for providing so much detail. Dr Clarke had earlier recommended the purchase of carbolic soap which he recorded could 'now be purchased in bars'. He believed this would be of 'great value for disinfecting and deodorising' the 'many dirty cases that were admitted and 'retained so long in the wards.'

<sup>24</sup> LRO, G/12/94, 30 Mar, 1874.

immediate relief from the 'constant harass and anxiety' experienced by the management.<sup>25</sup>

No action was taken and two years later Dr Clarke repeated his complaints.<sup>26</sup> An inspection report declared that the infirmary had been built with 'no regular plan.' Damning descriptions were provided of wards with water closets opening directly into them; venereal and itch wards that were not properly separated without any suitable means of examining patients. The female itch ward was described as 'unfit for human habitation.' Fever cases were only separated from the building by a party wall; upper bathrooms were used as lumber rooms; ventilation everywhere was defective; there were no dayrooms for convalescents; and only confined yards for exercise. The infirmary laundry was insufficient and inadequate laundry arrangements for the lying-in wards resulted in 'the washed clothing of puerperal women [being] hung to dry on the staircase.'<sup>27</sup>

Eventually the guardians proposed further alterations that would cost £650. For the past three years the infirmary had been full, particularly during the winter, and they realised the need to provide more room before the winter. The LGB architect discovered that the guardians did not possess any plans of the workhouse, or a list of wards with their dimensions, which he stated made it difficult for him 'to arrive at any definite conclusions upon the capabilities of the buildings.'<sup>28</sup> However, his opinion of the infirmary was scathing. For example, there were no dayrooms as all wards contained far more beds than recommended, and there was no kitchen, scullery or store room in the infirmary. The female itch ward, which measured 12' by 14, contained two beds that were occupied by two women and eight children. Furthermore, he observed that, given its scale, the infirmary should hold about 150 patients or 130 if some of the ground floor rooms were used as dayrooms instead of dormitories. When he visited in the summer there were 153 patients (63 men and 90 females) but at Christmas 1878 there had been 171 patients. He felt that it was inexpedient to spend more money on the present infirmary and

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<sup>25</sup> *Ibid.*, 1 Feb 1875.

<sup>26</sup> *Ibid.*, 20 Oct 1877.

<sup>27</sup> TNA, MH12/6489, 18 Feb 1878.

<sup>28</sup> LRO, G/12/57d/19, 8 Aug 1879.

that arrangements should be made for a new workhouse infirmary.<sup>29</sup> Similar complaints about overcrowding were made by Dr Clarke and by an LGB inspector.<sup>30</sup> As a consequence many alterations and temporary measures were put in place to try to improve the accommodation and alleviate the overcrowding.

The pressure on accommodation eased slightly when the children were removed from the workhouse in November 1884.<sup>31</sup> Initially the guardians reacted unfavourably to the LGB's suggestion that the vacated workhouse school could be converted to an infirmary. They referred to an inspector's disparaging report, stating that if the school was 'unfit for purpose [it] would hardly be suitable for the reception of the sick.'<sup>32</sup> The inspector retorted that there was 'no analogy whatever between the classes.'<sup>33</sup> The guardians later conceded that with some alterations the school would make a good infirmary.<sup>34</sup> Predictably, the guardians accepted the lowest tender of £6,119 for the conversion,<sup>35</sup> which took some considerable time because extensive structural alterations were necessary.<sup>36</sup> By June 1886 the new infirmary was occupied.<sup>37</sup>

The numbers in need of poor relief should have decreased when Leicester prospered in the 1890s but, as the population increased the absolute numbers of poor who were in need of the union medical services grew.<sup>38</sup> This strained the accommodation even further and the guardians were once more urged to provide better accommodation for infectious cases. In 1895 plans for further infirmary alterations received approval.<sup>39</sup> By then, plans of the workhouse had evidently been drawn up. A plan of the workhouse in 1894 (Figure 2), shows that the female infirmary occupied the former workhouse school and the male infirmary was on the other side of the workhouse, near to the railway line. At that time, the guardians also proposed to purchase land at North Evington on which to build further

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<sup>29</sup> *Ibid.*

<sup>30</sup> TNA, MH12/6490, 13 Jan 1880.

<sup>31</sup> Chapter 7 discusses the removal of the children.

<sup>32</sup> LRO, G/12/57b/6, 9 Mar 1881.

<sup>33</sup> TNA, MH12/6490, 3 Mar 1881.

<sup>34</sup> LRO, G/12/57b/6, 14 Jul 1881.

<sup>35</sup> *Ibid.*, 1 Apr 1885.

<sup>36</sup> *Ibid.*, 16 May 1882.

<sup>37</sup> LRO, G/12/8a/23, 22 Jun 1886.

<sup>38</sup> Rimmington, 'Treatment of the Sick Poor in Leicester', p. 93.

<sup>39</sup> LRO, G/12/57d/35, 27 Jul 1895.

workhouse accommodation.<sup>40</sup> They later decided it should be used for a new workhouse infirmary, but several years elapsed before the scheme came to fruition. In the meantime the overcrowding worsened and in 1897 an inspector recommended that the maximum number of workhouse inmates should be fixed at 1,078.<sup>41</sup> The altered infirmary contained one lying-in ward, thirteen wards for females and fourteen wards for males.<sup>42</sup> But serious defects were reported, for example, there were no slop sinks in the wards, floors were unpolished, bedsteads were too narrow and laundering was 'imperfect'.<sup>43</sup> The lock and itch wards were again described as 'inappropriate for any class of disease.' The day nursery was 'not as satisfactory or suitable as could be desired or expected in such an important union as Leicester.' The report noted that all these points had been brought to the medical officer's attention.<sup>44</sup> As he was supposed to regularly report defects to the guardians, criticism of him seems implicit. However, the guardians often either refused to remedy defects or were slow to act. On this occasion, they only partly complied with the recommendations. They agreed to fix slop sinks but only when they became worn out. The floor of the typhoid fever ward would be polished but not the other floors. They produced excuses for the defective laundry arrangements but claimed they would provide more modern machinery. They were not prepared to make any alterations to the itch wards but they maintained that the lying-in wards were under consideration.<sup>45</sup>

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<sup>40</sup> *Ibid.*, 14 Oct 1895.

<sup>41</sup> The maximum number was often exceeded, for example, the return for 1 Jan 1898 showed the total number of all classes in the workhouse to be 1,310, LRO, 12/57d/38.

<sup>42</sup> LRO, G/12/57d/37, 16 Aug 1897.

<sup>43</sup> LRO, G/12/57d/37, 2 Nov 1897.

<sup>44</sup> *Ibid.*

<sup>45</sup> LRO, G/12/57b/10, 18 Jan 1898.





Figure 2 Plan of the workhouse, 1894.  
 © Record Office for Leicestershire, Leicester and Rutland

A *BMJ* survey of fifty provincial workhouse infirmaries published the following year concluded that, apart from four infirmaries that were of the same standard as voluntary hospitals, the accommodation of the remainder were generally 'inadequate' or 'bad'. Most of the workhouse infirmaries inspected were in a dreadful state and provided a woeful medical service. Only 24 had a separate infirmary building; 17 had no fixed baths; 12 had no water laid on; 5 had cold water only and 15 had no isolation wards.<sup>46</sup> It is probable that Leicester's workhouse infirmary would have been considered more favourably in comparison with those infirmaries. Nevertheless, Leicester's infirmary had many defects and conditions were hardly appropriate for sick patients.

The discomfort the patients experienced from overcrowding was matched by the basic facilities. Iron bedsteads were provided but patients slept on straw mattresses. There was no privacy although the medical officer suggested that screens should be procured to put around the bed when an inmate was in a 'dying state'.<sup>47</sup> One round towel was supplied twice a week to each ward and each had just two combs.<sup>48</sup> *The Lancet* report in 1866 on the appalling conditions of metropolitan workhouse infirmaries was highly critical of a workhouse infirmary where the eight inmates of a female syphilitic ward had one towel a week instead of the usual practice for an ordinary ward of two or three towels which were changed twice a week.<sup>49</sup> Yet it appears that the Leicester union did not adhere to this 'usual' practice by the plainly unhygienic supply of one towel between several sick patients.<sup>50</sup>

The patients' surroundings were uncomfortable, dull and cheerless. They lacked prints, games, pottery wash-hand basins or even plates in the early days

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<sup>46</sup> *BMJ*, 26 Sep 1896. Unfortunately, Leicester was not included in the survey.

<sup>47</sup> LRO, G/12/94, 15 Nov 1880.

<sup>48</sup> TNA, MH32/67, 15 Apr 1867.

<sup>49</sup> *The Lancet*, 'Sanitary Commission for Investigating the State of the Infirmaries of Workhouses', cited in Abel-Smith, *The Hospitals*, pp. 60-65.

<sup>50</sup> *The Lancet*, 26 Oct 1901, p. 1138. Later comments by *The Lancet* indicate that possibly this practice was not so 'usual' after all. In 1901 the journal reported on a suggestion by an inspector of Hendon workhouse, that each workhouse child should be supplied with a separate towel, toothbrush, hairbrush and comb. Rather than pampering pauper children, the journal thought it would be a sensible innovation to prevent the typical spreading of disease from the common use of such items. It wryly remarked that the children themselves might regard such provision as 'irksome additions to the disciplines which rule their lives'.

when the patients ate from deep square tin cans.<sup>51</sup> Dr Clarke tried to make improvements by suggesting that a few flowers or plants in the female ward would have a 'pleasing effect alike on patients and visitors'. He thought there would be willing donations 'were the desirability made known',<sup>52</sup> as gifts were occasionally given for the sick paupers, such as a grapes for the use of the sick in the infirmary, 'by whom they were greatly appreciated', the master reported.<sup>53</sup> Similarly, twenty copies of a work entitled *Kind Words* were offered 'for the amusement of the children in the infirmary'.<sup>54</sup>

As for the food patients were given, the workhouse dietary was prescribed by the central authority with the intention that inmates should receive adequate but plain food. Unions were sent standardized dietary tables that specified the diet for the able-bodied; the aged, infirm and imbeciles and for children aged 2- 5, 5 -9 and 9-16, and set out the amount of food each class and gender should receive on prescribed days. The medical officer directed the appropriate class of diet for all inmates. The sick and infirm received slightly more meat and milk than able-bodied inmates and sometimes medical extras in the form of food, as discussed in Chapter 4. The monotonous diet was a frequent cause of complaint by inmates and food was often wasted because of its poor quality and cooking.<sup>55</sup>

In 1884, as an experiment, a fish dinner was given to the inmates once a fortnight for six months. Dr Bryan did not notice any appreciable change in the inmates' health, but he thought that the older inmates benefited from it.<sup>56</sup> They probably found it easier to chew and digest than the tough meat they were usually

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<sup>51</sup> TNA, MH32/67, 15 Apr 1867. It is unknown whether the Leicester union paupers were generally provided with cutlery but *The Lancet* made scathing comments on the decision of the Chester guardians to hire knives and forks for its paupers to eat their Christmas dinner. Its general rule was not to permit the paupers to have knives and forks which led the journal to remark that 'though destitute the pauper is something more than a carnivorous animal that tears and devours meat and he should be able to eat like other men.' *The Lancet*, 14 Dec 1889, p. 1242. By 1881 Leicester union provided earthenware instead of tins, MH12/6491, 20 Jan 1881.

<sup>52</sup> LRO, G/12/94, Medical Officer's Annual Report, 1873.

<sup>53</sup> LRO, G/12/8a/14, 15 Oct 1872.

<sup>54</sup> *Ibid.*, 26 Sep 1871. Crowther, *Workhouse System*, p. 206, noted that workhouse children received a steady diet of books for moral improvement.

<sup>55</sup> Crowther, *Workhouse System*, pp. 215-218 discusses the quality and possible adulteration of food supplied to workhouses as well as nutritional factors.

<sup>56</sup> LRO, G/12/57b/6, 3 Nov 1884.

given.<sup>57</sup> The elderly could not masticate the pea soup and salt puddings; quite apart from the inedibility of much of the food they were given.<sup>58</sup> Dr Bryan reported that the few able-bodied men and women in the workhouse liked the change and still had enough energy to work. The LGB doctor was sceptical that sufficient quantities of fish would be provided as he believed the workhouse diet was at best only at subsistence levels.<sup>59</sup> The fish dinners continued except during the summer when Dr Bryan authorised the master to discontinue them, presumably fish either became more expensive or went ‘off’ in the heat.<sup>60</sup> In 1901 Dr Bryan welcomed the LGB’s decision that milk, cocoa or milk gruel should be provided at 7.30 p.m., as he felt that the provision of a greater variety of food would particularly benefit the sick, and would ‘meet a long-felt want, as the time from supper to breakfast is too long without food and the patients will no doubt be able to sleep better for this addition.’<sup>61</sup> This small adjustment indicates that slightly more consideration was beginning to be given to the patients’ comfort and needs.

## **The patients’ treatment**

### **Disabled patients**

Paupers who were identified as ‘infirm’ were placed alongside groups such as the aged and sick who formed the umbrella group of the non-able-bodied. It is difficult to give an accurate picture of the true extent of disabilities suffered by those on poor relief as the umbrella term ‘infirm’ covered many types of infirmity. Undoubtedly a sizeable proportion of long-term workhouse inmates were people who would now be termed ‘disabled’.<sup>62</sup> The disabilities identified in census returns

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<sup>57</sup> A. Newsholme, *Hygiene: A Manual of Personal and Public Health* (1884, 1888), pp. 22-3, noted that ‘fish forms a very important and too much neglected article of diet ... is very valuable for those who habitually take an excess of meat, which is commonly the case with those leading sedentary lives, and in declining years.’ Newsholme worked in public health and his books sold very well, although it is impossible to determine whether the medical officers of Leicester union were familiar with his works.

<sup>58</sup> Smith, *The People’s Health*, p. 394. Paupers commonly had bad teeth, but most unions refused to supply dentures.

<sup>59</sup> TNA, MH12/6492, 31 Jul 1883.

<sup>60</sup> LRO, G/12/8c/1, 29 Jun 1896.

<sup>61</sup> LRO, G/12/188/9, 4 Jan 1901.

<sup>62</sup> A.N. Bergen, *The Blind, the Deaf and the Halt: Physical Disability, the Poor Law and Charity c. 1830-1890, with Particular Reference to the County of Yorkshire*, unpublished Ph.D. Thesis, University of Leeds, 2004, p. 22.

were either mental infirmities such as ‘lunatic’, ‘imbecile’ or ‘idiot’, or the physical handicaps ‘deaf’, ‘dumb’, ‘blind’ or occasionally ‘crippled’. Disabilities such as the loss of limbs or paralysis were not included.

The 1834 Poor Law Report and subsequent annual poor law reports contained very few references to the disabled poor. However, as Bergen observed, silence can be significant, possibly signifying a broad consensus or alternatively suggesting an unidentified or problematic issue.<sup>63</sup> It seems apparent from this present research that the lack of specific references to this particular group stemmed from an acceptance of their inevitable presence and an unawareness of the need for any special provision.<sup>64</sup>

The majority of disabled paupers received out-door relief but less is known about how they were perceived and treated,<sup>65</sup> although, workhouse records provide some insight into contemporary attitudes towards those with physical impairments. Disabled inmates were generally regarded as the ‘deserving’ poor. Nevertheless, their treatment could be unintentionally harsh. While adequate provision for the sick was barely considered in workhouses constructed to house the able-bodied, almost no concessions at all were made for the physical needs of disabled people.<sup>66</sup> One of the few earlier references to any form of medical aid for the disabled was the medical officer’s request in 1872 for 10s to purchase an ear trumpet ‘for the use of deaf patients ... [as] it is almost impossible to make many of them understand or to talk to them.’<sup>67</sup>

An 1887 return for ‘Blind and Deaf-Mute Persons’ showed that there were seven blind people in the workhouse or other institutions paid for out of the poor rates and fourteen blind people on out-door relief. Two females were in special schools for the blind at a cost of 8s a week. There were only two deaf and dumb

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<sup>63</sup> Bergen, *The Blind, the Deaf and the Halt*, pp. 21-2.

<sup>64</sup> This does not include those who were mentally disabled. Chapter 8 explores their situation.

<sup>65</sup> Some historians have argued that it is likely that the disabled were well integrated within the community. Borsay, *Disability and Social Policy*, p. 201, noted that the vast majority of disabled people had always lived outside state institutions with the support of relatives.

<sup>66</sup> Borsay, *Disability and Social Policy*, p. 26.

<sup>67</sup> LRO, G/12/94, 5 Feb 1872.

paupers on in-door relief and none on out-door relief.<sup>68</sup> The union continued to pay for disabled individuals to be sent to special institutions such as schools for deaf and dumb children or homes for the blind.<sup>69</sup> For example, Elizabeth Cross was sent to a home for deaf and dumb girls in Wolverhampton for a weekly cost of 3s 6d.<sup>70</sup>

Prosthetics were also provided. The surprisingly large sum of £4 was spent on dentures for a patient. Furthermore, she was sent to the Devonshire Hospital several times for treatment accompanied by a nurse and an attendant and extra fees were paid for her when the subscription allowance was exceeded.<sup>71</sup> A lesser sum of £2 was paid for an artificial leg for another infirmity patient.<sup>72</sup> A girl whose leg was amputated was given a wooden leg costing 5s and taken on as an assistant at the cottage homes for £1 a year pocket money.<sup>73</sup> Examples such as these confound the customary inhumane image of the poor law system, although it should be emphasised that by that time the guardians were beginning to move away from an obsession with economy towards a concern for a more humane poor law.<sup>74</sup>

There is some evidence that patients who suffered both physical and mental disabilities were sent to institutions that catered for mental infirmities. For example, a patient who lost a foot and a patient who was recorded as suffering from blindness and weak intellect were both sent to a home for the feeble-minded on a medical officer's recommendation. In 1913 the guardians demonstrated their concern for the blind when they wrote to the LGB to state that the board 'profoundly deplores the present unsatisfactory conditions under which the sightless poor of the country are compelled to strive for the most meagre form of subsistence.' They recognised that

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<sup>68</sup> LRO, G/12/57d/27, 3 Oct 1887.

<sup>69</sup> Borsay, *Disability and Social Policy*, p. 95, noted that by the late nineteenth century there were 50 blind institutions outside the metropolis and 26 deaf institutions.

<sup>70</sup> LRO, G/12/57b/13, 1 Mar 1909. It is unfortunate that a register of persons maintained in other institutions from 1901-1949 (G/12/18/1) is now closed for inspection due to the Data Protection Act 1998, as this source may have revealed many more institutions to which disabled paupers were sent.

<sup>71</sup> LRO, G/12/57B/12, 16 Nov 1905, 3 Aug 1906; G/12/57b/13, 24 May 1911. The hospital treated cases of rheumatism and arthritis.

<sup>72</sup> G/12/8j/3, 19 Sep 1912.

<sup>73</sup> LRO, G/12/8e/5, 12 Jul, 6 Sep 1910. Crowther, 'The later years of the workhouse', p. 52, noted that some guardians avoided providing more than the ordinary poor could obtain, for example, Poplar and Lambeth unions provided peg legs instead of more aesthetic but expensive artificial limbs.

<sup>74</sup> S. Cooper, *Rediscovering the 'Urban Variable': The Politics of the Leicester Poor Law Union and the Abolition of the Guardians, 1918-1930*, unpublished MA Dissertation, University of Leicester, 1996, p. 15.

both charitable and poor law services were insufficient to improve the situation of blind people and they urged the government to pass the Blind Aid Bill.<sup>75</sup>

### **The treatment of the ‘Aged and Infirm’<sup>76</sup>**

Difficulties arise in determining the treatment of sick aged paupers.<sup>77</sup> Few age-related statistics were published before 1890. The Admission and Discharge Registers for Leicester union did not record ages, although the date of birth was recorded making it possible to calculate ages. This study has relied upon the information given in minutes and letters to discover how sick elderly paupers were treated by this union. Page’s analysis of the 1881 census for Leicester showed that 38.3 per cent of the workhouse population were aged over 61.<sup>78</sup> A 1900 return of paupers aged 65 and above gave a total of 423 inmates in this category (261 males and 162 females); 232 of whom were in the infirmary. Those aged over 65 on out-door relief numbered 1,206, with the majority being female.<sup>79</sup> By 1910 a return showed that there were 289 men and 601 women aged over 70 on out-door relief and 201 men and 134 women aged over 70 in the workhouse. Dr Bryan declared that 160 of these aged inmates ‘could not satisfactorily take care of themselves’, and many inmates who displayed senile tendencies were placed in the imbecile wards.<sup>80</sup> These figures support Goose’s contention that the proportion of elderly inmates in workhouses was skewed towards men.<sup>81</sup> Booth also found that aged women on out-relief were much more numerous than men, while in-door aged men predominated.<sup>82</sup>

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<sup>75</sup> LRO, G/12/57b/14, 8 Oct 1913.

<sup>76</sup> PLC, *The Minority Report*, p. 30, commented that the aged and infirm made up about one-third of the entire pauper host, yet were the ‘most baffling of the categories into which the non-able-bodied poor are ... officially classified. ... [They] are always referred to as forming one and the same class, of which no official definition has ever been given.’

<sup>77</sup> For other discussions on the treatment of disability and old age in the workhouse respectively see Borsay, *Disability and Social Policy*; P. Thane, *Old Age in English History: Past Experiences, Present Issues* (Oxford, 2000).

<sup>78</sup> Page, ‘Pauperism and the Leicester Workhouse in 1881’, p. 89.

<sup>79</sup> LRO, G/12/57d/40, 1 Jan 1900.

<sup>80</sup> See Chapter 8.

<sup>81</sup> Goose, ‘Workhouse Populations in the Mid-Nineteenth Century’, p. 60, suggests that the prevalence of men was due to less competence in self-care or usefulness within the family.

<sup>82</sup> C. Booth, *Pauperism, a Picture, and the Endowment of Old Age, an Argument* (1892), pp.158-9.

Inquest details given by the medical officer provide some information as to how elderly patients were treated.<sup>83</sup> For example, an elderly imbecile died when he suffered a fit while being shaved. The verdict was that he died of natural causes, i.e. epilepsy.<sup>84</sup> Another inquest on a 77 year-old woman revealed that she had got out of bed to use a commode. Eventually the nurse had ordered her back into bed but she was unable to move without assistance. When she later complained of pains in her thigh, Dr Bryan discovered that she had sustained a fracture to her thigh bone. He recorded that he got the bone 'into position as near as possible but she practically sank and died' eleven days later. Witnesses stated that no force was used on her and the verdict was 'accidental death'. Dr Bryan stated it was impossible to say when the fracture occurred,<sup>85</sup> and the nurse was not accused of handling the woman roughly. These two examples aptly illustrate how a lack of care could easily contribute towards patients' injuries and death yet did not constitute outright 'neglect'.

By the 1890s the guardians were encouraged to discriminate between the 'deserving' and 'undeserving' aged poor who were generally classified by their past lives rather than their behaviour in the workhouse as recommended.<sup>86</sup> The 'deserving' old were given special privileges. Unions were recommended to provide a separate dayroom apart from 'those [who] cause them discomfort', for respectable old and infirm paupers whose circumstances compelled them to enter the workhouse. Workhouse rules became more relaxed for that class of inmate, except for diet.<sup>87</sup> The Leicester guardians self-righteously reported that they had already adopted a scheme for the classification of the aged and deserving poor and placed such inmates in various 'Merit Class' wards in the former old workhouse infirmary.<sup>88</sup> The 'undeserving' were required to work.

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<sup>83</sup> *The Lancet*, 18 Sep 1869, p. 417, called for all deaths in workhouses, lunatic asylums and prisons to be made the subject of legal inquiry as it claimed that many deaths had occurred in such places due to cruelty or neglect. However, inquests were only held on sudden or suspicious deaths in the workhouse.

<sup>84</sup> TNA, MH12/6494, 26 Jan 1886.

<sup>85</sup> MH12/6492, 16 Mar 1883.

<sup>86</sup> Crowther, *Workhouse System*, p. 200.

<sup>87</sup> LRO, G/57d/36, 31 Jul 1896.

<sup>88</sup> LRO, G/12/57b/11, 8 Jan 1901. Crowther, 'The later years of the workhouse', p. 46, noted that Coventry also introduced a merit class but with stringent conditions for entrance.



In the late 1890s during a debate by the guardians on the need for new infirmary accommodation, the chairman praised the workhouse conditions for old people, claiming that they enjoyed much greater health and comfort in their own special rooms than they would have had outside, although he conceded that they had less freedom.<sup>89</sup> Yet a local report in 1901 entitled ‘Alleged overcrowding at the Infirmary’, noted that a guardian had proposed that the general sick should be separated from the old and infirm as they needed ‘double the space the able-bodied needed’, but were ‘huddled together like cattle.’ Other guardians replied that insufficient space compelled them to put all the old people together, whether they were sick or well. One commented that people were not forced to go into the workhouse and if they had friends outside to look after them, they were always allowed out-door relief.<sup>90</sup> This statement illustrates the huge shift in attitude that had occurred over the provision of out-door relief, particularly for the elderly.<sup>91</sup> Some months later the board acknowledged the need for action and a corrugated iron building was erected as temporary accommodation for old men.<sup>92</sup>

### **Workhouse deaths**

The stigma of entering the workhouse was compounded by a dread of dying in the workhouse and the potential ignominy of a pauper funeral and unmarked grave. Even worse was the dread of dissection of the corpse.<sup>93</sup> The medical officer

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<sup>89</sup> LRO, G/12/188/1, 22 Apr 1896.

<sup>90</sup> *The Leicester Guardian*, 3 Aug 1901.

<sup>91</sup> Snell, *Parish and Belonging*, pp. 231-2, lists Leicester among the urban unions that granted comparatively low levels of out-door relief. The guardians later resolved that all aged and infirm and permanently sick or disabled in receipt of relief were to be given a ticket to obtain medical attendance and medicine instead of having to get an order from the relieving officer. LRO, G/12/8a/40, 12 Dec 1905.

<sup>92</sup> LRO, G/12/8a/36, 10 Dec 1901. It seems unlikely that such a building measuring 120’ by 22’ would provide much warmth or comfort, but it was probably envisaged that the workhouse infirmary could later be used for many of the inmates who were simply old and infirm but did not require nursing once the majority of patients were transferred to the new infirmary.

<sup>93</sup> See T. Laqueur, ‘Bodies, Death, and Pauper Funerals’, *Representations*, 1 (1983) for funeral conventions. For a case study on the implications that the crusade against out-door relief had upon the supply of pauper cadavers for dissection see Hurren, ‘A Pauper Dead-House’. Hurren, p. 82, noted that ‘Claude Douglas, the medical officer at Leicester Union’, approached the Chairman of the Leicester Board of Guardians in 1897 on behalf of the Cambridge anatomical school on the subject of the supply of unclaimed pauper cadavers. Hurren stated that Dr Douglas replied that the board of guardians had ‘emphatically refused’ to accede to the request. Claude Douglas was actually a district medical officer of the Leicester union for the years 1877-1886 and was not employed by the union in 1897. Furthermore, this study found no record of this approach in the guardians’ minutes or letter

certified and recorded the cause of death of every pauper in the workhouse. Yet little detailed information was found on deaths in the Leicester workhouse, and the registers of deaths did not state the cause. It is therefore difficult to analyse such fragmentary information. Dr Clarke listed the general causes of deaths from 1870 to 1873, as shown in Tables 6.1, 6.2 and 6.3 below. His figures do not quite tally with the number of deaths for the years listed in the register as shown in Table 6.4, although the numbers are not significantly different. The rise in the number of deaths is probably explained by corresponding rises in the numbers of patients.

**Table 6.1**  
**Workhouse infirmary deaths**<sup>94</sup>

<b>Cause of death</b>	<b>1870</b>	<b>1871</b>	<b>1872</b>	<b>1873</b>
Senile decay	14	18	19	16
Debility (chiefly infants)	9	6	9	12
Diseases of brain and spinal system	16	9	15	23
Inflammation of lungs, bronchitis, etc.	24	19	19	22
Consumption	7	10	8	6
Disease of heart and large vessels	5	3	6	4
Disease of liver, kidney or abdomen	11	9	5	14
Malignant disease and cancer	1	4	3	2
Diarrhoea and dysentery	5	6	2	2
Erysipelas	0	1	0	2
Diabetes	2	1	1	-
Typhoid fever	0	1	0	1
Smallpox	0	1	2	-
Measles	5	0	2	4
Other causes	4	5	2	7
	<b>103</b>	<b>93</b>	<b>91</b>	<b>115</b>

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books. Presumably the matter was discussed but the guardians did not see fit to record the approach or discussion.

<sup>94</sup> LRO, G/12/94, contained these figures in the medical officer's annual reports for the years 1870 to 1873.

**Table 6.2**  
**School Infirmary deaths**

<b>Cause of death</b>	<b>1870</b>	<b>1871</b>	<b>1872</b>	<b>1873</b>
Gastric disease	0	1	0	
Diarrhoea	0	1	1	
Other causes (typhoid, disease of lungs and brain)	8	0	2	3
Measles			2	
Congestion of lungs			2	
<b>Total deaths</b>	<b>8</b>	<b>2</b>	<b>7</b>	<b>3</b>

**Table 6.3**  
**Total number of deaths in adult and school infirmaries and ages of deceased**

	<b>1870</b>	<b>1871</b>	<b>1872</b>	<b>1873</b>
<b>Total number of deaths</b>	<b>111</b>	<b>95</b>	<b>98</b>	<b>118</b>
<b>Ages of deceased</b>				
Infants under 2	21	9	7	18
Children between 2 & 16	8	2	7	4
between 16 & 40	13	11	15	11
between 40 & 60	15	24	14	15
between 60 & 70	18	12	17	21
between 70 & 80	28	23	29	33
between 80 & 90	8	13	9	15
between 90 & 100	0	1 (aged 98)	0	1

**Table 6.4**  
**Number of workhouse deaths by year**<sup>95</sup>

<b>Year</b>	<b>Deaths</b>	<b>Year</b>	<b>Deaths</b>	<b>Year</b>	<b>Deaths</b>
1867	97	1880	135	1893	183
1868	105	1881	132	1894	151
1869	108	1882	130	1895	193
1870	122	1883	117	1896	189
1871	95	1884	107	1897	201
1872	101	1885	132	1898	228
1873	120	1886	105	1899	233
1874	118	1887	130	1900	240
1875	109	1888	160	1901	193
1876	119	1889	157	1902	228
1877	110	1890	164	1903	247
1878	108	1891	170	1904	279
1879	114	1892	160	1905	250

Dr Clarke was required to inform the central authority of the causes of deaths in the workhouse. Among the few surviving records, a letter from the central authority stated that ‘particulars are wanting’ in the return of deaths submitted for the workhouse for 1873, and he was requested to complete the list.<sup>96</sup> For several deaths he had simply put the cause as ‘debility’, which appears to be a symptom rather than a cause. The letter was later returned to the LGB with details of the disease scrawled on. Table 6.5 below shows his completed entries. Several conclusions may be drawn from this. Dr Clarke may not have had sufficient time to enter the cause of death properly. He may have thought that ‘debility’ was a sufficient description or he may not have been sure of the cause. He may even have resented complying with the regulations. The list was written in a casual manner and it is probable that recording deaths in the workhouse, together with all the other

<sup>95</sup> DE1768/82, 83, 84.

<sup>96</sup> LRO, G/12/57d/16, 16 May 1876

information to be recorded, was yet another irksome duty to be carried out as quickly as possible.

**Table 6.5**  
**Amended list of causes of death**

Month	Sex	Age	First entry	Additional entry
Jan	F	17	Imbecile (inquest)	Epilepsy
Mar	M	59	Debility	Blank
Mar	F	70	Debility	Old Aged Debility
May	M	66	Debility	Ulcer of leg
Jul	M	54	Debility	Blank
Aug	F	66	Debility	Bed sore
Sep	F	50	Debility	Prob. [sic] heart disease
Oct	M	50	Debility	From drunken habits
Oct	M	65	Debility	Imbecile
Feb	M	72	Syncope	Heart disease
Jun	F	77	Syncope	Heart disease
Feb	M	48	Diseased bone	Syphilitic
Apr	F	45	Disease of rectum	Syphilitic
Jun	F	57	Malig. Disease	Medulla cancer
Aug	F	64	Malig. Disease of throat	Stricture of oesophagus
Sep	F	37	Disease of throat	Debility
Nov	M	42	Disease of hip	Scrofula

1,770 deaths were recorded from the opening of NEI to November 1911 as shown in Table 6.6. Causes were not given but the ages of the deceased show that the highest numbers of deaths remained for those aged 70 to 80 as in the earlier years.

**Table 6.6**  
**Deaths at North Evington Infirmary, 1905-1911<sup>97</sup>**

Age	Number of patients	Age	Number of patients
Under 3	119	50 to 60	226
7 to 10	18	60 to 70	380
10 to 20	35	70 to 80	416
20 to 30	79	80 to 90	207
30 to 40	103	Over 90	16
40 to 50	171		

<sup>97</sup> LRO, G/12/8j/2, 16 Nov 1911.

Few suicides were mentioned in the records, although three inmates who attempted suicide were placed in the infirmary in 1880.<sup>98</sup> Any inmate who seemed in danger of committing suicide was sent to the asylum. It was therefore unusual to find a report on the suicide of an inmate, George Swifts. He was aged between 50 and 60, classed as able-bodied, and had been in the workhouse for six months. He apparently threw himself over the banisters from the second floor and died from a fracture of the base of his skull. An inmate with him at the time reported that Swifts had asked him if he thought that if someone threw himself down from there 'it would kill him?' The inmate replied 'I don't know - you'd better try.' The verdict of the inquest jury was 'suicide during temporary insanity.'

### **Venereal patients**

Some patients were regarded as respectable; others most definitely not, especially those suffering from venereal disease which was a substantial poor law problem. In its acute stages venereal disease led to unemployment and pauperism and, if congenital, possibly blindness and insanity thereby placing further demands on the poor rates.<sup>99</sup> Many cases of nervous disorder and general paralysis of the insane in workhouse infirmaries or asylums were due to advanced syphilis.<sup>100</sup> The lengthy campaigns for the extension and repeal of the Contagious Diseases Acts concentrated the public debate on the detrimental effects of venereal disease within the armed forces rather than the significance of the disease upon the poor law system.<sup>101</sup> Voluntary hospitals were reluctant to take venereal cases. Female sufferers were suspected of being prostitutes and it was feared that other patients and hospital benefactors would object to their presence in the hospital. The number of lock hospital beds was low and in most areas female venereal patients had to resort to the foul wards of the workhouse infirmaries.<sup>102</sup> The spatial separation of workhouse populations intended as a basis for appropriate treatment and as a

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<sup>98</sup> LRO, G/12/94, 15 Nov 1880.

<sup>99</sup> Hodgkinson, *Origins*, p. 302.

<sup>100</sup> Harris, *Private Lives*, p. 55.

<sup>101</sup> *The Lancet* and *BMJ* conducted vigorous debates on the Acts and the subject of venereal disease and its medical treatment.

<sup>102</sup> J. Walkowitz, *Prostitution and Victorian Society: Women, Class and the State* (Cambridge, 1980), p. 58. 'Foul' wards were for those suffering from venereal disease or skin ailments caused by living in filthy conditions.

deterrent to pauperism, also acted as a barrier against contagion, moral and physical.<sup>103</sup>

Estimation of the numbers of venereal patients in workhouse infirmaries is difficult as official statistics were not necessarily recorded or accurate. Scant information appears in the Leicester union's records about venereal patients, but the annual returns confirm that there were always such patients in workhouse infirmaries, including Leicester.<sup>104</sup> Itch and venereal disease patients were frequently placed together and incarceration in those wards could also be used for punishment. For example, a patient complained that he had been punished for being unable to undertake hard work given when he was ill. He questioned whether it was 'a right place for a man to be penned up in the itch and bad disorder ward for weeks together in bed with only a bad foot?'<sup>105</sup> An inspector noted that the man had the itch when he was in that ward, however, it is unclear whether he was placed there because he had scabies or as a punishment place where he subsequently caught it.

Despite the condemnation of the itch and venereal wards in 1897, nothing changed. Nine years later LGB inspectors again reported on their total inadequacy and unsuitability. Moreover, it appeared that Dr Bryan kept those patients confined to bed. The ward contained eight beds; seven itch patients and one venereal. There was one bathroom and water closet, the floor of which, the inspector noted, was 'foul with stale urine'. The patients were assisted by a pauper attendant from a ward with four beds occupied by three adults and a twelve year-old boy suffering from scabies and erysipelas. The inspectors stated that the boy should have been cared for by a nurse, not a pauper attendant. It was strictly against the rules to employ pauper nurses in any part of the workhouse.<sup>106</sup> Furthermore, the boy had been detained there for three months under Dr Bryan's orders but he should have been removed after four weeks. This report at last forced the guardians to improve the itch and venereal wards,<sup>107</sup> and appoint a female nurse to the venereal cases.<sup>108</sup>

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<sup>103</sup> Driver, *Power and Pauperism*, p. 65.

<sup>104</sup> *Return from Workhouses in England and Wales, January 1876, of numbers of cases of disease, distinguishing Venereal Diseases, and of Deaths in Workhouse, 1875*. This return showed there was one case of primary and one of secondary syphilis in the infirmary.

<sup>105</sup> TNA, MH12/6499, 8 Jan 1891.

<sup>106</sup> LRO, G/12/57d/46, 12 Feb 1906.

<sup>107</sup> *Ibid.*, 16 Oct 1906.

The North Evington Infirmary initially refused to take venereal patients, but by 1914 the medical superintendent identified 70 venereal cases, 44 of which were syphilitic, 26 were gonorrhoeal, and all were recorded as ‘acquired sexually’. Possibly some patients admitted for other illnesses also suffered from venereal disease. The venereal patients amounted to approximately ten per cent of the total medical and surgical cases.<sup>109</sup> Figures were not available for the workhouse due to the recent death of Dr Bryan senior. His deputy attempted to complete the statistics but without success, revealing further inefficient record-keeping. The local records do not disclose how the venereal patients were treated medically. However, an official report noted that the treatment of venereal patients at general hospitals was as inadequate as that of workhouse infirmaries. Generally neither type of hospital used modern methods for diagnosis and treatment.<sup>110</sup>

### **Problem patients and patients’ complaints**

Inevitably the patients who were identified in the records tended to be those who presented a problem. Information on them came from officials rather than from individual paupers. Nevertheless, the pauper’s view can be inferred from that material and occasional letters that were written by or on behalf of paupers to the central authority. Little significance was given to the patients’ voice in the records, but the following example of George Chamberlain, who was a recurrent problem to the workhouse staff, shows that patients were not always passive recipients.

In 1872 Dr Clarke reported that Chamberlain had been constantly swearing and using abusive language to the ward nurse. When Dr Clarke told the patient that he would not be allowed extras in his diet if he continued swearing, Chamberlain apparently replied with a ‘torrent of the most foul and filthy language ever uttered’,

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<sup>108</sup> LRO, G/12/8a/40, 20 Mar 1905.

<sup>109</sup> These figures were revealed when the LGB asked for statistical information on behalf of the Royal Commission on Venereal Disease that had been appointed in 1913.

<sup>110</sup> *Report on Venereal Diseases by Dr R.W. Johnstone*, XXXII (1913), pp. 23-6. For a detailed discussion on hospital treatment of venereal patients see T.J. Wyke, ‘Hospital Facilities for, and Diagnosis and Treatment of, Venereal Disease in England, 1800-1870’, *British Journal of Venereal Disease*, 49 (1973). See also K. Siena, *Venereal Disease and the Poor in London Hospitals, 1550-1800: The Foul Wards* (New York, 2004). Siena suggested that London workhouse infirmaries became the primary medical institutions for very poor female venereal patients from early in the eighteenth century.



whereupon he was removed to the 'foul' ward. Dr Clarke felt that Chamberlain was a bad influence on the patients because his behaviour was 'subversive of all authority'.<sup>111</sup> Chamberlain's profanities continued, causing Dr Clarke to suggest that he should be removed to the borough gaol. Evidently this suggestion was ignored as Dr Clarke later reported that when objecting to itch patients being put in the same ward as him, Chamberlain used language that was 'abominable and foul', a 'scandal to the establishment' and 'demoralising to the inmates'.<sup>112</sup>

The correspondence reveals that Chamberlain was blind and paralysed.<sup>113</sup> A pathetic letter was sent on his behalf to the LGB in which he stated that he was a 'poor helpless creature' whose disease was brought on by 'serving his country in a foreign climate'. He had formerly been a patient at the Chelsea hospital but he had returned to Leicester to live with his sister. She was unable to cope with him so his only recourse was the workhouse infirmary. He complained that the guardians had refused him admission unless he paid for his maintenance with his entire pension of 7s. He felt that 5s was quite enough and he wanted the extra 2s for 'a few necessities'.<sup>114</sup> His pension meant that he was not considered to be destitute. Additionally, the guardians felt justified in refusing him admission because of his 'conduct and violent character'.<sup>115</sup> They later relented provided that he handed over his entire pension which had by then risen to 10s 6d. As further justification, they remarked that he was in a helpless condition and required a separate room and constant attendance.<sup>116</sup> He received neither and was again placed in the itch ward. Dr Clarke moved him to the erysipelas and fever ward, although he anticipated that he would be just as difficult there. He regretted that because of Chamberlain's disabilities, they were unable to punish him except put him on an ordinary diet. He was at a loss to know what else they could do with him.<sup>117</sup> This may be an exceptional case but it illustrates how ineffectively the authorities dealt with this patient. They emphasised the nuisance he caused and expressed their frustration

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<sup>111</sup> LRO, G/12/94, 6 Jan 1872.

<sup>112</sup> *Ibid.*, Oct 1875 (day obscured).

<sup>113</sup> The 1881 census listed a George Chamberlain, aged 48, who was blind. It may have been another inmate with the same name as his occupation was frame-work knitter but the disability suggests that it was the same person.

<sup>114</sup> LRO, G/12/57d/16, 2 Apr 1875.

<sup>115</sup> LRO, G/12/57b/5, 8 Apr 1875.

<sup>116</sup> *Ibid.*, 23 Jun 1876.

<sup>117</sup> LRO, G/12/94, 3 Feb 1877.

that he could not be controlled because of his disabilities. One of the few powers open to patients was to cause a nuisance and George Chamberlain clearly felt justified in his demands and protests because he had an income, unlike the majority of patients.

Another Chelsea pensioner, William Sanderson, who had previously been an accident patient at the Kettering union hospital where he was charged 6d a day, came to Leicester and was admitted to the union infirmary when the wound 'broke out'. He stayed for fifteen days and the guardians sent a bill for £3 to the Chelsea Hospital. Sanderson was outraged that such a charge had been made, as he was on the ordinary workhouse diet and other unions only charged 6d a day. The guardians insisted that as he was entitled to £3 in pension during his stay in the workhouse that was the amount the union would claim. They remarked that he did not have to stay in the workhouse if he didn't like their arrangements and the current cost of maintenance was 4s 2<sup>3</sup>/<sub>4</sub>d per head per week. They thought it was wrong that people who were not destitute should 'quarter themselves upon the public at 6d a day.'<sup>118</sup>

Patients' complaints were usually about the iniquity of the system rather than about their medical treatment. This letter sent to the LGB in 1906 captures the plight caused when a medical officer decided that a sick claimant could still undertake light work.

'...I have been out of work for some weeks now, being displaced through machinery and compelled to go on the Labour Test up to a fortnight ago, when I fell ill, suffering, my own Doctor certified, from cardiac weakness of the heart, I declared on the sick funds of our [Trade}Union and am receiving 9/6 sick pay weekly.... I have a wife and 4 little children, dependent on me for a living, therefore, I made application to the Guardians to allow me supplementary relief, as when I have paid the Doctor 2/6, weekly rent 4/6 I have left, leaving a bare 2/6 to keep a wife and 4 children on. I had to get a certificate from the Parish Doctor for the Guardians, my own Doctor not being sufficient, ... the Parish Doctor certified I was suffering from general debility, through insufficient and improper food, but it appears having also added light work to it, therefore the Guardians refused my request for extra relief. You can see Sir that I could not do light work as the labour test, whilst on the Sick List of our Trade Union. They did certainly grant me a little meat and bread the first week I was ill, but no further, the Receiving

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<sup>118</sup> LRO, G/12/57d/13, 11 Jun 1869; LRO, G/12/57b/4, 16 Jun 1869.

Officer stating he could not do anything more. It appears, Sir, that being as I have made a little provision for times of illness &c, I am to have no help further, but my wife and little children are to nearly starve. I think it very hard and urgent, Sir. I am sorry to trouble you, but I think it right your attention should be called to it. I hope to get better soon, but I cannot get stronger on our present condition ... T.C. Peasgood.<sup>119</sup>

Typically, the LGB simply replied that it was up to the guardians to decide the manner in which relief should be given and it could not interfere. The guardians made no comment.

## **Supplementary medical aid**

The poor law medical services lacked the resources to cater for the many different types of sickness or disability encountered. Other specialist medical aid was sometimes necessary. The PLC originally decided, at least in principle, that unions should not subscribe to charities for other medical services. In practice, it allowed unions to subscribe to voluntary hospitals for the treatment of acute cases. The Poor Law Continuation Act of 1851 legalised the use of voluntary hospitals as the authorities realised it could be more economical for dangerous or difficult cases to benefit from superior medical skills or equipment.<sup>120</sup> As the poor law medical service steadily gained a significant role in public health measures, subscriptions to fever hospitals and sanatoria were also sanctioned. Like many other unions, Leicester subscribed to a variety of institutions for the medical treatment and convalescence of both in-door and out-door patients. Initially the union subscribed to the voluntary hospital and separately to its fever house. It added subscriptions to the Buxton Bath charity in 1857 and the Margate Sea Bathing Infirmary in 1866. Table 6.7 below lists the annual subscriptions paid in 1905 to show the extent to which the guardians procured external help.

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<sup>119</sup> LRO, G/12/57d/46, 13 Mar 1906.

<sup>120</sup> See Hodgkinson, *Origins*, pp. 196-204; and *ibid*, pp. 592-602 for more detailed information on the use of voluntary hospitals as auxiliaries to the poor law medical service.

**Table 6.7**  
**Subscriptions paid in 1905** <sup>121</sup>

<b>Charitable institution</b>	<b>Subscription</b>
Leicester General Infirmary	£20.0.0
Southport Convalescent Home	£3.6.0
Mablethorpe Convalescent Home	£2.2.0
Charnwood Convalescent Home	£10.0.0
Devonshire Hospital	£10.0.0
Surgical Aid Society	£2.2.0
N.S.P.C.C.	£15.0.0
Leicester District Nursing Association	£50.0.0
<b>Total</b>	<b>£110.8.0</b>

Subscriptions to other hospitals and institutions increasingly gave paupers access to wider medical attention than many of the working poor. However, in 1898 when the guardians noticed that there was a surplus of recommendations remaining under the union's subscription to the general infirmary, they decided that the relieving officers should offer these recommendations to benefit any suitable and deserving non-pauper poor person.<sup>122</sup> Yet subscriptions to the general infirmary were later increased as the need for specialist treatment, in particular for ocular-aural cases, outstripped the entitlement allowed.<sup>123</sup> On occasions the guardians had to obtain support from the COS for more patients to be treated at the general infirmary when the union's entitlement ran out. Constraints of space prevent discussion here of the involvement of the COS with the Leicester poor law union, although this is a topic that would be worthwhile pursuing as other studies have revealed that paupers received welfare from a variety of sources.<sup>124</sup> In 1904 the union paid ten guineas to enable an inmate to undergo a course of treatment at the National Hospital for the Paralysed and Epileptic in Bloomsbury.<sup>125</sup> On one occasion a local church paid half the cost for a consumptive patient to stay in a convalescent home, and the guardians paid the remainder.<sup>126</sup> The number of

<sup>121</sup> LRO, G/12/57b/12, 12 Jan 1905.

<sup>122</sup> LRO, G/12/8a/32, 11 Jan 1898.

<sup>123</sup> LRO, G/12/57b/12, 5 Sep 1906.

<sup>124</sup> See, for example, Humphreys, *Sin, Organised Charity and the Poor Law*, and R. Dryburgh, *The Mixed Economy of Welfare: the New Poor Law and Charity in Mid-nineteenth Century England*, Ph.D. Thesis, University of Oxford, 2003.

<sup>125</sup> LRO, G/12/57d/44, 12 Jul 1904.

<sup>126</sup> LRO, G/12/57d/45, 5 Apr; 13 Dec 1905.

subscriptions grew over the years as new institutions and medical treatments became established. For example, by 1909 the union subscribed to the Leicester Institute for Diseases of the Skin which had been established in 1898.<sup>127</sup>

## Summary

The scarcity of records that give the patients' opinions of their medical treatment hinders a full assessment of its quality. However, this chapter has provided an insight into the conditions at the workhouse infirmary that were experienced by the general sick. It has shown how attempts were made to accommodate the growing numbers of sick and non-able-bodied paupers as space and facilities became increasingly inadequate. However, despite piecemeal alterations, the accommodation was never large enough or suitable for the growing numbers of patients, their variable needs and the range of illnesses they suffered. The need for such facilities had not been foreseen. Moreover, limited space prevented substantial improvements even if there had been a willingness to plan holistically and spend sufficiently. The guardians dealt with situations in an *ad hoc* manner, often only when their hands were forced. By the 1900s the guardians acknowledged the need for more suitable accommodation and recognised that certain categories of patients required more specialised treatment. The next two chapters focus on the treatment of sick children and imbecile and epileptic patients.

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<sup>127</sup> LRO, G/12/57b/13, 19 Mar 1909. As shown, many patients suffered skin diseases.

## Chapter 7

### Sick pauper children

#### Introduction

Children formed one of the largest groups of paupers.<sup>1</sup> Numerous children whose families received out-door relief remained outside the control of the system.<sup>2</sup> But the children who comprised a large sector of the workhouse population came under the aegis of the guardians for their maintenance and education. Yet few detailed studies have been made of the experiences of pauper children in the workhouse.<sup>3</sup> This chapter aims to remedy that by examining the provision made for children by the Leicester union. The first section focuses on the situation of sick children in the workhouse, while the second section considers the effects upon the health of the children when they were removed from the workhouse to alternative accommodation.

#### Classification of children

Children could not be held to blame for their destitution. Along with the elderly and disabled they were considered to be ‘deserving’ paupers. Many children were regularly in and out of the workhouse with their parents. Children who were orphaned or deserted remained in the workhouse and the guardians acted *in loco parentis*; although some children were later adopted or boarded out with foster

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<sup>1</sup> See Tables 4.1 and 4.2 in Chapter 4 for the numbers of children who were relieved, either separately or with their families, by the Leicester union.

<sup>2</sup> H. Bosanquet, *The Poor Law Report of 1909*, p. 64, noted that guardians seemed never to have felt any great responsibility for children who received relief but remained under the care of their parents. Similarly, little mention was made in the Leicester records of children on out-relief, although occasionally the guardians recommended prosecution of the parents of any children found by receiving officers or district medical officers to be ill-treated or neglected. In 1911 the guardians requested the former to report on the condition of children under five whose parents were in receipt of out-door relief. LRO, G/12/57b/13, 26 Apr 1911.

<sup>3</sup> The exception is Crompton, *Workhouse Children*, a study of the treatment of children in the workhouses of thirteen Worcestershire unions from 1834 to 1871.

parents.<sup>4</sup> Occasionally children were taken in at times of family distress, for example if their mother was ill and unable to look after them while their father was at work. Table 7.1 below cites descriptions of the workhouse children's circumstances that were used by the Leicester guardians. It shows that the majority of children in the Leicester workhouse at that time were orphaned or deserted, but in 1877 the maintenance for seven children was paid for by their father.<sup>5</sup> Those under the age of sixteen were classified as children, but many further sub-divisions were made to delineate the precise situation of each child. Snell used the poor law sub-categorisation of children as an illustration of its intensity as a tool for policy decisions. He identified a possible ninety sub-groups from the division of children into three age groups and then into a possible fifteen descriptive groups.<sup>6</sup>

**Table 7.1**  
**Children in Leicester workhouse, 1874 and 1877<sup>7</sup>**

<b>1874</b>	<b>Number</b>	<b>1877</b>	<b>Number</b>
Mother living, father dead	28	Father dead, deserted by mother	27
Father living, mother dead	14	Mother dead, deserted by father	23
Deserted by father – most have no mother	40	Mother in House, deserted by father	36
Deserted by mother – all illegitimate	4	Deserted by father	28
Deserted by both parents	13	Deserted by both parents	17
Mother in asylum	4	Mother or father in asylum	3
Parents in prison	13	Father in prison	14
Orphans	61	Orphans, many without friends	69
Both parents in House	4	One or both parents in House	23
One parent dead, other in House - sick	21	Paid for by father	7
<b>Total</b>	<b>202</b>	<b>Total</b>	<b>247</b>

<sup>4</sup> Crompton, *Workhouse Children*, p. xv, noted that about 60 per cent of inmate children were in the category of 'orphaned and deserted'. They were usually apprenticed between the ages of nine and twelve.

<sup>5</sup> Crowther, *Workhouse System*, p. 236, noted that rural unions in Kent occasionally took in one or more children of large families, although the central authorities strongly condemned this practice.

<sup>6</sup> Snell, *Parish and Belonging*, pp. 245-6.

<sup>7</sup> LRO, G/12/94. This information was taken from two programmes for the workhouse Christmas entertainment that were inserted into the medical officer's report book.

## Workhouse accommodation, conditions and illnesses

Children under seven years were allowed to remain with their mothers in the female workhouse wards. Under workhouse policy, children aged from seven to fifteen were placed in single-sex children's wards and permitted just short periods of access to their parents. The guardians first considered separate workhouse accommodation for the children in 1864.<sup>8</sup> By 1867 new accommodation for up to 400 children was built where they were lodged, fed and taught under the daily management of the workhouse master and school matron.<sup>9</sup> A schoolmaster and mistress were employed for the infant and junior schools. Sick wards containing 40 beds were added in 1868,<sup>10</sup> and thereafter sick children were no longer sent to the adult workhouse infirmary.<sup>11</sup>

Dr Edward Smith noted that the Leicester workhouse school accommodation was 'excellent' with 'space to spare' and the 'best organised and managed' school in the provinces.<sup>12</sup> Yet by 1878 another inspector declared that the arrangements for sick children in the school were 'not at all satisfactory'.<sup>13</sup> Regardless of whether the school was well managed, the location and accommodation of the sick were obviously detrimental to the children's health, but, it was another six years before the majority of children were removed from the workhouse to more suitable accommodation.

The children's infirmary was well used, but the LGB thought the number of admissions in 1871 was 'excessive' considering that there were 335 admissions during that year but only about 170 children in the workhouse. Similarly, Dr Clarke reported that the large population of workhouse children were free from fever or

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<sup>8</sup> Thompson, *Leicester Poor Law Union*, p. 237.

<sup>9</sup> LRO, G/12/57b/5, 31 Jan 1880. The accommodation was referred to in the records as the 'workhouse schools'. On their retirement the assistant matron, Mrs. Lance was appointed as matron of the schools to allow the new master and matron more time to manage the workhouse. Mrs. Lance was responsible for clothing and the female section of the school, while the head schoolmaster was responsible for the school and stores.

<sup>10</sup> LRO, G/12/57D/19, 8 Aug 1879.

<sup>11</sup> LRO, G/12/57D/12, 28 Feb 1868. Dorothy Ward, who had recently completed her brief training as an assistant nurse in the male infirmary, was transferred to become the nurse at the school's infirmary on a salary.

<sup>12</sup> TNA, MH32/67, 21 April 1871.

<sup>13</sup> TNA, MH12/6489, 18 Feb 1878.



epidemic disease that year, although he had actually recorded 357 admissions to the school infirmary.<sup>14</sup>

Dr Clarke and the school matron attributed much disease to the coldness of the children's wards.<sup>15</sup> Beside the cold, the children endured other discomforts such as the 'filthy' small urinal and water closet to which Dr Clarke so graphically drew the guardians' attention:

'The accommodation is totally inadequate and unsuitable; the floor gets covered with urine and a number of boys raise the closet seats to urinate but with the result of soaking the floor with liquid which dribbles through to the ground below. There is no light provided, hence in winter they can't see where they are going and many go in barefooted and many stand in pools of urine which may possibly account partly as to the many sore feet and ulcerated chilblains which lay so many up in the winter. There are eighty boys to one small urinal lobby and one water closet on the second storey and eighteen boys on the third storey who have no urinal but who have to make use of the one closet in the way described.'<sup>16</sup>

Outbreaks of measles and scarlet fever occurred regularly and smallpox occasionally. In 1872, fifteen children under the age of eight caught measles with two fatalities. Smallpox was also prevalent in the town at that time, although only one case occurred in the workhouse school. It was fortunate that it did not spread as the fourteen-year-old girl had shared a bed with another girl for twelve days after her admission before it became apparent that she had the disease. She was then isolated and removed to the borough fever hospital. Happily for the medical officer her case was not severe and she soon recovered. The girl who slept with her was re-vaccinated and the disease did not spread.<sup>17</sup>

Crompton found that tuberculosis was surprisingly rare among the children in Worcestershire's workhouses, although he conceded that it may have been unrecorded.<sup>18</sup> However, Leicester's workhouse children commonly suffered from

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<sup>14</sup> See Table 4.4 in Chapter 4.

<sup>15</sup> TNA, MH12/6484, 1871; LRO, G/12/94, 30 Nov 1875.

<sup>16</sup> LRO, G/12/94, 4 Dec 1878. He urged that these be altered or chamber pots placed under each bed.

<sup>17</sup> *Ibid.*, Medical Officer's Annual Report of 1872.

<sup>18</sup> Crompton, *Workhouse Children*, p. 97.

scrofula.<sup>19</sup> Dr Clarke believed that the narrow, unventilated playground of the infant school promoted scrofula in addition to causing the general ill-health and infectious ophthalmia to which the children were prone. He described the playground as a 'long narrow strip of ground bounded on each side by walls so high as to prevent fresh air getting easily to it.' There were water closets at each end and over the wall on one side there was a yard from which he declared the 'most offensive smells often emanate, either from manure pits or piggeries.'<sup>20</sup> The playground offered little inducement for children to play and the medical officer urged the guardians to provide a larger more open playground.<sup>21</sup>

Dr Clarke frequently recommended that scrofulous children should be sent to the Margate Sea Bathing Infirmary for the sea air which he believed was highly beneficial for that disease. For example, a girl aged six, who suffered from severe scrofula, was sent to Margate in April 1872. On her return three months later, Dr Clarke was happy to report that she was 'greatly improved in health and strength, with all her abscesses healed and much fatter and stronger than she had ever been.'<sup>22</sup> When she relapsed a year later he recommended sending her there again. Such relapses occurred frequently because the Margate Infirmary would only take two cases at a time from each public establishment and often sent children back as soon as they appeared well. Consequently, Dr Clarke suggested to the guardians that similar cases should be boarded out at Woodhouse Eaves during the summer months to benefit from the country air.<sup>23</sup> The subscription to the Margate Infirmary indicates a constructive attitude by the guardians towards improving the health of the children. Nevertheless, they ignored his suggestion, despite Dr Clarke's warning that without a change of air cases only recovered after 'a long and tedious treatment, during which the disease became 'permanently engrafted.'<sup>24</sup> It was short-sighted of the guardians to disregard his suggestion as those children were likely to

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<sup>19</sup> Scrofula was the archaic term for tuberculosis of the lymph nodes, especially of the neck. It was common in children and young adults and was usually spread by drinking un-pasteurised milk from infected cows. Scrofula could also cause long-term visual impairment such as ophthalmia, an infectious inflammation of the eye. The tubercles in the skin and muscles caused swellings that restricted the blood supply and could even lead to the necessity for limb amputation.

<sup>20</sup> LRO, G/12/94, 12 Jun 1875.

<sup>21</sup> LRO, G/12/57d/19, 8 Aug 1879. Due to the limited playground the children were taken for a run in the fields once or twice a week.

<sup>22</sup> LRO, G/12/94, 29 Jul 1872.

<sup>23</sup> *Ibid.*, 30 Mar 1874.

<sup>24</sup> *Ibid.*, 28 Jun 1878.

become unhealthy adults with the distinct possibility of becoming permanently pauperised and continuing to be a burden upon the rates; a situation that guardians were anxious to avoid. The subscriptions to the Margate Infirmary continued though, and were even increased to ensure that there was always a bed for children who would benefit.<sup>25</sup>

Dr Clarke was eager for the children to have regular exercise and fresh air. In the 1870s he repeatedly recommended that a qualified militia drill sergeant (albeit in private clothes) should be employed to drill all the children over seven to 'develop the chest, improve the respiratory organs and promote the muscular actions of the body'. He considered this would enable the children to acquire a respectful demeanour and good deportment while also improving their physical powers and mental faculties because, in his view, many workhouse children were 'naturally sluggish in their movements and dull in their minds.'<sup>26</sup> He did not wish to train them in martial exercise even though drilling induced obedience which he thought would nevertheless be 'invaluable for their future.' Eventually the guardians engaged a drillmaster for an annual salary of £25,<sup>27</sup> which was a generous payment when compared with the salaries of other full-time workhouse staff.

There were strict regulations on the use of corporal punishment on children. Girls could not be beaten but boys aged between seven and fourteen could be punished with a rod or other instrument approved by the guardians. This punishment was administered personally by the workhouse master or delegated to the school master. Little mention was found of any punishments in the earlier records of the workhouse, although some incidents were recorded in later years when the children lived elsewhere.<sup>28</sup> Corporal punishment was socially acceptable

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<sup>25</sup> LRO, G/12/57b/6 15 & 25 Jun 1881, G/12/57d/21 24 Jun 1881, 1 Jul 1881.

<sup>26</sup> LRO, G/12/94, 23 Jul 1872, 16 Nov 1874, 20 Oct 1877.

<sup>27</sup> LRO, G/12/57b/5, 5 Dec 1877. Smith, *The People's Health*, p. 184, noted that Edwin Chadwick had advocated compulsory drill in factory schools since 1861 and medical spokesmen also called for military-type drill in schools in 1870. Thirty years later children in the scattered homes were allowed to attend gymnasium classes at a cost of 1s 2d 'for their health and physical development', G/12/8g/1, 14 Jan 1905. In 1907 the male imbeciles were instructed to drill by their assistant attendant, LRO, G/12/8j/1, 4 Nov 1907.

<sup>28</sup> A foster mother at the cottage homes who caned a child was reprimanded and put on probation. Punishments involved putting children on bread and water or excluding from an entertainment but for exceptionally bad behaviour the superintendent used a leather slipper on boys. The superintendents of the cottage, receiving and scattered homes also sought the approval of the

but if abused children were admitted into the workhouse these incidents were recorded.<sup>29</sup>

Admittance to the workhouse may have saved some children from further abuse at home, but the workhouse did not protect them from institutional illnesses or infectious diseases. Scarlet fever, measles, diphtheria and smallpox were the main infectious and destructive childhood diseases in the nineteenth century.<sup>30</sup> Diphtheria was rarely mentioned in the local records but the other diseases featured regularly. Infectious diseases put a great strain upon space and staff in both the workhouse and the school, and preventative measures were attempted. For example, the medical officer advised that children should not attend outside entertainments or visit the town when scarlet fever, smallpox and measles were rife. When infectious illnesses developed in the workhouse nurseries, he advised against any contact with the children in the school and ordered the wards to be disinfected with sulphur vapour, although this created problems in finding alternative space for sick children while wards were disinfected.

By 1879 the school infirmary became increasingly inadequate as the greater numbers of children admitted inevitably encouraged the rapid spread of illnesses. Recovering children were discharged before they were completely well in order to admit other more urgent cases.<sup>31</sup> The lack of space caused difficulties in allowing sick children to exercise without mixing with the other children. The infirmary wards were nearly always full which Dr Clarke believed led to a corresponding deterioration of the air and the further spread of the contagious ophthalmic complaints that many of the children experienced.<sup>32</sup> By 1880 there were 312 children compared with 240 in 1879. Dr Clarke appealed for no new admissions while the wards were infected with ‘both the measles and chicken-pox poisons’, or at least for new children to be put into wards completely away from the contagious

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guardians to use an ordinary school cane. LRO, G/12/8e/5, 3 Oct, 31 Oct 1911; G/12/8g/1, 20 Aug 1908.

<sup>29</sup> LRO, G/12/94, 16 Mar 1872.

<sup>30</sup> See Smith, *The People's Health*, pp. 136-170 and also A. Hardy, *The Epidemic Streets* (Oxford, 1993), pp. 43, 56, 67, 296, who noted that measles was widely accepted as inevitable, but that diphtheria was a new disease that appeared in 1856. Scarlet fever was one of the first diseases to have quarantine enforced on patients.

<sup>31</sup> *Ibid.*, 25 Jun 1879.

<sup>32</sup> *Ibid.*, 26 Aug 1878.

children as he believed there was ‘no likelihood of speedily getting rid of a disease so long as fresh children are being constantly put where they will catch it.’<sup>33</sup>

Dr Clarke’s complaints were supported by the scathing criticism of the school infirmary made by Dr Mouat, an LGB medical inspector, who visited the workhouse to investigate ‘much sickness’ among the children and ‘a considerable number of deaths in the school.’ The inspector did not mince his words. Arrangements for the large numbers of sick children were ‘inadequate and improper.’ Too many children had been admitted; the lavatory arrangements were ‘altogether insufficient’ and much of the sickness and mortality was due to the ‘incurable structural and other defects of the place.’<sup>34</sup> Dr Mouat requested Dr Clarke to send him a report, which he later commended stating that, ‘it is so complete, enters so minutely into the circumstances of the case, and reveals a state of matters so serious and dangerous that I can add nothing to its force.’<sup>35</sup>

Dr Clarke believed that a recent outbreak of measles had been introduced from the town, either at the Christmas entertainment or from children admitted who were incubating the disease. At the end of January 1880 there were thirty-nine measles cases and forty children with other illnesses. These high numbers resulted in twenty-six measles cases being put two to a bed in a separate dormitory. Dr Clarke stressed that this situation caused a reduction in cubic space for each patient and it was in that ward that three cases of gangrene attacking the face and genitals occurred. Those cases were immediately transferred to a small separate ward where two died and one recovered. He attributed ‘overcrowding’ as the probable cause of death. Two other children had also died earlier of the measles.<sup>36</sup>

In the main workhouse infirmary there were a further twenty-eight infants with measles, of which sixteen died. Dr Clarke complained that the infirmary accommodation was quite inadequate for the proper separation and classification of cases and it weekly became more difficult. Overcrowding in the adults’ infirmary resulted in measles cases being put in the infectious wards, the female skin ward

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<sup>33</sup> *Ibid.*, 10 Jan 1880.

<sup>34</sup> TNA, MH12/6490, 1 Mar 1880.

<sup>35</sup> *Ibid.*, 1 Mar 1880.

<sup>36</sup> *Ibid.*, 24 Feb 1880.

and a ward for bedridden and ‘offensive’ cases. Women in those wards had to be transferred to other wards. Dr Mouat was highly critical of the guardians’ proposed solution to erect temporary buildings in the gardens for sick children. He felt that it would not remedy the existing defects and it would just crowd even further, ‘an area already too much covered by buildings.’ In his view, ‘the evil is great and crying and needs an immediate remedy – such palliatives as temporary buildings in the garden, being insufficient and of more than doubtful efficacy.’<sup>37</sup>

The guardians protested vigorously at Dr Mouat’s ‘unfavourable’ report and exhibited remarkable complacency by stating how surprised they were to receive such a report considering that the school had only been erected thirteen years earlier in accordance with plans approved by the LGB. Moreover, the LGB architect had reported favourably on the buildings the previous year. While they admitted that the school had become less suitable because of the proximity of surrounding property, they claimed that it would compare ‘most favourably with most workhouse schools in the kingdom.’ They also disagreed that the numbers of children were too high as the school was certified for 400 children and, at the time of Dr Mouat’s visit, there had only been 304 children. According to the guardians, that was much higher than the usual average of 250 because of a severe trade depression in the town. They protested that the measles outbreak was soon ‘stamped out’ and only a small number of children had been affected. Besides, they did not believe the disease arose from structural defects in the building or a lack of care but that it was brought in from the town which, as the inmates were constantly changing, was a danger to which public institutions were exposed. The guardians stated that they were quite aware that the school would soon have to be moved to a more open situation and they had been considering the matter for some time. Yet they still did not think it was an urgent matter and the temporary building was erected.<sup>38</sup> Dr Clarke was more circumspect, perhaps because of his position with the guardians, but he recommended that a temporary building should be situated and constructed to easily allow an increase in accommodation and that it should have

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<sup>37</sup> *Ibid.*, 1 Mar 1880.

<sup>38</sup> LRO, G/12/57b/6, 16 Apr 1880.

bathing and kitchen accommodation and ensure complete isolation with plenty of air space around, and an additional nurse was necessary.<sup>39</sup>

The guardians again refuted Dr Mouat's subsequent contemptuous report on another outbreak of hospital gangrene among the children, two of whom had died. They were worried that his comments, which were reported in a local newspaper, might be misinterpreted and thus 'cause alarm in the minds of the public and hamper the discharge of their duties.'<sup>40</sup> Dr Mouat had examined all the very young children and stated that he found them 'labouring under mesenteric disease, which is indicative of a well-marked scrofulous condition, and of imperfect nutrition, both of which are productive of low vitality, and feeble powers of resisting disease.'<sup>41</sup> He criticised the closeness of rooms containing children suffering from mumps and ringworm. He found that, apart from one or two 'comparatively trifling changes', the defective arrangements were unchanged. He reiterated that he believed that the workhouse school was not a 'fit place for the education and training of the pauper children of Leicester', who he felt 'absolutely require a healthier locality and better means of gaining health and strength than are possible in the workhouse.'<sup>42</sup>

Dr Mouat declared the temporary wooden building was only suitable for those who were sick from 'ordinary diseases or one class of infectious disorder.' He recommended that a uniform temperature of at least 56°F should be maintained and a specially trained nurse employed.<sup>43</sup> He thought it necessary that all the mesenteric children should be given 'bread and milk instead of milk porridge' and that all unwholesome or imperfectly nutritious articles of diet should be removed generally,' and cod liver oil given to all the scrofulous children. He directed that all the children, whether sick or well, should be carefully examined every month by the medical officer.<sup>44</sup> His remarks imply that the medical officer was not already carrying out these measures.

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<sup>39</sup> TNA, MH12/6490, 24 Feb 1880.

<sup>40</sup> LRO, G/12/57b/6, 9 Mar 1881.

<sup>41</sup> TNA, MH12/6490, 4 Feb 1881. Mesenteric disease is abdominal tuberculosis.

<sup>42</sup> *Ibid.*, 4 Feb 1881.

<sup>43</sup> This seems rather a low temperature for sick children.

<sup>44</sup> TNA, MH12/6490, 4 Feb 1881.

Dr Mouat also maintained that the ventilation and bathing arrangements were defective and twenty or thirty boys were bathed in the same water and about seventeen girls in a single bath.<sup>45</sup> The guardians disputed these remarks and claimed that the closets ventilated into the wards if the doors were kept closed; adding defensively that the same could be said of ‘most buildings in Leicester which have been erected ten years and upwards.’ They claimed that the children, who Dr Mouat stated had ‘a sickly appearance’, were recent admissions. They blamed their unhealthy looks on the severity of the weather and lack of proper warmth, nourishment and clothing prior to their admission as their parents had been unable to provide the proper necessities of life and it was only as a last resort that these children had come into the workhouse. They added that the children were on the diet sanctioned by the LGB and if the medical officer had said a temporary diet was desirable for them it would have been altered.<sup>46</sup> Dr Mouat retorted that he had examined all the children, not just the recent admissions. Ten were suffering from measles, one of whom was in a dangerous state from threatened gangrene, despite, he added, the ‘very careful and judicious treatment’ of the medical officer. Nevertheless, he pointed out that, ‘with equal severity of weather and children of quite as feeble a type, [Leicester’s] is the only workhouse in which the fatal and perfectly preventable disease had [recently] occurred.’ He criticised the nursing, recommended that there should be no communication between the temporary building and the other sick wards and repeated the need for a specially trained nurse.<sup>47</sup>

The guardians duly appointed a temporary nurse to help with the infected children when the next outbreak of measles and scarlet fever occurred but swiftly dispensed with her services when measles cases ceased and fever cases were sent to the borough fever hospital.<sup>48</sup> Nine months later another temporary nurse had to be appointed to attend a further outbreak of measles and scarlet fever in the school infirmary.<sup>49</sup> Presumably there was insufficient room in the fever hospital, as was

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<sup>45</sup> TNA, MH12/6490, 3 Mar 1881.

<sup>46</sup> LRO, G/12/57b/6, 9 Mar 1881.

<sup>47</sup> TNA, MH12/6490, 3 Mar 1881.

<sup>48</sup> LRO, G/12/57b/6, 4 Jun 1881.

<sup>49</sup> *Ibid.*, 22 Mar 1882.



frequently the case.<sup>50</sup> As usual, the guardians were reluctant to employ an additional permanent nurse, preferring to deal with incidents as they occurred.

Despite the guardians' claim that moving the children was not urgent, these events forced them to reconsider. Their minutes recorded that they were fully aware that the growth of the town surrounding the school meant that it was no longer suitable and they conceded that the health of the children would improve if they were moved to a more 'open situation.'<sup>51</sup> Accordingly, they decided to assess the merits of the boarding-out and cottage home systems.<sup>52</sup> In 1881 a deputation of guardians visited Birmingham, Bolton and Leeds unions and concluded that the boarding-out system where children were placed with local foster-parents and attended local schools should be adopted by the Leicester union for its orphan and deserted children of which there were currently 120. The school staff could then be reduced. A Boarding-Out Committee was formed and local foster-parents were found. An allowance of 4s a week for each child's maintenance was paid to the foster-parents until the child reached the age of thirteen when he or she was either found a situation or adopted by the foster-parents. Individual guardians visited all the children and their schools every six months to check that they were well educated, cared for and healthy. District medical officers visited the children once a quarter or more often if a child was sick. Generally the guardians felt satisfied that they had placed the children in 'comfortable homes'.<sup>53</sup> Occasionally, however, children were removed from situations that were found to be unsuitable. A boy was removed when his foster-mother was found to have 'intemperate habits' and two boys were removed at the request of the foster-parents when they found them

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<sup>50</sup> Smith, *The People's Health*, p. 151, also noted that fever hospitals always had too few beds.

<sup>51</sup> LRO, G/12/8a/19, 5 Apr 1881. As shown in Table 1 in Chapter 3, the population in Leicester in 1881 had grown from 95,220 in 1871 to 122,351.

<sup>52</sup> The distinctions between the types of homes for children were that cottage homes were groups of purpose-built cottages on a distinct site. The boarding-out system was either under the control of a boarding-out committee using private homes to board individual children with foster-parents outside the limits of the union or, as in the case of the Leicester union, using private homes within the union limits but under the supervision of the guardians. Receiving homes were for children who were newly admitted or were ins and outs. Scattered homes were houses rented by the guardians in different parts of the town for groups of children. A foster mother and superintendent ran the home and the children attended local schools. The guardians do not appear to have considered the barrack-school system.

<sup>53</sup> LRO, G/12/8a/22, 19 May 1886.

unmanageable after their mother visited them. Another child was returned because she was ‘constantly ailing’.<sup>54</sup>

## Countesthorpe Cottage Homes

The committee felt that the cottage home system was more appropriate for the remaining children.<sup>55</sup> Fifty-five acres of rural land were duly purchased at Countesthorpe and with approval from the LGB eleven cottages were built.<sup>56</sup> A total of 250 children were distributed throughout the cottages; nine to house twenty-four children and two for sixteen children in each. Each cottage was intended to be ‘home-like’ with a house-mother for girls and a married couple for boys. An infirmary was provided with twenty beds, together with a ten-bed isolation block, workshops, stores, a laundry, swimming bath, schools, farm and outbuildings and the superintendents’ residence.<sup>57</sup> The children finally moved to the cottage homes in November 1884. Strict rules were imposed at the homes with the emphasis on cleanliness. From the age of fourteen, boys were trained on the farm or in the workshops for tailoring, carpentry, shoemaking, or painting, while the girls were trained in domestic skills.<sup>58</sup>

A part-time medical officer, Richard Steele, was appointed to the cottage homes. He was aged 29 and had been in medical practice for five years. He had previously worked as a district medical officer for the Lutterworth union and as a public vaccinator, which latter post he continued. His annual starting salary was low at £30 for the medical care of 250 children. It was ten years before the guardians raised his salary to £45. They justified the increase by stating that he

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<sup>54</sup> LRO, G/12/8d/1, 21 Sept, 26 Oct 1909; G/12/8e/5, 28 Nov 1911. This evidence contrasts with the lack of inspections made of boarded-out children conveyed in *The Minority Report*, pp. 142-3.

<sup>55</sup> LRO, G/12/8a/19, 5 Jul 1881. See [www.workhouses.org.uk](http://www.workhouses.org.uk) for information on 24 other cottage homes sites around the country.

<sup>56</sup> LRO, G/12/57b/6, 30 Nov 1881. The sum of £29,340 was spent on the purchase of the land and erection of buildings. Countesthorpe was described by C. N. Wright, *Wright’s Directory of Leicestershire, 1887-88*, (1888), p. 385, as a large village 6 miles south of Leicester. The cottage homes were situated about ¾ of a mile west of the village.

<sup>57</sup> K. Saunders, *et al*, *The Countesthorpe Cottage Homes: A World Apart* (Countesthorpe, c.1990), p. 4. The 46 acre farm supplied produce such as eggs, vegetables and fruit and stock to the workhouse as well as for consumption at the homes.

<sup>58</sup> LRO, DE1307, undated article on the cottage homes. When the children reached 16, they were placed in situations as apprentices or servants or sent to training ships.

provided a very efficient service and that he was the worst paid medical officer in the union.<sup>59</sup> As usual he had to pay for all medicines, medical and surgical appliances. He was not resident and lived two miles from the cottage homes although his surgery was within  $\frac{3}{4}$  mile.<sup>60</sup> Nor did he attend the cottage homes daily. A report in 1889 stated that he examined the children once a fortnight and in 1892 he was recorded as having visited the home 130 times during the year, which gives an average of 2.5 a week, so presumably on some weeks he visited once or twice, and occasionally three times.<sup>61</sup> Like most poor law medical officers, Dr Steele was a young practitioner earning his living and establishing himself in part-time public posts as well as receiving an income from private practice. Eventually he left for a post abroad in 1906. No fewer than six doctors applied for the vacancy. Unusually, his successor was an older experienced poor law medical officer, William Beresford, aged 51, who was appointed on £45 a year. By this time the guardians supplied medicines and appliances. Dr Beresford visited the homes three times a week.<sup>62</sup> Only one general nurse was appointed which again proved insufficient when infectious diseases occurred, yet it was not until 1900 that a general assistant was engaged to assist her.<sup>63</sup>

## Diet

In 1867 the guardians were reprimanded by the PLB for giving all children aged two to seven the same quantity of food. Separate dietary tables for children aged 2 -5, 5 -9, and 9-6 were then assigned with strict regulations on the quantities of food and drink. The guardians took some notice of the likes and dislikes of the children and occasionally requested permission to alter the children's diet. For example, in 1879 the guardians reported that the children preferred bread and cheese to the suet pudding. The LGB did not think that the former were as nutritious and suggested that if the suet was properly made and served with a sweet sauce the children might like it. The guardians insisted that they had already tried this and the children soon tired of it. They reported that the medical officer saw no objection to

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<sup>59</sup> LRO, G.12.188/1, 27 Feb 1894.

<sup>60</sup> LRO, G/12/57d/25, 23 Dec 1884.

<sup>61</sup> LRO, G/12/188/1, 20 Apr 1892.

<sup>62</sup> LRO, G/12/83/4, 11 Oct 1906; G/12/57d/46, 2 Nov 1906; G/12/8g/1 25 Feb 1915.

<sup>63</sup> LRO, G/12/8e.2, 27 Sep 1900; 1 Nov 1902. The nurse stayed there until her retirement at the age of 65 in 1902.

the changes which would save the present large amount of waste. The LGB swiftly acquiesced.<sup>64</sup>

The food provided at the cottage homes should have been more acceptable than at the workhouse as it was prepared and cooked on a much smaller scale in each cottage with some supplied fresh from the farm.<sup>65</sup> Dr Steele even became concerned that the children were being given too much rich food when he discovered that the leftovers from the 'extravagant' diet allowed for the officers were given to the children. He altered their diet to lighter food such as oatmeal which he felt was more nourishing for growing children.<sup>66</sup> Conversely, in 1900 an inspector reported that Dr Steele ought to check whether the children were being given enough food as he found that only one ounce of butter was allowed per week per child and he thought that twelve ounces of meat per week was insufficient for boys aged 9 to 16.<sup>67</sup>

### **Infectious diseases, isolation and the water supply**

In 1889 the children reportedly appeared to be very healthy.<sup>68</sup> Yet there were still regular outbreaks of infectious diseases and other illnesses as there had been at the workhouse. Preventative measures were taken but often proved ineffective. When seven cases of scarlet fever occurred in 1890 Dr Steele stated that as soon as a child was 'attacked', the child and its bedding were immediately removed to the infirmary. Other children from the infected child's cottage were also kept in isolation. The scarlet fever cases were kept in two large rooms with a nurse and an attendant. The nurse stayed in the infirmary throughout the course of the attack. However she soon had to cope alone when the attendant also became ill. This episode did not spread, but Dr Steele pointed out that if an epidemic occurred 'the present system of nursing would be utterly deficient.' A proper hospital and better precautions were needed to prevent potentially infective visitors from visiting

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<sup>64</sup> LRO, G/12/57d/19, 17 Jan 1879; 5 Feb 1879. LRO, G/12/57b/5, 8 Jan 1879; 22 Jan 1879.

<sup>65</sup> The children were expected to help prepare vegetables as well as undertaking other domestic tasks in their cottages.

<sup>66</sup> LRO, G/12/57d/26, 6 May 1886.

<sup>67</sup> TNA, MH12/6510, 31 Oct 1900. In 1872 the children were given 8 ounces of fish fortnightly in lieu of 2 ounces of meat. G/12/8a./27, 9 Feb 1892.

<sup>68</sup> TNA, MH12/6497, 29 Apr 1889.

the homes.<sup>69</sup> An inspector felt that isolation of the cases had not been as 'effective as it should have been.' However, he suspected that the disease could be attributed to the drinking water and he recommended further analysis as Dr Steele 'did not seem disposed to guarantee its purity.'<sup>70</sup> Yet the district medical officer and public analyst Dr Meadows had analysed the local water supply when the land was purchased and confidently declared that 'no better water would be likely to be obtained from any neighbourhood near Leicester.'<sup>71</sup>

The new analyst reported that two wells were 'polluted with animal organic matter to such a degree as to render them suspicious' and the water was 'unfit for drinking and ordinary domestic purposes.' Moreover the water was 'extremely hard'. The analyst did not think that the pure water in the third well would have a 'prejudicial effect' upon anyone drinking it. The guardians instructed that the two wells be emptied, cleaned and examined. They also intended to investigate another supply of water on the premises.<sup>72</sup> Two years later the prevalence of eczema amongst the children was attributed by Dr Steele to the hardness of the water and it was again analysed with the same results. This time the committee recommended that other sources of water be sought.<sup>73</sup> Within two years, in 1901, the corporation laid a new water supply to the cottage homes.<sup>74</sup>

Many children suffered skin diseases as a result of institutional living. This problem became so acute in 1913 that a specialist was consulted who found that twenty-nine children were suffering from scabies and/or contagious impetigo, a complication of scabies. The consultant recommended that the children with skin diseases should be completely isolated until they were entirely cured and better disinfection measures should be practised in future.<sup>75</sup>

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<sup>69</sup> TNA, MH12/6498, 3 Jan 1890.

<sup>70</sup> *Ibid.*, 5 May 1890. Scarlet fever is a streptococcal infection of the throat. It can be spread by airborne droplet infection or by touch. It could also occur through contaminated milk.

<sup>71</sup> LRO, G/12/57b/6, 8 Feb 1882.

<sup>72</sup> TNA, MH12/6498, 17 Sep 1890.

<sup>73</sup> *Ibid.*, 12 Jan 1900.

<sup>74</sup> LRO, G/12/8a/36, 12 Nov 1901.

<sup>75</sup> LRO, G/12/8e/6, 16 Apr 1913.

## Alterations to the homes

Despite the need for better infirmary accommodation, the guardians intended to erect an additional cottage for twenty-four children and to enlarge the girls' schoolroom. The LGB architect commented that the cottages used as an infirmary and a probation ward for new inmates were unsuitable as they had not been designed for this purpose. He recommended that money should instead be spent on a 'proper' new infirmary and probation ward and that a small mortuary was also necessary. Since the homes had opened there had been four fatal cases, several instances of severe illness, and, on one occasion, as many as sixteen patients in the infirmary cottage. The architect noted that 'batches of itch and measles had followed each other consecutively at short intervals at the end of 1884 and early part of 1885. The newly-arrived children had not been kept in quarantine at the workhouse for fourteen days as was usual, nor were they kept apart from the other children at the cottage homes for a sufficient period to ascertain whether they were carrying any infectious disease. Furthermore, the infirmary cottage did not have adequate means to separate the sexes. The children's committee had already recommended that an infirmary be erected, but the guardians had overruled in favour of more general accommodation. The committee hoped that the architect's views would strengthen their case for a new infirmary.<sup>76</sup> The guardians felt the cost would be too high. Instead they suggested that a wooden building would suffice as similar ones had been used in Leicester for the past twenty years.<sup>77</sup> The LGB refused this proposal as it felt that in order for it to be as 'complete and efficient as desirable', it would not be economical.<sup>78</sup> However, it did sanction the erection of an additional cottage and school room.<sup>79</sup>

Soon afterwards an LGB inspector became highly concerned about irregularities for preventing diseases spreading. He described how, in the absence of a nurse (who was untrained and incompetent in Dr Steele's view to deal with an epidemic), a charwoman had attended to a child admitted with scarlet fever. On the

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<sup>76</sup> TNA, MH12/6497, 1 Feb 1889.

<sup>77</sup> *Ibid.*, 23 Feb 1889. The estimated cost was £1,650. Mr Smith added in pencil on this letter that the corporation hospital for infectious cases was largely built of wood.

<sup>78</sup> *Ibid.*, 8 Mar 1889.

<sup>79</sup> *Ibid.*, 17 Jun 1889.

nurse's return, the medical officer sent the charwoman home with orders to disinfect herself. Four more scarlet fever cases were admitted to the infirmary. It transpired that an adopted child, who was suffering from scarlet fever which not been detected, had been returned to the cottage homes without the usual quarantine at the workhouse. Furthermore, isolation at the infirmary was not maintained. Two girls assisted the nurse and, although Dr Steele ordered them to leave as soon as the first case of scarlet fever was admitted, his order was ignored and they then had to stay in the infirmary. One of them subsequently caught the disease. The inspector was hopeful that this succession of mistakes had created a sense of alarm that would ensure that stricter isolation would be carried out in future. However, he thought that due to the errors it was highly likely that scarlet fever would spread throughout the homes.<sup>80</sup>

This incident, combined with pressure from the LGB, resulted in the opening of a new cottage homes infirmary in January 1893. In the meantime incidents of infectious diseases were reduced and the medical officer felt able to congratulate the guardians on the 'exceptionally good health' of the children during 1892, as there had been no epidemics in the homes and only one death from consumption.<sup>81</sup> In 1895 no deaths or infectious diseases were recorded and there was a 'complete absence of ophthalmia'.<sup>82</sup> This was probably a consequence of the directive in the rules and regulations for the cottage homes that stated that:

'Great care must be taken that a liberal supply of clean towels is always provided for the lavatory and for bathing purposes and should any child have any sign of ophthalmia or eruption of the skin, it must not be allowed to wash or bathe with the others, or use the same towels.'<sup>83</sup>

At least on this front there had been a considerable improvement from the earlier continual presence of ophthalmia in the workhouse where it was impossible to separate and isolate cases.<sup>84</sup>

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<sup>80</sup> TNA, MH12/6497, 23 Nov 1889.

<sup>81</sup> LRO, G/12/188/1, 20 Apr 1892.

<sup>82</sup> *Ibid.*, 26 Jun 1895.

<sup>83</sup> TNA, MH12/6507, Apr 1895. In 1897 the LGB urged medical officers to record cases of ophthalmia in newborn children and to direct midwives and nurses to cleanse the eyes of newborn babies with clean water and to instil a single drop of a two percent solution of 'nitrate of silver' [sic] into the eyes as a method of prevention.

<sup>84</sup> TNA, MH12/6490, 24 Feb 1880.

## **Infirmary cases**

Dr Steele's annual report for 1900 stated that out of 248 children (136 boys and 112 girls) there were about 50 out-patients per week. He regretted that three children had died from scarlet fever, heart disease and meningitis respectively but he was optimistic that the cases of eczema were decreasing and that otherwise the children's health was good.<sup>85</sup> His listed the cases treated in the infirmary as:

<b>Illness</b>	<b>Number</b>
Eczema	10
Chilblains	6
Abscesses	4
Ringworm	6
Spinal disease	1
Glandular	2
Ulcerated throat	4
Shingles	2
Psoriasis	1
Spnoritis [sic] of knee	2
Boils	2
Malignant scarlet fever	1
Heart disease (pericarditis)	1
Broncho-pneumonia	1
Membranes of brain (meningitis)	1
Acute rheumatism	2
Whooping cough	1
Phthisis	1
Affections [sic] of the eye	8

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<sup>85</sup> TNA, MH12/6510, 18 Jun 1900.



The list shows that skin and eye complaints continued to afflict the children, despite his earlier optimism. However, Dr Steele's confident views on the children's health were not shared by all. An anonymous guardian wrote to a local newspaper criticising the ill-health of the children due to the cottage homes system. He clearly preferred the boarding-out and scattered homes systems and felt that the monotonous and unnatural life at the cottage homes retarded the children's development and resulted in a low vitality that ensured that they easily and regularly contracted ophthalmia, scabies, measles and ringworm. Moreover, he felt that the cost of the homes was a 'heavy burden for the rate payer'.<sup>86</sup> Dr Steele strongly refuted these statements, claiming that in nine years there had been only one case of scarlet fever, nine of measles, twelve ophthalmia cases and seven ringworm cases. He believed that this was a very small number of infectious cases for a large institution close to a large manufacturing town that admitted many 'puny and emaciated' children. He considered that the general health of the children had been excellent in every way.<sup>87</sup> Understandably Dr Steele took the criticism personally, but his statement does not concur with the facts mentioned above; nor is it borne out by the problems that were experienced during the successive years as shown below.

### **Overcrowding**

In the early 1900s both the cottage homes and the workhouse, where children could still be found, were overcrowded. On admission, children were placed in receiving wards at the workhouse until they were passed free of infectious disease and sent to the cottage homes. As shown above, this practice often slipped. Babies and infants under two stayed with their mothers in the female wards or the nursery which was unappealingly described by Dr Bryan as a 'sunless' room where there had been an undue amount of sickness.<sup>88</sup> Accommodation at the workhouse was wholly unsuitable and measles often spread among the infants. A proposal went ahead to give the female imbeciles' ground floor room over for children, despite Dr Bryan's opposition to the children being placed in such close proximity

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<sup>86</sup> 'Boarding-Out for Poor Law Children by a Guardian', *Leicestershire Mercury*, 6 May 1905.

<sup>87</sup> LRO, G/12/8e/3, 10 May 1905.

<sup>88</sup> The cause was suspected to be adulterated milk. In 1897 an inspector had commented that the nursery was not as satisfactory or suitable as could be expected in such an important union as Leicester. TNA, MH12/6507, 29 Oct 1897.

to the maternity wards. He thought the frequent infectious diseases of the children would be very dangerous to the lying-in cases.<sup>89</sup> Much criticism was made of the use of a two-bed unheated isolation and venereal ward as a receiving dormitory for boys although it was claimed they only spent one night there. The ward opened into a common room where boys and men 'of all classes' could mix together. Remand boys were placed in adult male wards or, if they proved 'troublesome' in the male imbecile wards; a practice the inspector called 'indefensible'. It was decided that all children should be removed from the workhouse. To relieve the pressure on the cottage homes, two scattered homes for a maximum of twelve children were found in Leicester and a house was rented for a children's' receiving home.<sup>90</sup> A district medical officer, Dr Shearer, agreed to attend the children in the scattered homes for an extra £8 a year.<sup>91</sup> Dr Bryan attended the children in the receiving home. A home for twenty-four children who were 'Ins and Outs' was also established in 1910.<sup>92</sup>

Nevertheless, the numbers of very young children increased at the cottage homes. At one point there were 279 children and the workhouse master was instructed not to send any more children under three.<sup>93</sup> This led to a proposal to use the cottage homes infirmary for the two-to-five-year-olds (who numbered about 25) and to use one of the ordinary cottages for sick children; a situation that had been opposed some years earlier. In support, the guardians stated that the average number of in-patients had only been ten from 1896 to 1904 and for the past two years it had been twelve. The maximum number of beds used at any one time was 29. The nurse treated 20-40 out-patients daily in the infirmary.<sup>94</sup> This seems a high figure but presumably the causes were minor or routine. However, Dr Beresford deemed the present infirmary to be a necessity. He stated that there had been an average of fifteen in-patients during the past three months, and forty out-patients had been treated fortnightly, either in the cottages or at the infirmary dispensary. Among the medical cases there had been one of organic heart disease with dropsy, a severe case of curvature of the spine, scrofula, ringworm, middle ear disease, and

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<sup>89</sup> LRO, G/12/8a/40, 26 Mar, 2 Apr 1906.

<sup>90</sup> LRO, G/12/57d/46, 12 Feb 1906.

<sup>91</sup> LRO, G/12/8g/1, 11 Jun 1907. Dr Shearer optimistically asked for £8 a year for attendance on each home but he readily accepted £4 a year for each home.

<sup>92</sup> LRO, G/12/8g/1, 11 Jun 1907, 22 Feb 1910.

<sup>93</sup> LRO, G/12/8e/3, 16 Feb, 15 Sep 1905.

<sup>94</sup> LRO, G/12/57b/12, 28 Nov 1906.

several eye cases. He also listed recent accidents that had occurred, some of which were serious and required specialist treatment:<sup>95</sup>

- Child injured knee, septic inflammation with high temperature, sent into hospital, limb amputated.
- Splinter run into finger, much swelling and inflammation. Chloroform administered and nail removed.
- Injury to shoulder treated in infirmary.
- Injury to knee, inflammation, abscess opened.
- Fork run into big toe.
- Piece of pencil broken in ear.
- Cut face, one suture applied.
- Case of hernia.
- Other minor accidents.

Dr Beresford reminded the guardians that the use of a cottage as an infirmary had proved to be unsatisfactory and that none of the present cottages were suitable. The doctor pointed out that it was only recently that the guardians had decided to send very young children to the cottage homes and no proper arrangements had been made for them. He was quite certain that the need for the infirmary would become even greater in the future with so many very young children at the homes; already there was an urgent case of a four-year-old with double pneumonia.<sup>96</sup> Perhaps to appease the medical officer, and in recognition of the extra work caused by the larger number of children, the guardians increased his salary by £10 to £54.<sup>97</sup> Surprisingly, when the LGB refused permission to change the use of the infirmary, the guardians readily agreed and decided to build a nursery cottage instead.

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<sup>95</sup> LRO, G/12/57b/12, 15 Jan 1907.

<sup>96</sup> *Ibid.*

<sup>97</sup> LRO, G/12/57b/13, 4 Mar 1909.

## Other medical provision

By early 1900 special cases were sent to the general hospital or to North Evington Infirmary which was also overcrowded. The children were scattered throughout the infirmary rather than placed together in children's wards, which raised safety issues, such as the lack of fireguards. However, the superintendent of the hospital did not think it practicable to put the children in one ward because they had a variety of diseases, some of which were contagious. Consequently, the medical officer recommended that sick children would be better treated in the appropriate institutions.<sup>98</sup>

Evidence of developments to improve the children's general health is shown by the appointment of a dentist in 1906 to visit the cottage homes monthly and also to attend the scattered and receiving homes. The dentist was to examine all the children during the year, perform extractions and fillings and fix artificial teeth if a child's speech was defective due to the absence of teeth.<sup>99</sup> This appointment was very necessary as children's teeth were generally appalling, along with their eyesight.<sup>100</sup> Children with impaired eyesight were examined by a specialist and provided with spectacles which cost 3s 6d. Some children were sent to be treated at the General Infirmary and foster-parents were paid an extra 2s a week to cover medical extras for sick children.<sup>101</sup> Children with special needs continued to be sent to other institutions. Those parents who could afford to contributed towards the cost. For example, a boy was sent to the Derby Deaf and Dumb Institution at a cost of £20 a year. His father contributed 4s a week.<sup>102</sup> The guardians even arranged to send ringworm cases at a charge of 2s 6d per day to the Downs School run by the Metropolitan Asylum Board.<sup>103</sup> These changes coincided with the Liberal welfare reforms that introduced free school meals in 1906, national school medical inspections in 1907 and the Children Act in 1908.<sup>104</sup> No doubt these reforms

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<sup>98</sup> LRO, G/12/8j/2, 14 Jan; 2 Dec 1909; 27 Jan 1910; 3 Nov 1910. Forty fireguards were subsequently bought and fitted.

<sup>99</sup> LRO, G/12/57b/12, 23 Mar; 5 Sep 1906. He was paid a salary of £22.2s and travel expenses. The instruments were provided by dentist and drugs, materials and teeth by the guardians.

<sup>100</sup> Smith, *The People's Health*, p. 181.

<sup>101</sup> LRO, G/12/83/4, 14 Nov 1900; G/12/8d/1, 10 May, 6, 27 Jul, 1910, 17 Jan 1911.

<sup>102</sup> LRO, G/12/8a/23, 12 Mar 1889.

<sup>103</sup> LRO, G/12/8g/1, 8 Apr 1910.

<sup>104</sup> Harris, *Origins of the British Welfare State*, p. 154.

encouraged the guardians to pay increased attention to the health of workhouse children.

## **Summary**

The cottage homes provided a healthier environment than the workhouse. Yet similar problems of overcrowding were experienced due to the guardians' lack of preparation or holistic approach and their reluctance to spend ratepayers' money. Attempts to solve one problem often created another. Despite the intention to provide a more home-like, albeit isolated, situation for the children, cottages containing up to twenty-four children meant that infections spread easily as it was difficult to adequately separate the children. Outbreaks of measles and scarlet fever persisted and the seriousness of some accidents and illnesses points to a lack of adequate supervision or treatment. The provision for sick children at the cottage homes remained basically unchanged. Through much of the period, a part-time medical officer and one nurse were considered sufficient for over 250 children and an average number of twelve patients a week.<sup>105</sup>

The guardians believed that their intentions towards the care of pauper children were worthy and their attitudes reflected contemporary concerns. In return for their maintenance the children were trained to be useful, moral and obedient. While they were within the system, they were under the control of the guardians, not their own parents. In practice their treatment could be harsh. For example, it had been easier for children to have access to their parents in the workhouse. The cost of travelling to the cottage homes separated children and parents further.

The guardians' control over the children was extensive. For example, some children were returned to their parents if their situation had improved through re-marriage, relocation or obtaining work but in other circumstances children could be kept apart from their parents. Several children were sent to Canada, subject to passing a medical examination and the consent of their parents. In the matter of vaccination, however, the guardians were keen to protect parents' rights. The

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<sup>105</sup> LRO, G/12/57d/54, 15 May 1914.

guardians decided that they could exercise a parent's right to refuse to allow orphan and deserted children to be vaccinated.<sup>106</sup>

This chapter has, of necessity, concentrated on the in-door pauper children who were maintained, educated and medically treated by the union. In order to discover if their health was better than that of their out-door contemporaries, studies are needed on the children who received out-door relief. This is a seemingly impossible task due to the paucity of local out-relief records in Leicester. Despite the deficiencies of the poor law system, the workhouse children received treatment that their parents would not have been able to provide. Children who were admitted were often neglected, unhealthy, dirty and malnourished. In the cottage homes they were regularly attended by a medical officer and lived in clean conditions with adequate food. Their lives were regulated and their health was monitored. For children who had no parents, the board of guardians became in effect their administrative parents.

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<sup>106</sup> LRO, G/12/57d/30, 27 Dec 1890.

## Chapter 8

### Imbeciles and epileptics

#### Introduction

Many recent studies have been made of the history of insanity and institutions for the insane.<sup>1</sup> However, despite the importance of the poor law in the administration of pauper lunatics as highlighted by Bartlett, or the key role played by medical officers in the identification and treatment of the pauper insane,<sup>2</sup> very little is known about their treatment within the workhouse.<sup>3</sup> The workhouse clearly had its place within the mixed economy of care of the insane that historians now identify.<sup>4</sup> Yet, detailed work on workhouse provision for idiots and imbeciles is needed to shed light on the variety of institutional experiences of such patients.<sup>5</sup> This chapter attempts to redress the balance by providing an insight into the treatment and conditions experienced by paupers in the Leicester workhouse who were classified as ‘imbeciles’ or ‘insane’. Records relating to the district medical officers’ attendances on the out-door insane are not available to afford an insight into their treatment.

Rich details were found in the reports of the Visiting Commissioners in Lunacy (hereafter VCL) about the numbers of imbeciles, their behaviour, living conditions, and the attitudes of the central authority, the guardians and the

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<sup>1</sup> For example: Adair, *et. al.*, ‘A Danger to the Public?’, pp. 1-25; S. Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum/St Andrew’s Hospital c. 1810-1998* (Woodbridge, 2003); R. Hunter and I. Macalpine, *Psychiatry for the Poor: 1851 Colney Hatch Asylum-Friern Hospital 1973: A Medical and Social History* (Folkestone, 1974); J. Melling and B. Forsythe, *The Politics of Madness: The State, Insanity and Society in England, 1845-1914* (2006); J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (1999); C. Smith, ‘Family, Community and the Victorian Asylum: A Case Study of the Northampton General Lunatic Asylum and its Pauper Lunatics’, *Family & Community History*, 9 (2006), pp. 109-124; D. Wright, ‘Getting out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century’, *Social History of Medicine*, 10 (1997), pp. 137-155; D. Wright, *Mental Disability in Victorian England: The Earlswood Asylum, 1847-1901* (Oxford, 2001); D. Wright and A. Digby, *From Idiocy to Mental Deficiency: Historical Perspectives on People with Learning Disabilities* (1996).

<sup>2</sup> P. Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth Century England* (1999); Crowther, *Workhouse System*, p. 164.

<sup>3</sup> Miller, ‘The Role of the Poor Law in the Care of the Insane’, p. 22.

<sup>4</sup> P. Dale and J. Melling (eds), *Mental Illness and Learning Disability Since 1850: Finding a Place for Mental Disorder in the United Kingdom* (2006), p. 4.

<sup>5</sup> Wright, *Mental Disability in Victorian England*, p. 202.

workhouse officers towards their care.<sup>6</sup> These reports ranged from identifying significant defects to recommending small improvements such as providing table cloths and mustard to make ‘an agreeable and inexpensive addition’ to the patients’ meals.<sup>7</sup> This chapter focuses on the daily conditions and management of the imbeciles in the workhouse, in contrast to Bartlett’s study of the broader political and administrative aspects of poor law lunacy. Before discussing the patients and the medical officer’s involvement in their detention and care, the contemporary terminology that described the ‘insane’ is first explained and the legislative context is briefly outlined.

## Terminology

Nineteenth-century terminology used to identify people suffering from what is now referred to as ‘mental disability’ can be confusing.<sup>8</sup> Moreover, as Wright stated, when attempting to explain the contemporary meanings of such terminology today, ‘the linguistic heritage of the Victorian era, the accuracy required by academic historians and the sensitivities of people with disabilities must be considered.’<sup>9</sup> Nineteenth-century terms have now become unacceptable. Nevertheless in order to convey the contemporary mores, this study uses the language as expressed in the primary sources.<sup>10</sup>

In the nineteenth century the term ‘lunatic’ was often used as an umbrella term for any kind of mental illness or mental sub-normality.<sup>11</sup> Legally and medically the term ‘insane’ encompassed all those who were ‘of unsound mind’ and therefore unable to reason or control judgement or emotion. These terms were often used interchangeably. The delineation used by the central poor law authority in their returns for the numbers of in-door and out-door paupers was ‘*lunatics, insane persons and idiots*’, which covered anyone considered to have a mental disability.

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<sup>6</sup> The earlier treatment of the insane at Leicester workhouse is described by P. K. Carpenter, ‘The pauper insane of Leicester in 1844’, *History of Psychiatry*, VIII (1997), pp. 517-537 and Thompson, *Leicester Poor Law Union*, pp. 222-232.

<sup>7</sup> LRO, G/12/57d/15, 26 Jun 1874.

<sup>8</sup> Today’s accepted term ‘mental disability’ can mean either a mental illness or learning disability.

<sup>9</sup> Wright, *Mental Disability in Victorian England*, p. 9.

<sup>10</sup> Digby also points out that using the historical language helps understanding of past values and social attitudes. Wright and Digby (eds), *From Idiocy to Mental Deficiency*, p. 3.

<sup>11</sup> Ayers, *England’s First State Hospitals*, p. 37.



To break down the distinctions further, a person who was described as an ‘idiot’ was considered to be permanently mentally disabled probably from birth or a young age and incapable of ever possessing rational reasoning or behaviour. The term ‘imbecile’ referred to a low-to-moderate mental deficiency, that is, a mental age of two to seven.<sup>12</sup> Those two terms were often expressed together as ‘Idiots and Imbeciles’ with the implication of chronic but harmless mental conditions. Classification of workhouse inmates was imprecise, but in general this research has found that the Leicester union mainly used the term ‘imbecile’ rather than ‘lunatic’ to describe patients so classified. Interestingly, the margins of the guardians’ minute book for 1884-1886 listed some inmates as suffering from ‘mental disease’.<sup>13</sup>

## Legislation

The category of ‘lunatic’ or ‘imbecile’ was not specified in the list of classifications of pauper inmates in the 1834 Poor Law Amendment Act although lunatic wards were mentioned in the ‘Orders and Regulations to be Observed in the Workhouse’, issued by the PLC in 1834. Such inmates were therefore not necessarily segregated. However, the Act prohibited the detention of dangerous lunatics in the workhouse for longer than fourteen days, which implied that non-dangerous insane paupers were allowed to remain in the workhouse.<sup>14</sup> Lunatics could be sent to asylums that had been built following the permissive Counties Asylum Act, 1808. In 1845 new Lunacy Acts compelled every county and borough authority to provide asylums for pauper lunatics. The Acts also established the Lunacy Commission to be responsible for the regulation and inspection of licensed institutions and asylums for pauper lunatics. Eleven Lunacy Commissioners were appointed of which six, who were either medical professionals or barristers, were to regularly inspect and report on establishments where lunatics were in care, including workhouses. The Lunacy Act of 1853 strengthened the power of the Lunacy Commission and allowed chronic, harmless, incurable lunatics to be held in

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<sup>12</sup> H.G. Orme and W.H. Brock, *Leicestershire’s Lunatics: The Institutional Care of Leicestershire’s Lunatics during the Nineteenth Century* (Leicester, 1987), p. vii.

<sup>13</sup> LRO, G/12/8a/22, 10 Mar 1885, 15 Sept 1885.

<sup>14</sup> Bartlett, *Poor Law of Lunacy*, p. 44.

workhouse infirmary wards that met the standards required and approved by the Lunacy Commission.<sup>15</sup> The Lunacy Commission was given power in The Lunacy Act, 1862 to order the transfer of lunatics from workhouses to asylums as well as giving local asylum visitors and guardians the power to provide for a limited number of chronic lunatics in workhouses.<sup>16</sup> These stipulations were passed because lunatic asylums had become overcrowded and it was necessary to ensure that acute and dangerous cases could be detained in county asylums. Despite these powers, the Lunacy Commission's legal authority was limited and its recommendations to the central poor law authority and, indeed, to local guardians could be ignored as will be seen below.<sup>17</sup>

The General Consolidated Order, 1847 specified that it was the duty of the medical officer to give directions on the diet, classification, and treatment of paupers of unsound mind, and to report any pauper of unsound mind in the workhouse deemed to be dangerous, or fit to be sent to a lunatic asylum. Medical officers initially certified a pauper as insane. Thereafter the order to commit the person to the asylum was issued by a magistrate together with a relieving officer for the union in which the person resided. The Lunacy Act, 1862 gave the workhouse medical officer the duty to decide whether a lunatic was a proper person to remain in the workhouse and the 1867 Poor Law Amendment Act gave him the power to detain the insane pauper in the workhouse.<sup>18</sup>

## **Accommodation**

The first Leicester union workhouse provided no separate accommodation for the insane, although a few rooms were later used to manage some of those inmates more easily.<sup>19</sup> The union sent some insane and dangerous paupers to the Leicestershire and Rutland County Asylum which opened in 1837, or to asylums at

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<sup>15</sup> Melling and Forsythe, *Politics of Madness*, pp. 13-14.

<sup>16</sup> Hodgkinson, *Origins*, p. 586.

<sup>17</sup> For an analysis of the work of the Lunacy Commission see D.J. Mellett, 'Bureaucracy and Mental Illness: The Commissioners in Lunacy, 1845-90', *Medical History*, 25 (1981), pp. 221-250.

<sup>18</sup> Bartlett, *Poor Law of Lunacy*, p. 90.

<sup>19</sup> Carpenter, 'The Pauper Insane of Leicester in 1844', pp. 520-1.

Peckham, Birmingham or others around the country.<sup>20</sup> However, the 1851 re-built workhouse included separate ‘insane’ wards which were well used.<sup>21</sup> In 1857-8 the VCL reported that they contained 40-50 cases that would otherwise be in the asylum.<sup>22</sup> In 1865 the corporation decided to build its own asylum for the town’s pauper lunatics as the population of both the town and county had increased and the Lunacy Commission had objected to the county asylum being enlarged. An asylum was built on thirty acres of land in Humberstone and opened in 1869 for 300 patients. Further accommodation was added to the asylum in 1883 and 1890.<sup>23</sup>

The Leicester union was severely criticised by the VCL in a supplement to its Twelfth Annual Report in 1859 for its inadequate administration and medical treatment of imbeciles as well as for defective accommodation and deficient comforts and amusement. The criticisms subsequently appeared in *The Lancet* report on the ‘Maltreatment of Lunatics in Workhouses’. The guardians strongly refuted the charges and insisted that the workhouse had been misrepresented.<sup>24</sup> Later VCL reports were not as severe and tended to oscillate between dissatisfaction and approval of the treatment of the insane in the Leicester workhouse.

The criterion for removal of an insane pauper was predominantly managerial rather than medical.<sup>25</sup> It was less expensive to maintain paupers in the workhouse than in the asylum and, as the guardians frequently stressed, their main priority was to keep the rates down.<sup>26</sup> As Murphy pointed out, by 1852 there were more insane in some workhouses wards than in several county asylums.<sup>27</sup> When the government agreed to give a grant of 4s per head for each pauper lunatic removed to an asylum in 1874 it was expected that the numbers of insane in workhouses would

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<sup>20</sup> J. Storey, *Historical Sketch*, p. 47.

<sup>21</sup> Leicester was among the 104 workhouses noted by Mellett, ‘Bureaucracy and Mental Illness’, p. 239, that had built separate lunatic wards by 1877.

<sup>22</sup> Carpenter, ‘The Pauper Insane of Leicester in 1844’, p. 535.

<sup>23</sup> *Wright’s Directory of Leicester, 1898*, p. 266, noted that in 1898 it had over 510 patients and further enlargement was intended with a detached block for private patients. The charge for pauper patients was 10s 6d per week.

<sup>24</sup> Thompson, *Leicester Poor Law Union*, p. 230.

<sup>25</sup> Driver, *Power and Pauperism*, p. 106.

<sup>26</sup> Wright, ‘The Discharge of Pauper Lunatics from County Asylums in Mid-Victorian England: The case of Buckinghamshire, 1853-1872’, in Melling and Forsythe (eds), *Insanity, Institutions and Society*, p. 103, noted that asylum accommodation cost three times as much as workhouse provision, and five times as much as out-door relief.

<sup>27</sup> E. Murphy, ‘Workhouse Care of the Insane, 1845-90’, in P. Dale, and J. Melling (eds), *Mental Illness and Learning Disability*, p. 27.

significantly decrease. However, this was not the case, showing that financial factors were not solely responsible for pauper lunatics' asylum admission.<sup>28</sup> Although the numbers in asylums rose, large numbers of insane paupers were retained in workhouses, pointing to the general rise during the nineteenth century in incidents and diagnoses of insanity as noted by historians of insanity. It is difficult, however, to be precise about the numbers of insane in workhouses as there was always considerable local variation. According to the *Minority Report* of 1909, workhouse inmates certified as of unsound mind rose from 7,963 in 1859 to 11,151 by 1906. This figure excluded imbeciles who were not certified and the increasing numbers that the *Report* stated ought to be certified as 'distinctly feeble-minded.' The *Report* estimated that the total number of 'mentally defective' persons in the general mixed workhouses then amounted to 60,000 out of a total in-door population of approximately 200,000.<sup>29</sup> Table 8.1 below shows the fluctuation of numbers of imbeciles in the Leicester workhouse.

**Table 8.1**  
**Numbers of imbeciles in Leicester workhouse**<sup>30</sup>

Year	Males	Females	Total
1870	48	27	75
1875	48	35	83
1880	40	45	85
1885	40	53	93
1890	41	56	97
1895	36	39	75
1900	27	30	57
1905	23	24	47
Average	37.9	38.6	76.5

There was no significant difference between the numbers of male and female patients.<sup>31</sup> Imbecile patients did not form a high proportion of the Leicester workhouse inmates. Nationally the percentage of imbeciles in workhouses ranged

<sup>28</sup> R. Ellis, 'The Asylum, the Poor Law, and a Reassessment of the Four-Shilling Grant: Admissions to the County Asylums of Yorkshire in the Nineteenth Century', *Social History of Medicine*, 19 (2006), pp. 55-71.

<sup>29</sup> PLC, *The Minority Report*, p. 300.

<sup>30</sup> These figures are taken from the VCL reports. See also Tables 4.1 and 4.2 in Chapter 4.

<sup>31</sup> A. Shepherd, 'The Female Patient Experience in Two Late-Nineteenth-Century Surrey Asylums', *Clio Medica/The Wellcome Series in the History of Medicine*, 73 (2004), p. 228, explains that this was a similar situation in many asylums.

from 12 to 20 per cent.<sup>32</sup> But incurable and ‘harmless’ dependent imbeciles were likely to remain long-term inmates.<sup>33</sup>

### **Classification and diagnosis**

The VCL and workhouse medical officer’s reports usually referred to imbeciles as ‘patients’, indicating that they were recognised as a special category of inmate, although imbeciles could be considered able-bodied or not, which determined whether they were given work to do. Disparities in diagnosis occurred between the medical officer and the VCL who sometimes recommended that patients could ‘be taken off the list of the insane.’<sup>34</sup> Responding to recommendations in 1877 to send a patient to the asylum, the guardians defended Dr Clarke’s view that the patient was ‘a proper person to be detained in the imbecile wards of the workhouse.’<sup>35</sup> Dr Clarke clearly felt qualified to disagree with the VCL, perhaps because of his work at the mental hospital. However, the magistrate made the final decision as to whether a person was sent to the asylum.

Often physical conditions were confused with mental disability such as cerebral palsy or vision impairments.<sup>36</sup> In 1879The VCL found a paralytic woman whose speech was affected had been classed as an imbecile, but after questioning her and receiving rational answers, they concluded that she was not insane and should not have been so classed.<sup>37</sup> She was quickly removed from the imbecile wards.<sup>38</sup> Occasionally the VCL reported improvements in patients and recommended that they be ‘removed for a trial period’ to the main workhouse. For example, in 1883, Eliza Johnson, reported as ‘melancholic’ on admission, was considered to be much improved by the commissioners as ‘she conversed rationally’ and was ‘at work with her needle industriously.’<sup>39</sup> It is also possible that, on

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<sup>32</sup> M.A. Crowther, ‘The Later Years of the Workhouse, 1890-1929’, in P. Thane (ed.), *The Origins of British Social Policy* (1978), p. 49. In the period studied here, the highest percentage of imbeciles in the Leicester workhouse was 14.9 per cent in 1875 which dropped to 6.7 per cent by 1895.

<sup>33</sup> Borsay, *Disability and Social Policy*, p. 28.

<sup>34</sup> LRO, G/12/57d/25, 13 Feb 1885.

<sup>35</sup> LRO, G/12/57b/5, 25 Apr 1877.

<sup>36</sup> Borsay, *Disability and Social Policy*, p. 66.

<sup>37</sup> LRO, G/12/57d/19 12 Jul 1879.

<sup>38</sup> TNA, MH12/6490, 14 Jul 1879.

<sup>39</sup> LRO, G/12/57d/23, 22 Dec 1883.

occasions, senility was sometimes mistaken for imbecility.<sup>40</sup> As the workhouse medical officer wrote a few years later:

‘I have gone through the House, male and female, imbecile wards, the old infirmary, and those who are sick in the new infirmary and I have found that the number of feeble-minded are 155 [sic]. Of course, these include a large number whose ages vary from 70 to 85 years, who are really suffering from what may be called second childhood, but which are not cases which I would certify as Imbeciles or Lunatics.’<sup>41</sup>

Old people and epileptics were not certified as insane but were nevertheless placed in imbecile wards ostensibly to receive more care and attention.<sup>42</sup> In reality it was convenient for the workhouse management. Indeed a commissioner remarked in 1899 that he was ‘sorry to see as many as fourteen men and twenty-two women who ... display no mental disease.’<sup>43</sup> The medical officer justified this on the grounds that other commissioners had passed the patients as either epileptics or elderly people with ‘senile dementia’, and had told him not to certify them when they were old as it made the lunacy statistics look large, though they agreed that the imbecile wards were the best places for them.<sup>44</sup> An earlier VCL report in 1889 had indeed requested the medical officer to review the older men and women and to consider whether some who ‘appear to be only suffering from senile decay ... might not be subtracted from the list of insane, still keeping them under supervision in the imbecile wards and drawing a distinction between mere senility and insanity in the statistics.’<sup>45</sup>

In 1871 Dr Clarke recommended that some imbeciles who had ‘become insane’ should be admitted to the asylum, suggesting that perhaps they were not correctly diagnosed on admission. Of course, incarceration in the workhouse may have induced depression for some or even prompted suicidal tendencies which could have been viewed as insanity. Possibly further observation was required

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<sup>40</sup> LRO, G/12/57d/21, 2 May 1881.

<sup>41</sup> LRO, G/12/57d/40, 23 Sept 1900.

<sup>42</sup> LRO, G/12/57d/38, 21 Jun 1898.

<sup>43</sup> LRO, G/12/57d/39, 31 Jan 1899.

<sup>44</sup> LRO, G/12/57d/39, 12 Mar 1899. The term ‘senile dementia’ was used by the commissioner, although it is difficult to know whether it was applied as it might be today.

<sup>45</sup> TNA, MH12/ 6508, 4 Oct 1889.

before insanity could be diagnosed. Murphy noted that many unions preferred to delay admission to the asylum to see if the patient settled or improved sufficiently to go home within a few days.<sup>46</sup> This seemed to be the case in 1881 for four new admissions that had not yet been classed as insane but were advised by the VCL to be added to the lunatic list.<sup>47</sup>

There was reluctance to remove patients to the asylum, although cost was never given as the reason. In 1871 the VCL recommended that George Harris who was ‘much depressed’ and Joseph Shingles who was ‘excited at times’ and ‘so noisy at night that he was put in a single room’, should both be sent to the asylum.<sup>48</sup> However, the guardians replied that George Harris had left the workhouse and was ‘now in the custody of his wife’, and that Shingles had quietened and in Dr Clarke’s opinion there was ‘at present no need for his removal.’<sup>49</sup> An earlier VCL report in 1869 had praised the ‘watchfulness and care of Mr Clarke’ in sending cases ‘unfit for the workhouse’ to the asylum. Yet that same report drew his attention to two females who ‘may need to be sent to the asylum.’<sup>50</sup> The next report observed that one was restless but improved and unless she became worse, she could be properly retained under observation by Dr Clarke. She died shortly thereafter. However, the other patient was still very excitable and troublesome and she was duly sent to the asylum. A patient who the VCL considered would benefit from medical treatment in an asylum was brought before a Justice of the Peace in 1870 but he was not satisfied that she was insane and declined to order her removal to the asylum.<sup>51</sup> These incidents confirm Mellett’s observation that the intended function of the Lunacy Commission was legalistic rather than medical. Its only diagnostic method of judging insanity was by conversing with patients on brief intermittent visits.<sup>52</sup>

A standard letter in 1872 informed all unions that the duty of workhouse medical officers to justify the detention of lunatics, or alleged lunatics, in the workhouse beyond fourteen days was ‘very imperfectly observed,’ and called upon

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<sup>46</sup> Murphy, ‘Workhouse Care of the Insane’, p. 34.

<sup>47</sup> LRO, G/12/57d/21, 2 May 1881.

<sup>48</sup> LRO, G/12/57d/14, 27 Feb 1871.

<sup>49</sup> LRO G/57b/4, 5 Apr 1871.

<sup>50</sup> LRO, G/12/57d/13, 14 Jun 1869.

<sup>51</sup> LRO, G/12/57d/13, 8 Feb 1870; G/12/57b/14, 21 Mar 1870.

<sup>52</sup> Mellett, ‘Bureaucracy and Mental Illness’, p. 245.

guardians to ensure compliance with this requirement.<sup>53</sup> The Leicester workhouse medical officers appeared to comply, although in 1882 the VCL thought that the certificates ought to be kept in a bound book rather than in loose sheets which ‘could easily be lost’. They also noted that no medical examination book was kept which ‘should be remedied at once.’<sup>54</sup>

Besides disruptive and unmanageable patients, those who were considered curable were sent to the asylum. For instance, the VCL recommended that Arthur Winterbourne should be sent there for curative treatment,<sup>55</sup> and Sarah West, who was depressed and had threatened suicide, ought to have been under ‘special observation’ and removed to the asylum if she became worse.<sup>56</sup> Importantly, if patients were not classed as of unsound mind there was no legal authority to detain them against their will: a commissioner considered that an epileptic who appealed to be discharged was dangerous and aggressive, and ought to be in an asylum as he had been in an asylum twice before, but he could not be detained unless he was certified ‘insane’. As he answered questions sensibly, there was no statutory authority for his detention.<sup>57</sup>

The union medical officer’s diagnosis was recorded in the asylum admissions register. Melling and Forsythe found that there was reasonable concurrence between the initial diagnosis of the union medical officer and the subsequent description of the patient’s symptoms in the more elaborate asylum case books.<sup>58</sup> The register of patients for the Leicester Borough Asylum revealed the diagnoses of ‘mental disorder’ given by the district and workhouse medical officers for patients admitted. These included: chronic mania, melancholia, mental imbecility, imbecility, idiocy, epileptic mania, acute mania, puerperal mania,

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<sup>53</sup> LRO, G/12/57d/14, 27 Sept 1872.

<sup>54</sup> LRO, G/12/57d/22, 25 July 1882.

<sup>55</sup> LRO, G/12/75a/1, 20 July 1885. Arthur Winterbourne was sent to the asylum a few months later, where he died six months after admission.

<sup>56</sup> LRO, G/12/57d/25, 13 Feb 1885. It is questionable how much ‘special observation’ could be undertaken considering the numbers of patients under the care of one or two untrained attendants. Nevertheless, Sarah West was not sent to the asylum.

<sup>57</sup> LRO, G/12/57d/35, 28 Mar 1895.

<sup>58</sup> Melling and Forsythe, *Politics of Madness*, p. 61.



congenital insanity, simple mania, dementia, senile dementia, delusional insanity, and general paralysis.<sup>59</sup> A variety of causes for the insanity were given, including:

‘family trouble, injury to the head, hereditary, bad living, epilepsy, congenital defect, anxiety, drunkenness, jealousy, recent confinement, overwork, ill-treatment of husband, small-pox, intemperance, hyper-lactation, trouble, loss of daughter, seduction, menstrual derangement, paralysis, love affairs, mental worry, old age, change of life, domestic trouble, railway accident, disappointment in love, death of a relative, concussion of brain, syphilis, over-study, hysteria, pregnancy, destitution, apoplexy, money troubles, brain fever, business losses, typhoid fever, sunstroke, grief, religious excitement, and disappointment.’<sup>60</sup>

The limits of this present study precluded further investigation into the case studies of patients admitted to the asylum from the workhouse. However, further research would be useful to explore whether the Leicester medical officers’ diagnoses were similarly adopted and to track the differences in patients’ experiences in the workhouse and the borough asylum. Similarly, it would be useful to explore the differences between poor law and asylum medical officers. The medical officer at Halifax union, Thomas Dolan, felt strongly that the status and conditions of the latter were far superior.<sup>61</sup>

## Children

The returns for in-door paupers included a column for children under 16 in the ‘Lunatics, Insane Persons, and Idiots’ section. The numbers recorded for Leicester workhouse were low; generally around three to five and few children were mentioned in the VCL reports.<sup>62</sup> Some exceptions were Josiah Wedge, aged 15, who was reported to be ‘clearly of unsound mind’. He was sent to the asylum where he died five years later.<sup>63</sup> Detention was also enforced to protect a ‘weak-minded’ girl, Louisa Shipley aged 16. A commissioner considered that she should be detained if the medical officer agreed that her weakness amounted to

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<sup>59</sup> LRO, DE2853/11, Sep 1869-Aug 1892.

<sup>60</sup> *Ibid.*

<sup>61</sup> Dolan, ‘Some Remarks on Workhouse Hospitals’.

<sup>62</sup> Crompton, *Workhouse Children*, p. 82, stated that ‘insane, idiot and imbecile children were kept in the normal children’s wards, being tolerated if they were not dangerous or disruptive.’

<sup>63</sup> LRO, G/12/57d/25, 13 Feb 1885; LRO, 26D68/1147.

unsoundness. Her past history was undoubtedly a consideration. She had been in jail and the penitentiary; her sister was a congenital imbecile and he considered that Louisa was 'somewhat weak-minded'. She objected to being in the workhouse but the commissioner felt that if the medical officer classed her as unsound she could be legally detained which was, in his opinion, 'certainly desirable for her.'<sup>64</sup>

## **Epileptics**

Patients who suffered from epilepsy were not generally regarded as insane, although imbecile wards were felt to be more appropriate places in which to manage their fits. The wards were not especially designed for these patients but they had padded rooms where patients were occasionally secluded for short periods either due to mental disturbance after a fit or as a safer place during a fit. Seclusion was always recorded and reported to the medical officer and no restraint was used.<sup>65</sup> The commissioners' view was that when patients suffered a fit they should be placed on a low couch rather than in a cell though it was evident that the lack of staff and inappropriate seating presented dangers to such patients. Suitable couches and matting were recommended to prevent injuries when patients suffered a seizure. In 1881 it was reported that there were seventeen male and eleven female epileptic patients, some of whom had bruising as a result of falling during fits onto brick floors, and one old man was extensively bruised on the face from falling from bed at night. It was recommended that a second paid attendant be appointed and that a sane pauper be present at night to give assistance.<sup>66</sup> The guardians accordingly provided sides to the beds for the epileptics, but they did not cover the brick floors.<sup>67</sup>

The medical officers evidently agreed that epileptic patients should be retained in imbecile wards except in special circumstances. In 1874 an eighteen year-old epileptic, was transferred to the asylum, despite 'no special indication of insanity' and only 'weak intellect' on the grounds that he was not a suitable

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<sup>64</sup> LRO, G/12/57d/21, 2 May 1881.

<sup>65</sup> LRO, G/12/57d/12, 20 Apr 1868.

<sup>66</sup> LRO, G/12/57d/21, 2 May 1881.

<sup>67</sup> LRO, G/12/57d/22, 25 Jul 1882.

‘subject’ for the imbecile wards. Dr Clarke was prepared to certify the boy’s weakness of mind to the magistrate, but the decision may also have been influenced by the father’s willingness for his son to be transferred to the asylum and to pay for part of the cost of his maintenance.<sup>68</sup>

## Management

The medical officer visited the imbeciles three times a week,<sup>69</sup> but it was the untrained attendants who were responsible for their daily management. Attendants occasionally had to prevent imbeciles from harming themselves and other inmates. For example, in 1880 Dr Bryan recommended that Rosita Morley should be removed to the asylum as she was ‘unmanageable and dangerous’. She had ‘repeatedly struck the other inmates besides pulling off a quantity of hair from one of the others and greatly disturbing them at night’.<sup>70</sup> Violent inmates were sometimes placed in the padded room to protect other patients. For instance, Charles Durant had been ‘very violent in knocking the other inmates about’ and he was placed in the padded room on two occasions. Subsequently he was sent to the asylum.<sup>71</sup>

In 1875 the VCL confirmed that no workhouse imbeciles required removal to the asylum due to ‘excitement or violence,’ but they noted that several imbeciles were ‘troublesome’ and two of the women were often ‘fastened in their chairs by a wooden bar across the arms.’<sup>72</sup> The use of mechanical restraints such as straight-

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<sup>68</sup> LRO, G/12/94, 1 Dec 1874. The Lunatic List shows that John Grey was sent to the asylum on 11 Dec 1874, G/12/75a/1. A Register of Patients for the Leicester Borough Lunatic Asylum stated that he suffered from chronic mania, caused by epilepsy which started when he was aged 9. He died on 26 Dec 1892, LRO, DE2853/117.

<sup>69</sup> TNA, MH12/6484, 18 Jan 1873.

<sup>70</sup> LRO, G/12/94, 11 Oct 1880. The Lunatic List shows that Rosita Morley was indeed sent to the asylum on 12 Oct 1880, G/12/75a/1. The name Rosetta Morley also appears in a later Lunacy Committee Minute Book which presumably is the same patient as different versions of names were sometimes given for the same individual. This shows that she was still in the asylum some ten years later, 16 July 1900, 19 Nov 1900, G/12/8h/1. A Register of Patients for the Leicester Borough Lunatic Asylum lists Rosetta Morley as suffering from mania. She died on 18 Feb 1905, LRO, DE2853/117.

<sup>71</sup> LRO, G/12/94, 1 Nov 1880.

<sup>72</sup> LRO, G/12/57d/16, 28 Oct 1875.

jackets and chains had been banned nationally in 1853,<sup>73</sup> but seemingly chair bars did not count as a form of restraint. Dr Clarke also earlier recommended the purchase of broad wrist straps to prevent sick imbeciles undoing their dressings or ‘bedaubing themselves with their dirt in bed.’<sup>74</sup> Historians have noted that poor law officers were inconsistent when defining violent behaviour. However, potentially suicidal patients and those who displayed disruptive behaviour were usually quickly removed. For example, Thomas Hanbury who was ‘melancholic and possibly suicidal’ and Ann Gates who was ‘much disposed to strip herself’ were both rapidly transferred to the asylum.<sup>75</sup>

In 1874 the VCL reported that there was ‘considerable ... resort to seclusion’. Difficult imbeciles were put in the “Black Hole” referred to in Chapter 3 for four to six hours. The commissioners felt that patients, who were controlled by periods in solitary confinement, would be more suitably treated in an asylum.<sup>76</sup> Insufficient attendants undoubtedly resulted in the seclusion of patients. For much of this period there was only one male and female paid attendant for the superintendence and care of the imbecile and epileptic patients, although the female ward had a sane pauper assistant. The VCL felt there ought to be another assistant in the upper dormitory at night as six epileptic patients slept there with only the other patients to help them if necessary. They pointed out that those patients should also have low padded bedsteads,<sup>77</sup> presumably to avoid injury to their heads when they suffered fits.

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<sup>73</sup> K. Morrison, *The Workhouse: A Study of Poor-Law Buildings in England* (Swindon, 1999). p. 162. Hunter and Macalpine, *Psychiatry for the Poor*, p. 14, recorded that in 1839 John Connolly had abolished the use of mechanical restraint and ‘initiated the non-restraint system which became the banner of enlightened asylum care.’ Ayers, *England’s First State Hospitals*, p. 40, stated that the use of mechanical restraints although forbidden by the Lunacy Commissioners was tolerated because workhouse staff could not manage without them. Such use of mechanical restraints was evidently recognised and allowed to continue. The letters from the LGB to the Leicester union contain copies of regulations on such use. In 1895 a regulation was issued stating that a register of mechanical restraint must be kept giving the details of the patient, the restraint used and providing a certificate from the medical superintendent or attendant which stated the grounds for such use. LRO, G/12/57d/35, 15 Jul 1895. A VCL report of a visit in 1896, stated that ‘no mechanical restraint is employed’, LRO, G/12/57d/36, 24 Sep 1896. However, the next year a similar report mentioned that there had been one instance of mechanical restraint by means of a jacket, which use conformed to the VCL’s regulation, TNA, MH12/6507, 7 May 1897.

<sup>74</sup> LRO, G/12/94, 19 Jun 1872.

<sup>75</sup> TNA, MH12/6508, 4 Oct 1889; 18 Nov 1889. For a longer discussion on the removal of disruptive or dangerous patients see Adair, *et al.*, ‘A Danger to the Public’ pp. 13-17.

<sup>76</sup> LRO, G/12/57d/15, [no day given] Feb 1874.

<sup>77</sup> *Ibid.*

## Care and recreation

In most reports the VCL commented that the women appeared to be clean and tidy and their rooms and beds well attended, which was thought to reflect the 'kind and efficient, attention and supervision' of the paid attendant. It seems that the men did not receive the same attention as they frequently appeared to be in a less satisfactory state of cleanliness, with 'dirty and worn' clothes, their caps 'unfit for them to wear.'<sup>78</sup> But not all attendants were kind. The superintendent twice complained to Dr Clarke about the inefficiency and disobedience of Alice Gulliver, the assistant nurse. He asked the guardians to consider removing her. A few days later she pushed an old woman down causing an 'excoriated wound of the nose.'<sup>79</sup> Shortly thereafter she resigned with the cause given as 'not suiting her place.'<sup>80</sup> Bryan Timpson, the attendant of the male imbecile ward, was reported by Dr Clarke to be 'so influenced by drink as to be unfit for duty.' He had absented himself on two nights during the week, which the medical officer stated was 'a proceeding quite at variance with the proper safety of imbeciles and epileptics at night.'<sup>81</sup>

The attendants' competence was undeniably questionable. The type of work, low salary and unappealing conditions were unlikely to attract dedicated or trained staff. The records reveal the continual turnover of attendants in common with other workhouse staff. Using unpaid pauper assistants was problematic. In 1877 the VCL reported that there was insufficient assistance for the eighty-nine imbeciles in the workhouse. However, they had been informed that 'owing to the class of pauper women received there 'it was very difficult to get suitable sane pauper assistants.' Once more, the commissioners advised extra provision for emergencies at night, particularly as two of the wards were some distance from help. They recommended fixing bells in those wards to communicate with the nurse's room and sanctioned the assistance of other imbeciles by stating that it would be necessary for the bells to be put next to the beds of the most 'intelligent'

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<sup>78</sup> LRO, G/12/57d/16, 28 Oct 1875.

<sup>79</sup> LRO, G/12/94, 23 and 29 Jan 1880.

<sup>80</sup> TNA, MH9/10. Alice Gulliver was appointed in October 1878. The medical superintendent of Leicestershire and Rutland County Lunatic Asylum where she had previously been employed as an assistant nurse stated that she was 'generally kind and careful to the patients and her conduct was generally good.'

<sup>81</sup> LRO, G/12/94, 28 Dec 1877. The attendant resigned a year later.

of the imbeciles.<sup>82</sup> A woman night attendant visited the male and female wards intermittently, but this was felt to be ‘an insufficient safeguard for epileptics’.<sup>83</sup>

The medical officer had also requested a competent young person to assist with the forty-two imbeciles in the female imbecile ward.<sup>84</sup> The arrangements in the male ward were equally unsatisfactory, particularly as two of the inmates were violent and insubordinate.<sup>85</sup> Finally, in June 1878 the guardians appointed an assistant nurse for the female imbecile ward, but insisted there was no need for a further attendant for the male ward.<sup>86</sup> Surprisingly this was supported by the VCL due to the decrease of male patients, but with the rider that any increase would make such an appointment ‘indispensable’.<sup>87</sup>

Insufficient assistance for the male imbeciles exacerbated problems. In 1881 the VCL were still dissatisfied with the condition of the ward and patients. There was one paid attendant for thirty-seven patients, seventeen of whom were epileptics. However, both the VCL and guardians merely considered getting a sane pauper to sleep in the male dormitory at night. The VCL noted that two inquests had been held on a patient who died of head injuries after a fall and another who choked to death. However, their report stated that ‘in both cases no blame appears to have been attached to the attendants’.<sup>88</sup> The guardians remained confident that one attendant and a pauper assistant were sufficient.<sup>89</sup> However, the VCL commented again that the couches were too high and were made of easily bent basketwork. During their inspection, a woman ‘fell off one in a fit and struck her head severely on the bare brick floor’, which was unsuitable and dangerous for a ward ‘inhabited by so many epileptics’.<sup>90</sup> The following year the guardians ordered new couches and they finally decided that the floors should be ‘wholly covered with cocoa-nut

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<sup>82</sup> LRO, G/12/57d/17, 19 Dec 1877. The problem remained unresolved. In 1896 the VCL urgently called for improvements as an epileptic patient had recently died from suffocation during a fit. LRO, G/12/57D/36, 24 Sep 1896.

<sup>83</sup> LRO, G/12/57d/38, 21 Jun 1898.

<sup>84</sup> LRO, G/12/94, 9 May 1878.

<sup>85</sup> *Ibid.*, 11 Nov 1878.

<sup>86</sup> LRO, G/12/57b/5, 3 Jun, 7 Aug, 30 Oct 1878.

<sup>87</sup> LRO, G/12/57d/19, 14 Jul 1879.

<sup>88</sup> LRO, G/12/57d/23 22 Dec 1883.

<sup>89</sup> LRO, G/12/57b/6, 22 Jan 1884.

<sup>90</sup> LRO, G/12/57d/23, 22 Dec 1883.

matting.’<sup>91</sup> The VCL were also pleased that a second paid male attendant had at last been appointed. A recent incident aptly justified the appointment. An epileptic patient, Benjamin Lythall, had, according to the VCL report, been roughly handled in a violent attempt to master him by other inmates of an unsound mind, who had been called to assist the paid attendant when the patient had struck him on the head with a towel roller. This occurrence led the commissioner to comment, not only on the danger of employing just one attendant so that he was compelled to call on ‘irresponsible individuals for help in the discharge of his duties’, but also on the need to secure such ‘dangerous weapons as towel rollers’ which were questionable ‘fittings in lavatories for the insane.’<sup>92</sup> Following this report, Lythall was quickly removed to the asylum where he was registered as suffering from epileptic mania.<sup>93</sup>

The male assistant also had other workhouse duties, causing the VCL to comment that the male imbeciles were supposed to be supervised by two paid attendants but one of the attendants was ‘much employed in the garden or conducting funerals’.<sup>94</sup> In 1889 an assistant attendant was transferred to the post of labour master at the workhouse.<sup>95</sup> Unusually, on this occasion, his replacement had previous experience of working with the insane as he had previously been an assistant attendant at Broadmoor Criminal Lunatic Asylum which he had left to ‘better [his] position in business.’<sup>96</sup>

Deficient bathing arrangements doubtless contributed greatly to the male patients’ lack of cleanliness. In 1867 the VCL had been optimistic that the bathing arrangements for imbeciles would vastly improve when the children were removed to the new school building. Their baths would then be used exclusively for the imbeciles.<sup>97</sup> However, over a year later, the bathing arrangements were still ‘unsatisfactory and greatly require[d] attention.’ The baths were long and narrow and to save time and water, four patients were placed in the bath together. The water was changed after eight patients had been bathed. The VCL insisted that

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<sup>91</sup> LRO, G/12/57b/6, 22 Jan 1884; 12 Nov 1884.

<sup>92</sup> LRO, G/12/57d/24, 22 Oct 1884.

<sup>93</sup> LRO, DE2853/117, 1 Oct 1884.

<sup>94</sup> LRO, G/12/57d/40, 2 Apr 1900. See also Chapter 5 above.

<sup>95</sup> This example confirms that workhouse staff sometimes changed posts in the workhouse.

<sup>96</sup> TNA, MH12/6497, 22 May 1889.

<sup>97</sup> LRO, G/12/57d/12, 22 Apr 1867

every patient should be bathed in clean water and that smaller baths should be provided.<sup>98</sup> The guardians maintained that no alterations to the baths could be made and in any case it was unnecessary, although they grudgingly conceded that, ‘if necessary fewer patients may be bathed at once and the water changed more frequently.’<sup>99</sup> But the practice was simply reduced to bathing three men together instead of four and a further three men were then bathed in the same water. The same practice applied for the women, causing the VCL to state that, ‘This highly objectionable and indecent practice should at once be discontinued and baths of ordinary size be substituted in which one patient at a time should be bathed.’<sup>100</sup> This practice was widespread leading the PLB to issue a circular with rules and guidance stipulating that only one patient was to be bathed in the same water.<sup>101</sup> Despite their assurances, there were many lapses: a commissioner discovered that the bathing rules displayed had been altered in pencil ‘so as to permit six persons to be bathed successively in the same water.’ The attendant admitted this was the practice although no-one would admit to altering the notice.<sup>102</sup> Eventually the VCL were confident that fresh water was provided for each bath though discrepancies continued. The men had weekly baths; the women only fortnightly. Not only were the women bathed less often but two were bathed before the water was changed.<sup>103</sup>

Imbeciles who were sufficiently able-bodied were expected to be occupied. In return for their keep they could provide useful labour. Females were employed in needlework, cleaning and helping in the kitchen. Men carried coals, cleaned wards, chopped sticks and picked oakum. One inspection report noted that two men were out helping at a funeral.<sup>104</sup> Lack of exercise was one of the many deficiencies in the treatment of imbeciles. The VCL felt that the females particularly needed more exercise and ought to have country walks two or three times a week like the men. There was also insufficient entertainment: few indoor games and few

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<sup>98</sup> *Ibid.*, 20 Aug 1868.

<sup>99</sup> LRO, G/12/57b/4, 9 Sep 1868.

<sup>100</sup> LRO, G/12/57d/13, 22 Jun 1869. For a discussion on the ‘scandalous’ issue of bathing vagrants raised by James Greenwood’s article in the *Pall Mall Gazette* in 1866 on ‘A Night in a Workhouse’, see S. Koven, *Slumming: Sexual and Social Politics in Victorian London* (Oxford, 2004).

<sup>101</sup> Hodgkinson, *Origins*, p. 589.

<sup>102</sup> LRO, G/12/57d/24, 22 Oct 1884.

<sup>103</sup> TNA, MH12/6507, 7 May 1897. Perhaps the regular criticism of their dirtiness encouraged more frequent bathing of the men, to such an extent that their baths became worn out and had to be replaced. LRO, G.12.57d/36, 24 Sep 1896.

<sup>104</sup> LRO, G//12/57d/46/, 4 Apr 1906.



illustrated papers.<sup>105</sup> The guardians were recommended to purchase a musical box for the female imbeciles for their amusement as several other workhouses had done. This probably unintentional form of music therapy apparently had the beneficial effect of ‘producing much pleasure and tranquillity among the more imbecile and idiotic patients and even among those of a turbulent disposition.’<sup>106</sup> No doubt the workhouse staff also found it beneficial to keep their patients calm. The VCL were soon pleased to note that a musical box had been procured which proved to be a ‘source of great amusement to the [female] patients.’<sup>107</sup> However, music was only recommended for the females; a bagatelle board was recommended for the males which the VCL found was usually ‘much enjoyed by insane patients.’<sup>108</sup>

The VCL generally considered the imbecile patients to be quiet, well-behaved and in reasonable physical health. But, as shown above, conditions and attitudes towards male and female patients were variable. After the earlier criticisms, by 1867 the VCL reported that the inmates were quiet and orderly and the accommodation was clean and in proper order. Their recommendations for warm underclothing and blankets had been taken up but other recommendations had not. For example, the guardians determinedly ignored the frequent recommendations to change the straw mattresses as they felt these were ‘more easily cleansed than beds made of other material’.<sup>109</sup>

In 1867 imbeciles received the ordinary diet although this was considered by the VCL to be ‘low in scale for persons of unsound mind who generally require a specially [sic] nutritious diet.’ There were too many soup dinners which patients disliked or refused and nothing else was offered except bread. Of the sixty-seven imbeciles in the workhouse, the medical officer reported that only nine patients were on an extra diet with meat provided daily.<sup>110</sup> As Bartlett noted, the ‘universal opinion’ in the debate over workhouse dietaries in 1867 was that insane paupers

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<sup>105</sup> LRO, G/12/57d/14, 23 Mar 1871; G/12/57d/13, 8 Feb 1870.

<sup>106</sup> LRO, G/12/57d/15, Feb 1874. The guardians experienced some conflict with the auditor over their claim for the purchase of the musical box, which he considered to be an unlawful expenditure of poor law funds. The LGB later ruled that the purchase was lawful and disallowed the surcharge.

<sup>107</sup> LRO, G/12/57d/16, 28 Oct 1875.

<sup>108</sup> LRO, G/12/57d/12, 22 Apr 1867.

<sup>109</sup> LRO, G/12/57d/17, 29 Mar 1877.

<sup>110</sup> LRO, G/12/57d/12, 22 Apr 1867.

should receive the same diet as the aged and infirm and their diet was accordingly changed.<sup>111</sup> The guardians heeded some recommendations and substituted roast mutton for soup on Fridays.<sup>112</sup>

The VCL inspection reports always commented on the accommodation and comfort of the imbeciles. For example, although one of the newly-painted dayrooms for female imbeciles was considered by the inspector to be comfortable, their other room still lacked matting on the brick floor or backs to the benches. Despite additional recommendations in 1856 for ‘the introduction of prints and amusing books for the males,’<sup>113</sup> the men’s sitting room remained ‘dark and cheerless’, without matting or comfortable seats for many years.<sup>114</sup> Recommendations for alterations to ‘enliven’ the male imbeciles’ dayroom were disregarded. Years later they still remained ‘very cheerless and uncomfortable’ with the only amusement for the male imbeciles an ‘out of repair’ bagatelle board – otherwise there were no games, newspapers or books.<sup>115</sup> The guardians’ response was that in addition to the bagatelle board, the inmates danced while the attendant played music!<sup>116</sup> By 1885 the VCL were pleased to report that the men’s ward had been much improved, but niggling defects continued. For instance, the supply of cold water to the women’s bath stopped when taps were used elsewhere, and there were no under-blankets provided for wet cases.<sup>117</sup> Increased means of entertainment were slowly introduced. A piano was purchased for the women’s dayroom in 1898, and the occasional entertainment was given.<sup>118</sup> Books and papers were also provided as well as dominoes and caged birds.<sup>119</sup>

Most recommendations were eventually implemented. Nevertheless, a lack of care and thought still resulted in discomfort for patients. In 1883 the doors to the

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<sup>111</sup> Bartlett, *Poor Law of Lunacy*, p. 138.

<sup>112</sup> *Ibid.*, 20 Aug 1868. The guardians reported that a sane pauper now slept among the patients in every dormitory, apart from one; and a bagatelle board had been provided for the amusement of the men.

<sup>113</sup> LRO, G/12/57d/7, 20 Oct 1856.

<sup>114</sup> LRO, G/12/57d/15, Feb 1874.

<sup>115</sup> LRO, G/12/57d/23, 22 Oct 1884.

<sup>116</sup> LRO, G/12/57b/6, 12 Nov 1884.

<sup>117</sup> LRO, G/12/57d/25/13 Feb 1885.

<sup>118</sup> LRO, G.12.57b/10, 16 Mar 1898. A commissioner noted on one visit that a visitor was playing to the patients and ‘most of them seemed to recognise the dance music and were dancing about in great style.’ LRO, G/12/57d/46, 4 Apr 1906.

<sup>119</sup> LRO, G/12/57d/39, 31 Jan 1899.

lavatories in the men's ward were found to be dangerous after a patient fell while inside and great difficulty was experienced in removing him.<sup>120</sup> Eleven months later, the delay in altering these doors was described by the VCL as 'most mischievous [when] a few shillings outlay would make them safe'; they could easily 'contribute to the death of an epileptic patient'.<sup>121</sup> The guardians responded that they had ordered the closet doors to be hung on side hinges.<sup>122</sup> The work had still not been done by the next inspection, leading the commissioner to remark that 'their state, dangerous for epileptics, invokes the guardians in grave responsibility.'<sup>123</sup> This lack of action suggests that the guardians did not consider the work to be urgent. They may have believed that merely stating they had ordered the work to be done was enough to satisfy the commissioners. Yet, in 1890 a commissioner was 'favourably impressed by the management of the insane wards from every point of view and found nothing to criticise adversely.' The only patient with a bedsore had that before admission and the other two bedridden cases that needed great care, struck the commissioner as 'remarkably sound, stout and dry.'<sup>124</sup>

## Changing attitudes

By 1897 the guardians' attitudes towards improving conditions for imbeciles appeared to be changing when they wrote to the LGB to suggest that:

'The present scheme does not appear by any means to be satisfactory; and it is difficult in a Workhouse to provide suitable accommodation and means for treating (in any way beneficially) the unfortunate poor, who are suffering from mental and nervous disorders.'<sup>125</sup>

They requested permission to ascertain the views of the Leicestershire, Rutland and Nottinghamshire unions on the desirability of uniting to establish an institution 'in which special training might be given to develop if possible the physical, mental and moral powers of the Imbecile and Epileptic Poor.' At this time the guardians were proposing to buy a site for a new workhouse infirmary where

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<sup>120</sup> LRO, G/12/57d/23 22 Dec 1883.

<sup>121</sup> *Ibid.*, 22 Oct 1884.

<sup>122</sup> LRO, G/12/57b/6, 12 Nov 1884.

<sup>123</sup> LRO, G/12/57d/25, 13 Feb 1885.

<sup>124</sup> LRO, G/12/57d/30, 15 Mar 1890.

<sup>125</sup> TNA, MH12/6507, 30 Sep 1897.

they planned separate buildings could be erected for ‘imbeciles, epileptics and weak-minded paupers’. They anticipated that these inmates could be put to useful work on the land, which would have the twofold benefit of improving ‘their condition and be helpful in many ways’, and would release workhouse accommodation for the ever-increasing numbers of old and infirm paupers.<sup>126</sup> There were no facilities for separating different categories of mentally disabled patients or those who were of sound mind but suffered from epilepsy or were simply elderly and confused. The problem of mixing the sane and insane was noted by the VCL who regretted that the accommodation was so limited that it was necessary to lodge together epileptic and non-epileptic though weak-minded young men.<sup>127</sup> Despite the guardians’ concern, they would not send imbecile children to the Midland Counties Asylum when offered this facility for a charge of £40 per case.<sup>128</sup>

The workhouse imbecile and epileptic patients were gradually transferred to the new infirmary which opened in 1905. A detached building was not provided although separate imbecile wards were. Sick imbeciles were usually put in the infirmary’s general wards but in 1906 the committee resolved that a ward be set apart for the ‘disagreeable cases of sick male imbeciles’ with specific attendants rather than the ordinary nursing staff.<sup>129</sup> The nurses apparently found male imbeciles more difficult than ‘ordinary’ patients. In 1907 the VCL were concerned that there was still no padded room for violent patients.<sup>130</sup> There were 74 certified imbeciles and 58 uncertified epileptic and senile patients in four wards, which were kept separate ‘to a certain extent’. The number of attendants had increased to six and the LGB suggested that they be designated ‘Nurse-Attendants’, thereby raising their status.<sup>131</sup> The VCL considered that the transferral of these patients to a ‘high, health-giving spot’ had already had a ‘distinctly beneficial’ effect upon them.<sup>132</sup> Their surroundings, food, care and attention had improved, but the VCL thought

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<sup>126</sup> LRO, G/12/57b/10, 14 Apr 1896. An apparently beneficent attitude towards this class of pauper was often qualified by the condition that they should be useful wherever possible.

<sup>127</sup> LRO, G/12/57d/43, 3 Jan 1903.

<sup>128</sup> LRO, G/12/8a/36, 19 Nov 1901.

<sup>129</sup> LRO, G/12/8j/1, 2 Jan 1906.

<sup>130</sup> A padded room was provided in 1911. Its overuse was criticised in 1914 – 14 men had spent a total of 2,112 hours and 20 women a total of 1,766 hours in the room. Many were apparently awaiting removal to the asylum. G/12/57d/54, 2 Feb 1914.

<sup>131</sup> LRO, G/12/57d/46, 12 Jul 1906.

<sup>132</sup> LRO, G/12/57d/47, 4 Jul 1907.

that several patients who ought to be in the asylum were instead certified to remain in the infirmary.<sup>133</sup>

The difficulties in recruiting and retaining suitable staff continued even though salaries had increased. Some attendants were now allowed to live off the premises and previous experience was considered desirable.<sup>134</sup> Despite these conditions, the workhouse porter was promoted to assistant imbecile attendant, although he too left after eighteen months.<sup>135</sup> The medical officer received complaints of bruised imbecile patients. Ill-treatment was unproven against two attendants although they were found to be untrustworthy, careless and rude. Yet they were simply warned and reprimanded rather than dismissed,<sup>136</sup> even though an epileptic patient sustained a severe head injury through falling while in a fit and subsequently died.<sup>137</sup>

In 1908 the Royal Commission on the Care and Control of the Feeble-Minded recommended special accommodation and treatment outside the poor law.<sup>138</sup> The guardians accordingly wrote to the Lunacy Commission, the Prime Minister, Leader of the Opposition and the LGB with their resolution on the subject of the ‘appalling increase’ of such people. In essence they protested against enforced sterilisation, giving as their reasons:

‘It is contrary to Christian ethics; it is not agreed by Doctors and Biologists, that such mutilation would solve the problem of the Feeble Minded; it would affect principally the poor and particularly the female poor; it may, by removing a barrier now existing cause more immorality and thus greater mental and moral deficiency, and thereby accentuate the evil it professes to abolish.’

The guardians agreed that ‘mental weakness’ could in some cases be due to hereditary causes, but asserted that account should be taken of the ‘proximate

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<sup>133</sup> LRO, G/12/57D/49, 13 Nov 1909.

<sup>134</sup> LRO, G/12/8j/3, 2 Oct, 11 Dec 1913; 8 Jan, 2 Apr 1914.

<sup>135</sup> LRO, G/12/8j/2, 18 May 1910.

<sup>136</sup> LRO, G/12/8j/2, 30 Dec 1909.

<sup>137</sup> *Ibid.*, 20 Oct 1910.

<sup>138</sup> Crowther, ‘The Later Years of the Workhouse’, p. 41

causes' which they claimed were drunkenness, immorality, worry and environment.<sup>139</sup>

## **Summary**

Conditions at the workhouse were undoubtedly drab, uncomfortable and sometimes dangerous. Patients were at risk of harm from staff and other patients, and from the inappropriate and inadequate furniture and fittings which the guardians were reluctant to improve. The VCL recommendations were not mandatory and could be ignored or disputed. The guardians usually reacted defensively to criticism. Most recommendations were eventually implemented but a lack of urgency towards the safety, care and comfort of the imbeciles prevailed and there was reluctance to spend money, even on inexpensive improvements.

Imbeciles were regarded as 'blameless' paupers, but their inability to complain effectively and their long-term confinement doubtless influenced the attitudes taken towards their treatment by guardians and workhouse staff. The medical officer appeared to have little involvement apart from the regulatory visits. The daily management of imbeciles was undertaken by a usually lone untrained attendant who was overseen by the master or matron. Few reports appeared in the medical officer's report book on the conditions in the imbecile wards, although it is unfortunate that the medical reports were made on loose sheets as these may have provided more detailed information about these patients. Presumably these records were lost or destroyed. Perhaps the inspections made by the VCL absolved the medical officer from more direct intervention. The imbeciles received care rather than medical treatment. Therefore, apart from removing dangerous lunatics or curable cases, the medical officer's role seems to have been minimal.

A deterrent system was inevitably inappropriate for the care of mentally disabled people. There was little or no differentiation of patients' abilities or needs. The efficient running of the workhouse was the main priority, not understanding the patients' mental conditions or providing appropriate medical treatment and

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<sup>139</sup> LRO, G/12/57b/13, 22 Dec 1909.

stimulating care. According to a VCL report in 1900 the workhouse imbeciles were 'happy and contented and many expressed gratification at their treatment.' Perhaps institutionalisation was preferable to an uncertain life outside the workhouse, or maybe after many years the workhouse was regarded as 'home'.<sup>140</sup> By 1912 the VCL report on the imbeciles at NEI maintained that,

'...there was a pleasant air of contentment about them ... they are taken out into the extensive grounds several times a week. Pianos and gramophones, books, papers and games are provided in each division and the men play football, cricket and bagatelle. Wards were in excellent order, warm and comfortable and beds and bedding good and clean.'<sup>141</sup>

Regrettably there are no direct records from the patients to reveal what they felt about their life in a poor law institution.

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<sup>140</sup> Shepherd, 'The Female Patient Experience', pp. 243-4, found that many women chose to remain patients in asylums.

<sup>141</sup> LRO, G/12/57d/53, 13 Dec 1912.

## Chapter 9

### ‘The Palace on the Hill’: North Evington Poor Law Infirmary

The original proposal to purchase land at North Evington in order that ‘poor persons’ could be set to work for wages, was first mooted by the guardians in 1895. The LGB insisted on a local inquiry,<sup>1</sup> which determined that no more than twenty acres should be purchased for such a use.<sup>2</sup> However, it confirmed that consideration would be given to any other use of the land that might be ‘of advantage’.<sup>3</sup> Strong objections were made by the Leicester Ratepayers and Property Owners Association to the use of the land for the unemployed and to the erection of a new workhouse. The Association claimed erroneously and somewhat disingenuously that there was ample accommodation at the workhouse and no need for a new one.<sup>4</sup> After this setback, the guardians proposed instead that the land could be used for separate buildings for imbeciles and epileptics, but they then abandoned the idea and informed the LGB that negotiations were closed.<sup>5</sup> Nevertheless, some months later, they proposed to erect a new workhouse infirmary on the land with additional wards for imbecile and epileptic patients.<sup>6</sup> The LGB had regularly urged the guardians to provide new and better infirmary accommodation; therefore it readily gave permission for the purchase of 62 acres of land at North Evington with a loan of £7,000.<sup>7</sup>

To help the guardians plan the infirmary, on the advice of the LGB, they inspected similar workhouse infirmaries at Portsea Island, Stoke-on-Trent and Leeds and two private institutions: The Home of the National Society for the Employment of

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<sup>1</sup> LRO, G/12/57d/35, 14 Oct 1895.

<sup>2</sup> 59 Geo. III, c.12.s.12.

<sup>3</sup> LRO, G/12/57d/36, 28 Mar 1896.

<sup>4</sup> *Ibid.*, 7 May 1896.

<sup>5</sup> LRO, G/12/57b/10, 13 Nov 1896.

<sup>6</sup> TNA, MH12/6508, 5 Jul 1898.

<sup>7</sup> LRO, G/12/57d/38, 21 Nov 1898.



Epileptics at Chalfont-St-Peters and the Home for Epileptics at Magull, Liverpool.<sup>8</sup> But the guardians were more impressed by a new union infirmary at Solihull and they appointed its architect as assessor for the competition to find an architect for their new infirmary.<sup>9</sup>

Debates over the plans and cost of the new building ensued. Finally by March 1902 the LGB were fully satisfied with the plans for the new infirmary.<sup>10</sup> In common with the contemporary 'pavilion principle' of hospital building, the infirmary was built with four pavilions because doctors believed that light and ventilation were essential to prevent the spread of infection.<sup>11</sup> The building committee suggested that corridors be built to form an open covered way between the pavilions to enable the patients to be wheeled out in their beds in warm, fine weather. The infectious block had separate entrances from the verandah, and the mortuary had accommodation for twelve bodies.<sup>12</sup> The comfort of the patients was reportedly given every consideration.<sup>13</sup> After the overcrowded, airless conditions at the workhouse, they no doubt experienced greater comfort from the spacious, light accommodation; especially when electric lights started to be fitted above each bed.<sup>14</sup>

The infirmary was officially opened on 28 September 1905. Figure 3 shows an illustration of its front elevation that was printed in a local newspaper.<sup>15</sup>

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<sup>8</sup> LRO, G/12/57d/38, 12 Oct 1898. The guardians occasionally sent some epileptics to both those institutions, for example, a consumptive woman on outdoor relief was sent to the Chalfont St Peters Home at a cost of 10s a week on the recommendation of the district medical officer.

<sup>9</sup> Rimmington, 'Treatment of the Sick Poor in Leicester', p. 96.

<sup>10</sup> LRO, G/12/8a/36, 18 Mar 1902. For details on the building process see Mackay, *Palace on the Hill*.

<sup>11</sup> Crowther, *Workhouse System*, p. 62.

<sup>12</sup> MH12/55, 10 Dec 1900.

<sup>13</sup> *Leicester Daily Post*, 29 Sep 1905, p. 5.

<sup>14</sup> LRO, G/12/8j/2, 30 Nov 1911.

<sup>15</sup> *Leicester Daily Post*, 28 Sep 1905, p. 7.

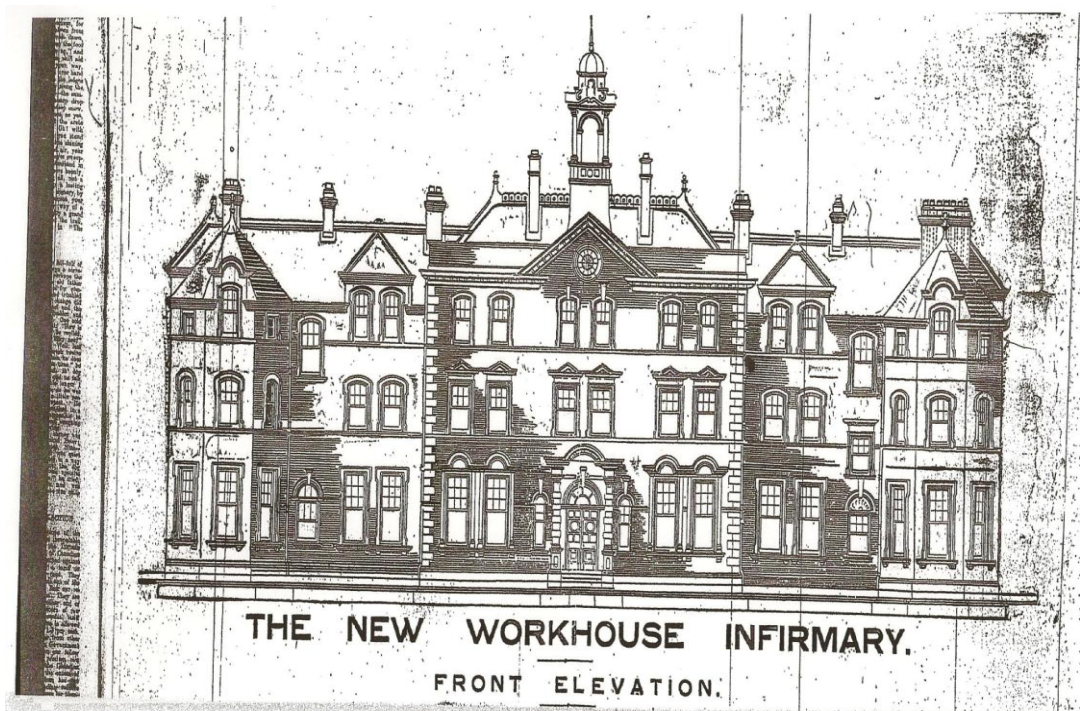


Figure 3 Illustration of frontage of North Evington Infirmary

A description of the infirmary was given by the *BMJ* to delegates who were to attend its annual conference to be held at Leicester that year:

‘[It is] a poor law infirmary of imposing dimensions ... on the outskirts of the town, which represents in concrete form the latest approved theories for buildings of this class. Its total cost will be over £80,000 and it will normally furnish beds for 512 patients, though at any time 300 more beds can be put into use. It has two blocks for male patients and two for female, and each of them is divided into twelve wards – four large containing 28 beds, four small with three beds and four with only single beds for special cases. A central administrative block divides the male and female quarters and in this are a library, committee room, kitchen, offices and the quarters of the whole staff. Laundry washhouses and disinfectors are placed in the rear. The whole building stands on 62 acres of ground and is on a slight eminence.’<sup>16</sup>

The infirmary was one of the seventy separate infirmaries that provided 30 per cent of all poor law accommodation for the sick.<sup>17</sup> A local newspaper commented that the cost of £120,000 was a ‘large sum of money’, but the ratepayers would ‘derive some satisfaction ... in the knowledge that the new infirmary was admitted by experts to be one of the finest and largest in the country.’<sup>18</sup> Much of the land was used for grazing and farming. The grounds were surrounded by six feet high spiked railings, with closed large gates between two lodges at the bottom of the drive.<sup>19</sup> The location and construction of the infirmary inspired local people to call it ‘The Palace on the Hill’.<sup>20</sup>

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<sup>16</sup> *BMJ*, 3 June 1905, pp. 289-291. The article provided information on Leicester to potential delegates of the 73<sup>rd</sup> Annual British Medical Association meeting which was held in Leicester.

<sup>17</sup> Crowther, *Workhouse System*, p.186. The new matron had previously worked at a similar newly-built infirmary at Portsmouth which was about two miles from the town with accommodation for 500 patients and 200 imbeciles.

<sup>18</sup> *Leicester Daily Post*, 28 Sep 1905, p. 7.

<sup>19</sup> The railings did not deter determined inmates from escaping. The police reported that Walter Wood climbed the fence to go to an inn in the nearby village and returned to the infirmary ‘with bottles of drink in his possession.’ LRO, G/12/8j/3, 17 Oct 1912. Similarly, several inmates were reported to have absconded with their institution clothing. One who had climbed over the railings on a Saturday returned on a Tuesday having pawned his boots. LRO, G/12/8j/2, 11 Jul 1912.

<sup>20</sup> Mackay, *Palace on the Hill*, p. 18.

The Leicester guardians have been praised for being ahead of their time by erecting the new infirmary on the outskirts of the city.<sup>21</sup> It appears that they took a similarly progressive approach to its name. In answer to the Registrar General's enquiry by what name the infirmary should be known by for the registration of births and deaths, the committee resolved that it should be known as 'The North Evington Infirmary', thus omitting the words 'Poor Law', at least for those purposes.<sup>22</sup> Their intention may have been to shorten the name rather than de-stigmatise it, but it appears from the union's records that the shorter version was commonly used. Alternatively, they may simply have tried to avoid confusion between the 'old' and 'new' infirmaries at the workhouse and the newly-built infirmary. New infirmary facilities could even be superior to some voluntary hospitals, but longstanding attitudes towards patients were slow to change. Gradually, however, less stigma became attached to entering a separate infirmary rather than the sick wards of a workhouse.<sup>23</sup>

## **Medical staff**

### **Medical officers**

New officers were appointed to work at NEI. Nurses had long resided at the workhouse but now full-time residential medical officers (hereafter RMO) were appointed.<sup>24</sup> Table 9.1 below provides details of the ages and length of service of the medical officers appointed during the period. A part-time non-resident medical superintendent was appointed to head the new infirmary medical staff. Dr John Dodd had been in practice for 22 years. He had not previously held a union post although he had been a guardian for the De Montfort Ward in Leicester, which he then resigned.<sup>25</sup> Dr Dodd also had a private practice and resided two miles from NEI. Unlike other

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<sup>21</sup> D. W. Arch, (ed.), *Leicester General Hospital, 1905-1976* (Leicester, 1976), p. 5; Mackay, *Palace on the Hill*, p. 15.

<sup>22</sup> G/12/8j/1, 10 Oct 1905. In 1904 the Registrar General instructed that the workhouse should no longer be recorded as a child's place of birth; fictitious addresses were often given instead.

<sup>23</sup> Crowther, 'The Later Years of the Workhouse', p. 52.

<sup>24</sup> Metropolitan infirmaries had employed full-time resident medical officers for many years.

<sup>25</sup> LRO, G/12/57d/45, 13 Jun 1905.

union medical officers, he did not have to provide medicines or medical and surgical appliances. Regrettably no medical records kept by Dr Dodd during his term of office are extant.<sup>26</sup> However, the union's records provide ample evidence of his administration which did not run smoothly, in part due to his non-residency as will be shown.

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<sup>26</sup> Arch, *Leicester General Hospital*, p. 8.

**Table 9.1**  
**Medical officers appointed to the North Evington Infirmary, 1905-1914.<sup>27</sup>**

Post <sup>28</sup>	Name	Date appointed	Age on appointment	Salary on appointment	Date left post	Reason for leaving	Years in service
VMS	J. Dodd	Jun 1905	44	£130.00	Jul 1914	Infirmary administration re-arranged.	9
RMO	S. C. Roy	Jun 1905	31	£110.00	Oct 1905	Post not found suitable.	0
RMO	S. Murray	Oct 1905	26	£130.00	Jul 1906	Conflict with Dodd.	0
RMO	W. Magill	May 1906	26	£120.00	Aug 1907	Took post at Edmonton.	1
RMO	W. O. Welpby	Oct 1906	22	£120.00	Jan 1908	No reason given.	0
RMO	P. C. Peace	Nov 1907	27	£120.00			
RMO	D. J. Smith	Feb 1908	30	£120.00	Sep 1913	Friction between staff.	5
RMO	W. D. Coghill	Jun 1908	23	£120.00	Sep 1909	Became MO at Wolverhampton Union.	1
RMO	J. M. Harold	Oct 1909	26	£120.00	Mar 1910	No reason given.	0
RMO	S. Wilkinson	Sep 1910	23	£130.00	Feb 1912	Became Assistant House Surgeon at Leicester General Infirmary.	2
RMO	W. N. Davies	Mar 1912	26	£130.00	July 1912	Died.	0
RMO	T. Murray	Oct 1912	24	£130.00	Jul 1913	Obtained post at another poor law institution.	0
RMO	J. W. Grice	Oct 1913	32	£200.00	Apr 1914	Conflict with Dodd.	0
RMO	A. G. Fergus	Oct 1913	32	£150.00	Apr 1914	Conflict with Dodd.	0
RMO	J. T. Cameron	May 1914	23	£200.00	Sep 1914	Voluntarily resigned.	0
RMO	F. J. Devlin	Sept 1914	23	£200.00	Feb 1915	Became MO at Brownlow Hill Workhouse, Liverpool.	0
RMO	J. Savage	Oct 1914	25	£200.00			
RMS WH/RH	E. Hadley	May 1914	39	£400.00 £120.00	1940	Retired.	26

<sup>27</sup> VMS = Visiting Medical Superintendent; RMO = Residential Medical Officer; RMS = Residential Medical Superintendent; MO = Medical Officer, WH = Workhouse; RO = Receiving Homes

<sup>28</sup> The medical officers were appointed either as a 1<sup>st</sup> medical officer or a more junior 2<sup>nd</sup> medical officer. Some were promoted to take the place of others who left.

As Table 9.1 shows, few resident medical officers remained in post for long and almost immediately there were problems. Dr Roy resigned his infirmary post after just a month as he did not think the position was suitable for him.<sup>29</sup> It transpired that some unstated charges were brought against him. He stated that the charges were untrue and not proven and he asked the board to withdraw them as they would be ‘detrimental’ to his future ‘institution work.’<sup>30</sup> The advertisement for his replacement requested that applicants were qualified, unmarried men, prepared to work full-time solely for the institution which was described as ‘divided into medical, surgical and phthisical [sic] wards,’ with facilities provided for ‘microscopical, bacteriological and pathological work.’<sup>31</sup> Several applications were received and Dr Stuart Murray was appointed. Glowing references accompanied his letter of application. He had previous experience as a junior resident medical officer at the Nottingham workhouse infirmary and he appeared to be keen and ambitious. No doubt a new purpose-built workhouse infirmary offered good opportunities for advancing his career.<sup>32</sup>

Interestingly, Dr Murray was appointed on the same salary as his superior Dr Dodd. However, he immediately experienced difficulties in their relationship and he resigned nine months later. The infirmary committee were keen to retain him but he declined which led the committee to seriously question Dr Dodd’s medical administration and even to recommend that he should not be retained. The guardians found that ‘Dr Dodd commanded no respect in the institution and several cases ... appeared to indicate incompetency.’ Dr Dodd strongly refuted this statement. He claimed that differences of opinion between him and the RMOs were ‘unavoidable’ where there were ‘superior and subordinate medical men’. Dr Dodd stridently informed the committee that an enquiry into the medical treatment of patients was beyond the scope of the committee and was most ‘improper’. The committee cited four cases which they believed demonstrated his incompetence. In the first case he delayed an operation on a man with an intestinal obstruction and then instructed Dr Murray to

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<sup>29</sup> LRO, G/12/8j/1, 10 Oct 1905.

<sup>30</sup> See Chapter 4 on further charges against Dr Roy as a district medical officer.

<sup>31</sup> LRO, G/12/57d/45, 17 Oct 1905. Presumably women were not expected or encouraged to apply.

<sup>32</sup> Arch, *Leicester General Hospital*, pp. 6-8, NEI was considered to be very modern and was frequently visited by interested groups from other towns and other medical men.

carry it out. In the second case Dr Murray complained that Dr Dodd had not placed a catheter on a patient when it was necessary. Dr Dodd blamed the nursing sister for not informing him of this necessity. In the third case Dr Dodd ignored the advice of both RMOs to amputate a patient's diseased foot but insisted on treating it to try to save it. He was accused of not examining the foot for several weeks. His defence was that he wanted to use a treatment that had been found to be successful by eminent surgeons. He believed the patient had improved with the treatment, although he had to admit that eventually the treatment had failed and the foot had to be amputated. His excuse for his lack of attention to the patient was that, 'the treatment was with the girl, not with the foot.' The last case involved a patient admitted and certified by the RMO to be suffering from pneumonia. Dr. Dodd initially claimed that it was not pneumonia but three days later he said that 'he supposed it was.' Dr Dodd simply stated that he could not recognise this case without a fuller statement of facts.<sup>33</sup>

The minutes did not record any subsequent discussion by the committee other than that the matter was adjourned *sine die*. Rimmington observed that there was frequent interference in poor law infirmary administration from workhouse officials who were neither medically qualified nor primarily interested in sick people.<sup>34</sup> However, on this occasion when interference would have been justified, the lay guardians presumably felt unequal to judge such medical matters, particularly in the face of Dr Dodd's evident confidence in his superior medical authority and status. They may also have been reluctant to challenge their own choice of medical superintendent so early and decided to let matters lie. Although the guardians doubted his competence Dr Dodd remained in post until July 1914, despite the guardians on one occasion disclaiming all responsibility for his report on the infirmary for which he was only able to provide approximate figures, claiming that precise figures could not be given because of a lack of material.<sup>35</sup> His record-keeping was similarly careless. His non-residency and arrogant attitude towards his juniors continued to create administrative problems as the younger, inexperienced RMOs had to deal with

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<sup>33</sup> LRO, G/12/8j/1, 17 July 1906; 7 Aug 1906; 17 Aug 1906.

<sup>34</sup> Rimmington, 'Treatment of the Sick Poor in Leicester', p. 97.

<sup>35</sup> LRO, G/12/8j/2, 25 Feb, 11 Mar 1909.



immediate situations. Their responsibilities for large numbers of patients without support from consultants were heavy in comparison with the situation of young doctors in voluntary hospitals.

Dr Dodd's aptitude was clearly questionable. Nevertheless, he indicated his confidence and eagerness for the development of large state hospitals and the role of the medical specialist in his vision for poor law infirmaries which was published in *The Lancet* soon after the opening of NEI. The journal reported on the annual meeting of the North Midland Poor Law Conference held at Leicester in 1905 at which Dr Dodd said that it had been the practice to regard such institutions as 'places for the aged and sick to die in.' In his view, it was economic to spend money on providing sufficient and efficient means of medical treatment to treat pauper patients and fight disease as sickness was a serious economic loss to the individual and to the community, particularly as the number of such patients was much larger than of those in voluntary hospitals. He recommended that medical superintendents and officers should be subsidised for training infirmary nurses and he predicted that the main work of poor law infirmaries would be to 'restore wage earners to health as soon as possible', while mental cases, epileptics and the aged would be cared for in different institutions. Furthermore, he thought that patients from smaller unions who required special treatment would be sent to the larger infirmaries, 'thus freeing the voluntary hospitals.'<sup>36</sup>

Dr Dodd's capability was also questioned by an LGB Inspector who felt that two insane patients ought to be in the asylum. Florence Cooke was described as 'a powerful woman with a violent temper' and Sarah Jacques suffered from 'delusions and melancholy'. Dr Dodd retorted that he was astonished at the report as he had already arranged for their removal to the asylum although it had been difficult for him to convince the magistrate that Cooke was a suitable case. He carefully reminded the

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<sup>36</sup> *Lancet*, 4 Nov 1905, pp. 1351-2.

guardians that they had been informed that the asylum was becoming overcrowded and that great care should be taken in sending patients there.<sup>37</sup>

A second medical officer, William Magill, was appointed in May 1906 but resigned by August 1907. Concerned at the swift departure of officers, the committee resolved to interview staff who resigned before they left the service.<sup>38</sup> A replacement medical officer, Dr Peace, even stated in his application that he was ‘anxious to take up hospital work for some two or three years more’, obviously indicating his intention to move on after gaining more experience.<sup>39</sup> The high turnover of young doctors was widespread. Poor law infirmaries were always inferior to the voluntary hospitals and there was little incentive for a good doctor to stay when pay and conditions were unattractive. Furthermore, infirmaries could be used for training nurses but not medical students, which discouraged development of medical education.<sup>40</sup> Disparities in salaries could easily be noticed by potential applicants. An NEI post advertised at £130 appeared in *The Lancet* alongside two other advertisements for similar posts offering £200 and £175.<sup>41</sup> When Dr Smith, a senior RMO, resigned his junior declined promotion and in fact he also resigned as he had obtained a post of assistant house surgeon at the Leicester General Infirmary. Mindful of the need to retain medical officers, the guardians attempted to persuade Dr Smith to stay by offering him a substantial increase of £60. He realised that he was in a good position to make demands and agreed to stay providing that assistance was given for dispensing medicines and keeping medical records and that the junior RMO was under his control. Furthermore, he boldly asked the guardians to pay £15 18s 4d damages to the guardians of the Brentford union as he had failed to take up an appointment there. The guardians readily agreed to all his requests.<sup>42</sup>

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<sup>37</sup> LRO, G/12/57b/12, 29 May 1907.

<sup>38</sup> LRO, G/12/8j/1, 15 Aug 1907.

<sup>39</sup> LRO, G/12/57d/47, 3 Dec 1907. He had been an assistant house physician at Sheffield Royal Hospital prior to his appointment at NEI. A few months later he was promoted and appeared to still be in the post in 1914.

<sup>40</sup> Crowther, ‘The Later Years of the Workhouse’, p. 50. In 1913 the LGB handed authority over sick wards to medical staff. After the war the large infirmaries opened for medical students.

<sup>41</sup> LRO, G/12/57d/52, 24 Oct 1912.

<sup>42</sup> LRO, G/12/8j/2, 25 Jan, 6, 8, 22 Feb, 13 Jun 1912.

## The Matron

The first matron appointed to NEI on an annual salary of £130 was Miss Clarke. Her role was to ‘govern and control all the officers, assistants, and servants in the infirmary, under the supervision of the medical officer of the infirmary.’<sup>43</sup> A qualified and experienced assistant matron, Miss Masters, was also appointed.<sup>44</sup> She was soon seriously ill from an abscess on her kidney which Dr Dodd operated upon with the assistance of an external doctor who was paid £10. It was claimed that her illness had been brought on by the extra work caused by the opening and organising of the infirmary.<sup>45</sup>

Differences soon arose between young male RMOs and the older female matron, perhaps because she had worked solely for the poor law system, while some of the young medical officers had also worked in voluntary and teaching hospitals. Moreover, Miss Clarke did not form a good relationship with Dr Dodd or the nurses. Eventually the guardians became so concerned about the detrimental effect on the management of NEI that they asked the matron to resign. The night superintendent nurse was appointed acting matron until the matron was replaced. There were thirty-one applicants for the post and the former assistant matron, Miss Masters, was duly appointed.<sup>46</sup>

The hierarchy of NEI undoubtedly suffered from the lack of a strong, respected leadership. The new matron also clashed with Dr Smith over the scope of his administrative duties. This again affected the discipline and management of the staff. However, the guardians strongly supported Miss Masters and swiftly dismissed two nurses in order to dispel the ‘partisan spirit’ among the staff. The guardians persuaded the matron and young doctor to improve their working relationship.<sup>47</sup> However, the

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<sup>43</sup> LRO, G/12/57d/45, Infirmary: Regulations and Accounts, 21 July 1905, Article 48.

<sup>44</sup> LRO, G/12/57b/12, 21 Jun 1905; 7 Sep 1905.

<sup>45</sup> *Ibid.*, 12 Jul 1906.

<sup>46</sup> LRO, G/12/8j/2, 13 Jan 1910. In the intervening years, she had gained further experience as matron at Birkenhead Hospital.

<sup>47</sup> LRO, G/12/8j/3, 16 Jan, 6 Feb, 20 Feb, 1913.

improvement was short-lived and Dr Smith resigned six months later. This time he was not persuaded to stay.<sup>48</sup>

## Nurses

The number of nurses at NEI was considerably higher than at the workhouse infirmary. At the outset forty-five nurses were appointed but permission was soon given to increase the nurses to fifty-three.<sup>49</sup> These were: 1 night superintendent nurse; 8 charge nurses; 8 staff or ward nurses; and 36 probationer nurses. In addition 6 ‘nurse-attendants’ were employed to take charge of sick and bedridden imbeciles in addition to the ordinary attendants on imbeciles and epileptics.<sup>50</sup>

The LGB was prepared to regard the infirmary as a training school for nurses but suggested that certificates should only be granted if good reports were given by the medical superintendent and matron on the efficiency and conduct of each nurse during their training. Probationer nurses initially undertook three years of general training. This consisted of twice-weekly lectures by the matron and senior RMO on practical and surgical nursing, and anatomy and physiology for five months with an oral and paper examination. The guardians provided the necessary materials, books, bones and diagrams.<sup>51</sup> A few years later Miss Masters’ proposal to extend the training to a fourth year to include midwifery, massage and ‘sick cookery’ was accepted. In common with many other general hospitals and infirmaries, it was hoped that this would help to retain nurses who had entered for a three-year period of training as well as enhance their skills.<sup>52</sup> Dr Dodd was appointed a lecturer in midwifery by the Central Midwives Board in 1908.<sup>53</sup> In order to provide the nurses with sufficient experience to enable them to obtain the midwifery certificate, the guardians granted them gratuities of £8 for expenses in obtaining the necessary minimum number of twenty cases under qualified

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<sup>48</sup> *Ibid.*, 4, 18 Sep 1913. Miss Masters remained in post until 1934.

<sup>49</sup> LRO, G/12/57b/12, 30 May 1906.

<sup>50</sup> MH9/10, 1906.

<sup>51</sup> LRO, G/12/57b/12, 21 Nov 1906.

<sup>52</sup> LRO, G/12/8j/3, 9 Jan 1913. White, *Social Change*, p. 151.

<sup>53</sup> LRO, G/12/8j/2, 3 Dec 1908, 11 Aug 1910. He received a fee of £10 for a course of lectures.

midwives with the proviso that they remain at NEI for at least six months as a staff nurse before receiving their diploma.<sup>54</sup>

Regular changes of nurses persisted. Within four months of opening, six nurses resigned giving reasons such as 'preferred private nursing', 'gave up nursing'; 'did not like the work'.<sup>55</sup> The requirement for institutional living-in, particularly at an isolated location, was no doubt a contributory factor for many departures. There were few leisure facilities for the nurses. In addition, nurses had to be single which eliminated many potential applicants. Heavy, menial work was required and those who were not sufficiently robust were swiftly removed.

To resolve retention problems, the matron proposed to abolish the post of staff nurse and to keep trainees at various stages in training, filling vacant posts with probationers. She discovered that most of the nurses wanted to gain experience by taking a different branch of the work when they completed their training. Consequently the position of staff nurse was filled briefly either by current nurses or new employees, neither staying long once something better occurred. She proposed that nurses were committed to train for four years after which their position would terminate unless the position of sister arose. In this way, all the nurses would be trained by the institution and would be retained for four years. The guardians readily accepted her proposal.

## **Patients**

Reports on the patients' conditions reveal that the accommodation was distinctly superior to that of the workhouse infirmary. Wards were set apart for tuberculosis cases and special seats were obtained for consumptive and convalescent patients for open air treatment. Dr Dodd agreed that consumptive patients could be put to light work on the farm.<sup>56</sup> Fresh air and exercise were thought to be good for such

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<sup>54</sup> *Ibid.*, 17 Dec 1908.

<sup>55</sup> LRO, G/12/57b/12, 3 Jan 1906.

<sup>56</sup> LRO, G/12/8j/1, 13 Mar 1906; 19 Jun 1906.

patients. The patients experienced a more hospital-like environment as the infirmary was now administered by qualified medical staff. However, in other respects a punitive and discriminatory attitude still prevailed. For example, venereal cases were not admitted. Any that were discovered were transferred to the workhouse.<sup>57</sup> Consumptive patients who did not behave were sent to the workhouse, although Dr Bryan, who probably diagnosed these patients in the first instance, usually immediately sent them back to the infirmary.<sup>58</sup> Sending recalcitrant patients to the workhouse punished them as well as eliminating disruption. For example, a consumptive patient Thomas Lockwood was reported to be insolent and insubordinate and was discharged for absconding from the infirmary for two days without leave. Two other patients were discharged for refusing to do light outdoor work for four hours a day. Another patient was discharged for refusing treatment and two other patients were discharged for escaping and getting drunk. In each case the RMO reported that there were no physical signs of past or present tuberculosis and that cases should be discharged at his discretion.<sup>59</sup> The committee was also initially reluctant to provide for maternity cases, but when the borough fever hospital agreed to take NEI patients it was decided that with some alteration the isolation wards could be used for maternity cases.<sup>60</sup>

Improved facilities for surgery were provided at NEI, although six years after opening, the medical officer reported that the operating table and appliances were inadequate and the provision of a steriliser was a 'pressing necessity'. A new operating table was ordered at a cost of £75, but decisions on the steriliser and a proposal to build a new operating theatre were deferred for a year.<sup>61</sup> Guardians often agreed to inexpensive requests but delayed decisions where a high outlay was necessary. However, they sometimes acted on suggestions from medical staff. For example, to avoid duplication of work and give more time for patients, the LGB was asked if instead of keeping a medical register, case book and bed card, case papers for each

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<sup>57</sup> LRO, G/12/8j/1, 24 Oct 1905, 26 Mar 1907.

<sup>58</sup> *Ibid.*, 19 Dec 1907.

<sup>59</sup> *Ibid.*, 2 Jan 1908.

<sup>60</sup> *Ibid.*, 22 May 1906; G/12/57b/12, 29 May 1906. The borough fever hospital did not admit erysipelas or chicken pox cases but it would admit enteric fever cases from NEI. The guardians paid the corporation 25s per week for the treatment of such patients. G/12/57D/49, 18 Nov 1909.

<sup>61</sup> LRO, G/12/8j/2, 5, 15, 19 Oct 1911; G/12/8a/48, 27 Jan 1914 an operating room was erected in 1914.

patient could be kept in folders at the head of the bed. The guardians pointed out that the LGB had agreed to this system for the Poplar and Stepney Sick Asylum.<sup>62</sup> By 1910 the LGB made use of case papers for all patients compulsory,<sup>63</sup> showing a marked change in the efficiency of record-keeping.

## **Medical differences**

A number of patients continued to reside in the sick wards of the workhouse where Dr Bryan continued his duties.<sup>64</sup> In 1907 there were still 59 male and 30 female inmates in the infirm wards of the workhouse.<sup>65</sup> Predictably this situation created tension between Dr Bryan and the NEI medical officers arising from differences in medical opinion and decisions to return workhouse patients after treatment at the infirmary. One case concerned the discharge of a patient that an RMO considered to be suffering 'probably' from 'chronic alcoholism', primarily from 'nervous debility' and probably some 'fatty degeneration of the heart'. As the patient presented no cardiac symptoms and did not complain of illness to the RMO on his daily visit, he was discharged. The patient complained and Dr Bryan was then requested to examine him. He diagnosed 'fatty degeneration of the heart' or 'fibroid degeneration'. He said it was impossible to say which but in either case the treatment was the same – rest, good diet and suitable medicine. He felt this was a genuine case of illness.<sup>66</sup>

Another incident involved a patient who had suffered a stroke twelve months earlier resulting in partial paralysis. He was sent from the workhouse to the infirmary after he had fallen out of bed and suffered bruising. When the bruising recovered he was returned to the workhouse where he died the following evening. Dr Bryan reported that death was due to syncope and conditions at the workhouse were not good for such a patient in his 'helpless state'. However, Dr Dodd reported that the deceased had

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<sup>62</sup> LRO, G/12/57b/12, 24 Nov 1906.

<sup>63</sup> White, *Social Change*, p. 148.

<sup>64</sup> LRO, G/12/57d/54, 15 May 1914 stated there were no nurses at the workhouse, only attendants on the sick.

<sup>65</sup> LRO, G/12/57d/47, 1 Jul 1907.

<sup>66</sup> LRO, G/12/8a/40, 26, 28 Feb 1906.

shown no symptoms to indicate that death was likely to be sudden and had he shown heart symptoms he would not have been discharged. Once he was recovered he was returned to the workhouse, 'as is usual'.<sup>67</sup>

On occasions the NEI refused patients admission and sent them to the workhouse where they were speedily sent back to NEI by Dr Bryan. A patient admitted to NEI with ulceration of the arms and legs was reported by Dr Dodd to be in a 'shockingly offensive condition'. She had to be placed in a general ward as there was no available isolation ward. The complaints by nurses and patients about 'the stench' were to be ignored but after three days she was sent to the workhouse. Dr Bryan immediately returned the patient as she 'was not a suitable case for the lock ward. However, Dr Dodd declared that the case was too offensive for 'any but a lock ward' and she was once again transferred to the workhouse, where she was finally retained.<sup>68</sup> The differences between the two doctors led to a joint interview with two guardians who stated that they received a 'satisfactory pledge' from them that if either did not agree on the transfer of a patient to his institution, the patient should not be returned until they had discussed the matter together in person. If they could not agree, either committee would arbitrate.<sup>69</sup>

Disagreements between Dr Bryan and the RMOs continued, which led to a recommendation that no cases should be sent down from the infirmary to the workhouse without the consent of Dr Dodd. However, Dr Dodd stated that the RMOs acted under his regulations and were 'extremely careful'.<sup>70</sup> Whether he completely trusted their judgement or did not want the trouble of attending each case is debatable. Dr Bryan was vindicated in his view that a patient sent from NEI to the workhouse as a venereal case should have first been thoroughly examined as she was in fact suffering from carcinoma of the uterus. The guardians called in a pathologist to examine her who confirmed Dr Bryan's opinion. The guardians wrote to the patient's husband to

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<sup>67</sup> LRO, G/12/57d/47, 8 Nov 1907.

<sup>68</sup> LRO, G/12/8j/1, 9 Apr 1908.

<sup>69</sup> *Ibid.*, 9 Jun 1908.

<sup>70</sup> LRO, G/12/8j/2, 17 Dec 1908.



confirm the diagnosis which implies that the first mistaken diagnosis caused much distress to the patient and her husband.<sup>71</sup>

Despite the higher numbers of beds, NEI became overcrowded with both general and mental patients. According to the matron, there were a large number of children in the hospital and a 'great many' old people who were 'quite helpless' and required 'constant attention.'<sup>72</sup> Receiving and district medical officers and the General Infirmary were instructed to send only patients who could not be treated elsewhere.<sup>73</sup> The numbers reached 517 in 1912 compared with 451 the previous year.<sup>74</sup> The total number of in-patients during 1913 was recorded as 1,365. Eventually it was suggested that the overcrowding might be relieved by sending patients who did not require constant nursing to the workhouse where a ward could be equipped to accommodate them.<sup>75</sup>

The problems of overcrowding and transferral of patients continued. In 1914 the guardians asked Dr Bryan for his observations on cases that had been sent from NEI to the workhouse and whether they should have been kept in the infirmary. All the patients Dr Bryan listed were elderly females, who clearly required a great deal of nursing assistance, but nevertheless were sent to the workhouse despite its unsuitability and even though infirm wards at NEI had been provided for patients who were not considered to require sick nursing.<sup>76</sup> The list and Dr Bryan's comments are quoted below in Table 9.2.

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<sup>71</sup> LRO, G/12/8a/ 48, 24 Mar, 7 Apr, 20 Apr 1914.

<sup>72</sup> LRO, G/12/8j/2, 14 Dec 1911.

<sup>73</sup> LRO, G/12/8j/3, 24 Feb 1910.

<sup>74</sup> LRO, G/12/57b/14, 26 Sep 1912.

<sup>75</sup> LRO, G/12/8j/3, 31 Oct 1914.

<sup>76</sup> LRO, G/12/8j/1, 4 Nov 1907. White, *Social Change*, p. 142 noted an increasing tendency in the developed infirmaries towards taking more of the younger age groups and drafting the aged inmates into nearby workhouses.

**Table 9.2****Patients sent from North Evington Infirmary to workhouse<sup>77</sup>**

Name	Age	Condition
Goodacre, Mary Ann	76	Paralytic came down from NE on Jan 3 <sup>rd</sup> and was sent back on Feb 10 <sup>th</sup> .
Sutton, Sarah Ann	67	Bronchitis sent down Jan 3 <sup>rd</sup> , sent back on Feb 1 <sup>st</sup> .
Simms, Ellen	74	Incontinence of urine, came down Jan 8 <sup>th</sup> sent back Feb 10.
Burt, Ann	81	Bedridden occasional bronchitis
Childs, Hannah	78	Very bad case, bedridden contracted limbs, very wet changing case.
Chesterton, Louisa	64	Perfectly helpless, changing case contracted arms, passes all under her, very bad case.
Gamble, Sarah	72	Bedridden. Changing case.
Wale, Elizabeth	65	Abdominal tumour, she was sent down Jan 9 <sup>th</sup> , sent back Feb 11.
Wright, Elizabeth	68	Mental Helpless, Paralysis, changing case.
Warner, Emma	83	Sent down on Jan 1 <sup>st</sup> died on Jan 22 <sup>nd</sup> from Bronchitis.
Petty, Elizabeth	74	Sent down Jan 2 <sup>nd</sup> died on Feb 8 <sup>th</sup> . Cardiac Disease. She was subject to heart attack and would have been better in hospital. This case passed by the coroner as she suffered from heart disease.

‘I can manage with most of the male cases but I am of opinion that Walter Johnson aged 24 Imbecile should be at NE. He was sent down on Jan 1<sup>st</sup>. If the other cases of females remain with me, I hope that an extra nurse will be provided particularly to keep with the changing cases at night or bedsores must inevitably develope. [sic] With reference to the latter clause of your letter as to what class of case should be sent down to the workhouse, in my opinion they should be all those that are able to get about during the day and are able to a certain extent to help themselves.’<sup>78</sup>

<sup>77</sup> LRO, G/12/8j/3, 15 Feb 1914.

<sup>78</sup> *Ibid.*

## Attitudes

The regulations for the new infirmary showed that official attitudes towards patients were unchanged. On admission the ‘poor person’, if not seen immediately by a medical officer, was placed in a receiving ward to await examination to determine the appropriate ward. Unless the medical officer objected, the person was then ‘thoroughly cleansed’ and clothed in a ‘suitable dress’. Patients were searched and prohibited articles removed. Visitors were not permitted to give patients food or drink and gifts of reading matter had to receive approval of the guardians. Books and local daily newspapers were provided for the patients by the guardians. Clothes worn on admission were purified and stored, to be returned on discharge or disposed of at the guardians’ direction if the person died. The two sexes were kept separate ‘without communication.’<sup>79</sup> The regulations stipulated that workhouse inmates were not to be employed as attendants in the infirmary unless approved by the medical officer but, if sanctioned by him, patients were allowed to cut up bread and distribute but not serve meals.<sup>80</sup> A partially able-bodied workhouse inmate was sent to the infirmary to attend the telephone.<sup>81</sup> Children aged eight and over were allowed to visit their parents. Younger children were also allowed to visit at the discretion of the matron.<sup>82</sup> Occasionally patients were permitted to visit a spouse in the asylum or a child in the receiving home.<sup>83</sup> Infrequent treats were given to patients. In place of the ‘ordinary summer treat’, extra ‘fare’ and an evening concert were given to the patients and the staff were permitted to hold a dance.<sup>84</sup> Biscuits and sweets were provided for the women patients as an equivalent of the tobacco supplied to the men,<sup>85</sup> and according to the VCL the food served on the imbecile wards was ‘of excellent quality’.<sup>86</sup> Presumably the dietary was much improved for all the patients.

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<sup>79</sup> LRO, G/12/57d/45, North Evington Poor Law Infirmary Regulations.

<sup>80</sup> LRO, G/12/8j/1, 21 Nov 1907.

<sup>81</sup> *Ibid.*, 24 Oct 1905.

<sup>82</sup> *Ibid.*, 29 Aug 1907.

<sup>83</sup> LRO, G/12/8j/2, 22 Oct 1908.

<sup>84</sup> *Ibid.*, 19 Oct 1911.

<sup>85</sup> LRO, G/12/8j/1, 13 Mar 1906.

<sup>86</sup> LRO, G/12/57d/47, 4 Jul 1907.

In contrast to the workhouse infirmary records, occasional letters of gratitude from patients or their relatives were recorded in the NEI records. For example, the relatives of Edward Cuthbert wrote to acknowledge the 'great kindness and attention' the nurses gave to their brother during the time he was an 'inmate of the infirmary.'<sup>87</sup> Samuel Mills seemed particularly thankful that his late wife's uncle was kept 'very clean' and had the 'best of attention'.<sup>88</sup> The use of the term 'inmate' rather than 'patient' signifies a continuing acceptance of that status.

Not all patients were grateful for their treatment. The few complaints that were recorded were, however, all made by male patients. One patient complained that a nurse had eaten custards and drank milk and beef tea intended for the patients. The nurse's defence was that the custards had been made from eggs sent by her friend and that the milk and beef tea had to be tested daily in accordance with the matron's instructions. The patient was informed he was mistaken.<sup>89</sup> Another patient's complaint to the LGB revealed how patients could end up in the NEI in an iniquitous situation. Alfred Gilbert wrote that he had had the 'misfortune' to have been at NEI for a year. He had received a head injury during the Boer War when thrown from a horse. Consequently he suffered fits and was invalided out of the army. On his return to Leicester he worked as a gardener for the Corporation and the Borough Asylum. Ironically he was discharged from the Asylum when he suffered a fit as the medical superintendent felt it was unsafe for him to continue his employment there. Unable to obtain a permanent job because of his condition, he was sent to NEI where he was asked to work in the gardens. He stated that he was happy to do this but, not unreasonably, asked the guardians why it was considered safe for him to work in the gardens unpaid as an inmate but they would not employ him as a paid man. He was told by the steward that it was against the law to employ him but as an inmate he had got to work for his living, clothes and boots. As Gilbert was working alongside paid men, he felt this situation was unjust, particularly as the union took 4s 1d a week for his maintenance out of his army pension of 4s 8d. The RMO stated that Gilbert was a very

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<sup>87</sup> *Ibid.*, 5 Nov 1908.

<sup>88</sup> LRO, G/12/8j/2, 16 Jul 1910.

<sup>89</sup> *Ibid.*, 13 Feb 1906.

good worker and, despite his epilepsy, he was kept in a general ward where he got more freedom and was given many extras and tobacco. It seemed that his complaint was made after an altercation with the head gardener. The RMO added that Gilbert had an ‘overbearing manner’ which annoyed the officers. In addition, outdoor work was good for his treatment and many other epileptic and phthisis patients also worked outside. Nothing more was recorded; doubtless Gilbert had no choice but to accept his situation.<sup>90</sup>

Complaints about medical treatment are lacking, perhaps because patients felt more secure complaining about conditions but were uncertain about challenging medical treatment. One patient complained about his medical treatment but unfortunately the papers only record that the senior RMO produced the medical case papers and it was resolved the treatment given was satisfactory. It must be remembered, however, that the guardians were not usually medically qualified and as a rule accepted the opinion of medical staff rather than the patients.<sup>91</sup>

### **Paying patients**

Although the requirement for admission to NEI was ‘destitution’, the infirmary’s function was described as for the ‘sick poor’. Increasingly the poor and non-destitute made use of poor law infirmaries due to lack of other accessible hospital facilities. The chairman of the guardians stipulated when NEI opened that ‘men who were sick and could not receive proper attention at home, might be brought there with the aid of friendly societies, trades unions or private help.’<sup>92</sup> *The Lancet* noted that Salford guardians changed the word ‘pauper’ to ‘patient’ on the bed-cards and told the LGB that the guardians and the people of Salford detested the word ‘pauper’ and insisted that it was a ‘sick hospital’ as non-pauper patients were also treated in the hospital and the word was not ‘sufficiently expressive’.<sup>93</sup> Patients who were discovered

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<sup>90</sup> LRO, G/12/57d/49, 20 Feb 1909.

<sup>91</sup> LRO, G/12/8j/3, 2 Oct 1913.

<sup>92</sup> *Leicester Daily Post*, 29 Sep 1905, p. 5.

<sup>93</sup> *Lancet*, 14 Sep 1895, p. 699.

to have money were charged for their maintenance but treated as paupers in contrast to the free treatment for the non-pauper sick poor provided by the voluntary hospitals. For example, Samuel Johnson was admitted with £30 6s 9d in his possession. He was charged 14s a week maintenance.<sup>94</sup> The guardians consented to admit a woman with cancer whose husband was not destitute as he received 30s a week as a railway guard. However, he was paying 9s a week to a nurse to tend to his wife while he was at work. He offered to pay the guardians 10s a week for her maintenance in the infirmary because he was in danger of losing his job due to having to tend to his wife when he was at home and not getting sufficient rest before attending work.<sup>95</sup> Sick clubs also paid for employees' maintenance. The committee granted an allowance of 6d per week to John Richardson out of money paid by the Great Central Railway Sick Fund on his account.<sup>96</sup> The cost of maintenance at NEI was 18s 11½d per head per week in 1911 and 19s 1½d by 1914.<sup>97</sup>

New infirmary facilities could even be superior to some voluntary hospitals. The Leicester General Infirmary sent patients it would not admit to the workhouse; they were then usually sent to NEI. The workhouse porter's report gave examples of two such admissions which show the convoluted procedure patients often had to undergo to gain admission. Thomas Breeze had fractured his collar bone and walked from Coalville to the General Infirmary. Despite having a recommendation, he was refused admission and directed to the relieving officer who refused him an order for the workhouse as he had not slept in the town the previous night. He was then sent to the NEI porter without an order. The porter stated that the man was destitute but he did not appear to be a 'man of the casual class'. As he was not fit to undertake the fourteen mile walk to Coalville that night, the porter took him into the receiving ward. Breeze returned to the relieving officer the next morning and was finally given an order. Dr Bryan immediately sent him to NEI. The second man, a pensioner, Frank Grainger, was brought to the workhouse in the fire brigade ambulance. Dr Bryan happened to be

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<sup>94</sup> LRO, G/12/8j/3, 1 May 1913.

<sup>95</sup> LRO, G/12/57b/12, 7 Mar 1906.

<sup>96</sup> LRO, G/12/8j/2, 20 Oct 1910.

<sup>97</sup> *Ibid.*, 13 Jul 1911.

present and at once ordered him to be taken NEI in the workhouse ambulance. Grainger had been discharged from the General Infirmary that morning and had applied at the poor law offices for an order for NEI but had been refused. The firemen stated that he had been in the ambulance for three hours and they refused to take him any further.<sup>98</sup> Grainger was admitted to NEI but all his pension was taken for his maintenance.

## Inquests

Information on routine medical treatment is lacking, however, inquest reports reveal fascinating details. For example, an inquest on the sudden death of a 68 year old man disclosed that he died while he was under chloroform administered for an elective operation on his nose. He suffered from tuberculosis of the lower bowel to such an extent that it was inoperable. However, he also had a ‘marked overgrowth of the tissues of the nose, with deformity of the nasal bones’. Dr Smith and a temporary medical officer, Dr Power, examined him and felt it was safe to administer chloroform. While injecting adrenalin solution into the nose tissues, the patient stopped breathing. The two medical officers tried artificial respiration for an hour and gave him injections of brandy, strychnine and oxygen, but to no avail. Dr Smith carried out a post mortem and found the heart to have ‘extensive fatty disease.’ He believed that it had been impossible to ascertain the condition of the patient’s heart from an external examination, although ‘the heart sounds were soft’ which was attributed to ‘advancing age’. The jury attached no blame to the doctors.<sup>99</sup> This incident is interesting because it shows not only that the patient requested this treatment, but also the difficulties the RMOs experienced in judging a patient’s suitability for an operation even though Dr Power had been qualified for five years and had previously administered chloroform in eighty cases. It is also surprising that a doctor who was involved in a patient’s death was allowed to carry out a post mortem. *The Lancet* had earlier reported that the Strand union had recommended that post mortems should only be carried out by an

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<sup>98</sup> LRO, G/12/57b/12, 13 Mar 1906.

<sup>99</sup> LRO, G/12/57d/52, 19 Aug 1912.

independent doctor on anyone dying in the union buildings as medical officers ought not to conduct a post mortem on someone they had attended when alive to avoid any scandal of professional interest.<sup>100</sup>

## Changes

Recurrent problems and friction caused by the non-resident medical superintendent decided the guardians to promote the senior RMO to medical officer with full administrative responsibility. He was put on a higher salary than Dr Dodd, whose position was altered to that of consulting medical officer. This change was put into effect for a year-long trial.<sup>101</sup> Despite this slight on his status and capability, Dr Dodd agreed to the alteration provided that he had security of tenure and continued to receive the same salary. He declared that he had had all the ‘organising, heavy and unpleasant work’ for the past four years and it was inequitable that his salary should be reduced. He also specified that he should have the right of entry and resources of the infirmary for the purposes of diagnosis and examination of patients at his discretion.<sup>102</sup>

By 1913 the committee felt that more drastic action was necessary. The guardians decided that the visiting position held by Dr Dodd should be abolished. Instead, a resident medical superintendent would be appointed with an assistant RMO and visiting consultants, namely a physician, pathologist and surgeon.<sup>103</sup> A separate residence would be built for the new medical superintendent. At the same time two replacement RMOs, John Grice and Annie Fergus, were appointed. A female doctor was appointed for the first time at the Leicester union, albeit as the more junior officer on a lower salary. There were difficulties in finding suitable accommodation for her as the employment of female doctors had not been anticipated. However, the matron agreed temporarily to give up her room.<sup>104</sup>

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<sup>100</sup> *The Lancet*, 31 Aug 1895, p. 567.

<sup>101</sup> LRO, G/12/8j/2, 11 Mar, 17 Nov 1909, 10 Mar, 23 Mar 1910.

<sup>102</sup> LRO, G/12/57b/13, 22 Dec 1909, 5 Feb 1910.

<sup>103</sup> LRO, G/12/8j/3, 23 Sep 1913.

<sup>104</sup> LRO, G/12/57d/53, 25 Oct, 17 Nov 1913. G/12/8j/3, 2 Oct, 13 Nov 1913.



Doctors Grice and Fergus quickly made an unwelcome impression when they complained to the committee about the infirmary administration. They discovered that certified lunatics and mentally deficient patients were in the ordinary wards because the imbecile and epileptic wards were overcrowded. Imbecile male patients had also been used to carry stores and coals and thus had free access to the corridors and kitchens of the female wards. They complained that the lack of attendants provided opportunities for male and female imbecile patients to mix. This situation even led them to remove one girl to an imbecile ward as they feared that ‘she might at some future time occupy the maternity block.’ Furthermore they objected to patients being given work to do without the RMO’s consent. They also identified instances where patients were at risk, such as an epileptic patient found up a ladder cleaning windows; another patient with laryngitis was scrubbing floors, and a child with heart disease and phthisis was carrying buckets down the stairs. The doctors were anxious to disclaim responsibility for this situation and to protect their medical professionalism.<sup>105</sup>

Predictably, Dr Dodd dismissed their complaints and claimed that mentally deficient patients had been in most of the wards since the opening of NEI. He suggested that the RMOs should concentrate on their own work and leave the administration to the ‘proper authorities’. The matron agreed with him. However, the committee agreed that lunatics and mentally deficient patients should not be placed in ordinary wards and confirmed that any certified lunatics ought to be in the asylum. It also agreed that patients should not carry out work without the permission of the medical officer.

Following this incident an inquest held on a patient who died from ‘convulsions following digestive disturbance’ added a rider that Dr Fergus thought there were insufficient nurses in the wards and a nursery containing fourteen children all under three years, should not be left alone at night. As a result, an additional nurse was placed in the nursery wards.<sup>106</sup> However, the committee were disconcerted by Dr

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<sup>105</sup> LRO, G/12/8j/3, 18 Jan 1914.

<sup>106</sup> LRO, G/12/57b/14, 16 Feb 1914.

Fergus's comments. Shortly afterwards she organised a surreptitious inspection of NEI by Sir Henry Burdett, 'the national authority on hospitals',<sup>107</sup> who wrote a highly critical report. Dr Dodd complained strongly about her conduct and she was forced to resign. Dr Grice also resigned.<sup>108</sup> The committee evidently could not tolerate accusations of bad management from the medical officers even though the administration by Dr Dodd had been consistently problematic and a new superintendent was soon to take over. When asked for a reference for Dr Grice, the guardians commented that he discharged his medical duties to their satisfaction, but added that 'his attitude towards the chairman, committee and ... Dr Dodd left much to be desired.'<sup>109</sup>

In order to streamline the management of the indoor medical services, the guardians decided that the new RMS should also take responsibility for the workhouse and receiving homes for an additional salary. Dr Bryan agreed to resign and leave two weeks after this new appointment was taken up on condition that he received a gratuity equal to two years salary. However, before an appointment was made Dr Bryan unexpectedly died. His son took over as interim workhouse medical officer until the new RMS was appointed.<sup>110</sup> Dr Dodd left two months later. There were eight applicants for the post aged from 27 to 40. Four were from other union infirmaries, while three local applicants worked in private practice, at the County Asylum and at the Leicester Royal Infirmary.<sup>111</sup> The successful applicant, Dr Hadley, was experienced, having been in practice for fourteen years, although this was his first poor law post.<sup>112</sup> He had previously worked as resident surgeon at Birmingham General Dispensary and as RMO at the Jaffray Hospital at Erdington, Birmingham. He supplied excellent references and had clearly been a high attaining medical student.<sup>113</sup> Dr Hadley proved to be a vast improvement on Dr Dodd. He was respected and even feared as he

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<sup>107</sup> Pickstone, *Medicine and Industrial Society*, p. 216.

<sup>108</sup> LRO, G/12/8J/3, 10 Mar, 14 Apr 1914.

<sup>109</sup> LRO, G/12/57b/14, 18 Jun 1914.

<sup>110</sup> *Ibid.*, 25 Feb, 9 Apr 1914.

<sup>111</sup> The voluntary Leicester General Infirmary was renamed the 'Leicester Royal Infirmary' in 1912.

<sup>112</sup> LRO, G/12/8a/48, 28 May 1914.

<sup>113</sup> LRO, G/12/57d/54, 28 May 1914.

reputedly ruled the hospital 'with a rod of iron'.<sup>114</sup> In this, he was aided by amendments to the infirmary regulations that stipulated that the RMS's duties were 'to govern and control all the officers, assistants and servants in the infirmary and generally to hold the supreme position in the institution.'<sup>115</sup>

In 1913 the LGB abandoned the 'workhouse' label and renamed such establishments 'poor law institutions'.<sup>116</sup> From 1914 the words 'Poor Law' were officially dropped from the infirmary's title, although, as noted above, this designation had not been used locally. However, patients of NEI once again experienced workhouse conditions. At the beginning of the First World War, Dr Hadley wrote to the guardians to suggest that it would be a 'patriotic action' to offer the government the use of a number of NEI beds and staff for the sick and wounded. One ward of thirty-two beds was offered.<sup>117</sup> The following year, however, the guardians were asked to place the whole of NEI at the disposal of the War Office. The guardians readily agreed.<sup>118</sup> The War Office offered to find and pay for any other extra buildings required for sick or other pauper inmates. The guardians asked the Sanitary Committee to take the tuberculosis patients but it would only agree to take 21 female patients and 6 boys at a cost of 30s per week for adults and 15s for children. Its refusal to take adult male patients led the guardians to decline the offer. When the LGB recommended that consumptive patients should not be placed at the workhouse due to its limited area and the general accommodation of the wards, negotiations were re-opened and the Sanitary Committee then agreed that adult male patients would be taken when space became available.<sup>119</sup>

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<sup>114</sup> Mackay, *Palace on the Hill*, p. 27.

<sup>115</sup> LRO, G/12/8j/3, 2 Apr 1914.

<sup>116</sup> By the 1920s poor law infirmaries began to be called 'hospitals'.

<sup>117</sup> *Ibid.*, 15 Aug 1914.

<sup>118</sup> *Ibid.*, 12 Nov 1914. The guardians resolved that all officers joining the army would receive half pay until the termination of the war or their relief from military service. Many other poor law institutions were also requisitioned for military hospitals and medical officers and nurses volunteered for war service.

<sup>119</sup> LRO, G/12/8a/49, 18 Feb, 2 Mar, 6 & 20 Apr, 1915.

NEI was handed over to the War Office on 16 March 1915 and temporarily became the North Evington Military Hospital. The newly-erected superintendent's residence was used by the military authorities for accommodating its nurses and the guardians had to find suitable houses for Dr Hadley and the infirmarium dispenser.<sup>120</sup> A local school was turned into a temporary nurses' home and the nurses' salaries were raised temporarily during the war to compensate for their extra travel costs to the workhouse and also for outdoor uniforms. Some officers remained at NEI.<sup>121</sup> It is unclear whether these included any nurses, although the Leicester guardians did agree to support the Birmingham guardians' protest against proposals by the War Office to pay poor law probationers in infirmaries taken over as military hospitals a lower rate than the Voluntary Aid Detachment probationers.<sup>122</sup>

Surprisingly the transfer of patients to the workhouse received very little mention in the union records or local press, apart from a brief note that the guardians had resolved to pay all the officers one guinea and each of the maids 10s 6d for working at the weekend to move the patients from NEI.<sup>123</sup> No doubt attention was focused primarily on the war situation. This study ends at that point. However, further research would be useful to assess the treatment of patients during the war and also from 1918 to 1930 when the North Evington hospital reverted to poor law use. This would reveal the full extent of the transition from a workhouse infirmarium administered by lay officials to a poor law hospital regime managed by medical professionals.

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<sup>120</sup> *Ibid.*, 6 & 13 Apr 1915.

<sup>121</sup> LRO, G/12/57d/55, 19 Apr 1915. A staff return noted that 14 men and 9 women were now paid by the government.

<sup>122</sup> LRO, G/12/8a/49, 30 Nov 1915. The unoccupied Leicestershire and Rutland Lunatic Asylum was used as the base war hospital in Leicester.

<sup>123</sup> LRO, G/12/8j/3, 29 Apr 1915.

## **Chapter 10**

### **Conclusion**

This thesis has provided an intensive case study of the poor law medical service of one union. The intention has been to produce a balanced assessment of the medical service within the poor law system, which was castigated by many contemporaries and is often dismissed by historians as a flawed concept and cruel practice. The usual stereotype of the new poor law has been promulgated by a concentration on the various scandals and frequently inadequate treatment of those who sought poor relief. Nevertheless, some historians have believed that the poor law was a forerunner of improved public medical services within a national welfare system. Others argue that those services developed as the inability of the deterrent and stigmatising poor law to cope with the growing numbers in need became increasingly apparent, and as attitudes towards those in poverty and the causes of poverty changed.

This study has focused upon a significant feature of poor relief which has generally escaped the rhetoric or arguments over the new poor law, namely, the medical service. It has assessed the practice and changing nature of medical treatment under the poor law in an important union in England, for an industrial town notorious for religious and political nonconformity, and with a longstanding reputation for being unhealthy. The study engages in a detailed micro-history that attempts to escape bland generalisations and looks at local detail and personalities which are contextualised against national poor law history and the social history of medicine.

The limited availability of direct sources on the work of the district medical officers and the experience of patients has inevitably meant that it has only been possible to present a partial view of the medical service. Nevertheless, this study has included salient details of the district medical service and the patients among the topics covered by the different chapters. Poor law midwifery, disability, insanity, medical officers, nurses and patients have often been treated by other historians in

general ways, but this study has provided a tight focus in the concentration on Leicester.

The research uncovered some surprising findings. For instance, although many patients suffered chronic illnesses, numbers of acute cases increased and the workhouse medical officer undertook surgery such as cataract operations and the newly-discovered procedure of skin-grafting that were far beyond expectations. In addition, the guardians subscribed to external medical services for treatment that the poor law service could not provide. The union also employed and trained paid nurses much earlier than was required by the central authority. Lastly, despite the intention of the poor law that workhouses were solely for the destitute who claimed poor relief, patients with funds such as pensions were permitted to receive medical treatment for payment.

During the nearly fifty years covered here, the perception of pauperism changed from an initial view that it was necessary to deter the able-bodied male, to a more complex perspective. The poor law changed as the medical origins of pauperism became more clearly significant. The Leicester union gradually recognised and came to terms with this, and started to make adjustments. However, no place is typical; each needs to be set against the local economy and circumstances. Comparisons with medical services of other unions would be valuable to build up a more comprehensive picture of a medical service that has been neglected in the history of nineteenth-century medical provision.

Despite its growing prosperity, Leicester had periods of unemployment and poverty was a regular occurrence for many of its population. As in many nineteenth-century towns, unhealthy conditions and ill health persistently affected the poorest. Patchy and costly medical provision precluded many from receiving medical treatment unless poor relief was sought. As for the quality of care, the thesis has argued that there was a limited range of medical provision available to the sick poor of Leicester. Consequently, despite its deficiencies, the medical service for both in-door and out-door paupers provided treatment and care that patients would not otherwise have obtained.

The calibre of medical officers improved from 1867. Newly qualified doctors were usually appointed as medical officers. Initially they may have lacked experience, but equally patients may have benefited due to the medical officers' recent training in modern medical techniques and knowledge. A few of the doctors left their posts to advance in their medical career. However, many of the workhouse and district medical officers remained in post for a substantial number of years providing consistency in the medical treatment of patients, together with local knowledge of their conditions and needs. As the medical officers grew more medically experienced and established within the poor law system, they were better equipped to challenge the guardians and became increasingly confident in asserting their expertise and its value to the union, ratepayers and patients.

The thesis has shown that the medical officers carried out more than basic medical care and treatment. It has revealed that there was continuity at the Leicester union workhouse where medical treatment through the provision of nutrition, nursing care, isolation of infectious diseases and surgery contributed to a relatively low death rate, particularly as the majority of inmates were children, the sick and the elderly. Few records were found relating to pauper patients' complaints about their treatment and the central authority was generally supportive and approving of the medical officers. The medical officers' lengthy terms in office show evidence of their satisfaction with their working conditions and commitment to the medical service despite its second-class reputation. Their poor law experience clearly did not prevent them from having private patients or obtaining other posts. Nevertheless, research on the private practices held by poor law medical officers would be useful to enable comparisons about the way they treated different classes of patients.

The detailed primary sources have enabled an in-depth account to be assembled of the organisation and management of this local poor law medical service. Issues of power emerged in each of the different areas examined. The local board of guardians required the approval of the central poor law authority for many of its actions. However, the central authority lacked the power to significantly influence the guardians if it disagreed with their actions. This thesis has shown that, although the guardians were careful to protect the economic interests of the rate

payers, they were not unduly influenced by the central authority's policy of retrenchment from the 1870s. Indeed, throughout the period the guardians conducted debates with the central authority when they felt better qualified to decide upon the appropriate approach or action from their detailed local knowledge. For instance, the guardians insisted on using midwives and resisted attempts by the central authority for medical officers to attend all childbirth cases, even when the employment of a qualified midwife increased costs. The attitude of the guardians towards the LGB is perhaps aptly illustrated by a quote from an address on 'Relief by the Community' given to the Leicester Literary and Philosophical Society in 1907 by the vice chairman of the Leicester board of guardians: 'Most Guardians are only too familiar with the pettifogging interference with the details of our work and the vexatious delays which occur in consequence of the procedure of the Local Government Board.'<sup>1</sup>

The guardians had financial power and authority over the medical officers and they were similarly prepared to reject the medical officers' opinions, although at times they also complied with their judgement. The thesis has shown though that subtle shifts in the balance of power evolved between the guardians and medical officers. In the later years, when the workhouse medical officer, Dr Bryan, asserted his professional expertise, the guardians exhibited a slightly more deferential attitude, which suggests the influence of the growing power of state medicine through medical advances, the rising status and authority of the medical profession and the development of the modern hospital.

Although, the guardians resented the central authority's criticism of the workhouse conditions for children, after some protests, they acknowledged the desirability of removing the children from the overcrowded and forbidding workhouse and provided a more homely and healthy environment for them, either in cottage homes or with foster-parents. Their removal briefly helped to ease the overcrowded situation at the workhouse, but, more importantly for the children, it showed recognition of the need for a different approach to their welfare. Even so

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<sup>1</sup> G.M. Moore, 'Relief by the Community', *Transactions of the Leicester Literary and Philosophical Society*, 12 (1908).



for children who became sick, the cottage homes infirmary was never wholly suitable for the numbers and types of cases it received and the guardians resisted making substantial improvements. The guardians acted more slowly to improve conditions for other inmates and patients. Insufficient attendants were employed for imbecile and epileptic patients, particularly at night, and the guardians prevaricated in providing accommodation for infectious cases.

In contrast to the medical officers, the turnover of nurses was consistently high, showing their dissatisfaction with their work and conditions, and their lack of importance to the guardians. Despite enhancements to their training by the early twentieth century, the guardians restricted it simply to the immediate needs of the patients and the infirmary administration. Moreover, they wanted to ensure that the nurses were not influenced by others who might encourage them to challenge the authority of the matron or guardians.

The problems caused by the way that the poor law system dealt with the poor became evident from the increasingly severe overcrowding at the Leicester workhouse by the late 1890s and the guardians were eventually forced to acknowledge that both the workhouse and infirmary accommodation were inadequate. To overcome this problem they built more spacious accommodation, rather than addressing the causes of poverty and keeping people out of the workhouse. In this way, the removal of the workhouse infirmary from the workhouse to better facilities at North Evington was a positive move for both patients and staff. The grandeur of the 'Palace on the Hill' and the considerable financial outlay on superior medical facilities for pauper patients was justified by emphasising its boost to Leicester's civic pride. Sending recalcitrant patients to the workhouse shows that the moral undertones of the system persisted and the inferior conditions at the workhouse were considered an apt punishment. Furthermore, pauper patients at the new infirmary were still expected to work for their maintenance wherever possible, although this was also justified as beneficial to their health. As shown in Chapter 9, however, and in common with other poor law infirmaries, North Evington Infirmary began to take non-pauper patients while continuing to be underpinned by the philosophy of the poor law system.

The make-up of the board of guardians gradually changed when more women and working-class guardians were elected. The board's priority with economy became tempered by the prevailing concerns over poverty, unemployment, public health and the moral and physical degeneration of the poorer classes. The majority of guardians were Liberals; it would therefore be expected that they would concur with and be influenced by the early twentieth-century Liberal reforms to improve public health. The guardians were involved in the operation of the various Acts that were passed to bring about improvements in public health.<sup>2</sup>

By the end of the period studied, the guardians began to regard the separation of patients who required different, more specialised care, as a preferable option. The guardians thought that the general poor law medical service was inappropriate for imbecile and epileptic patients, in theory at least, although little was actually done to improve their situation at the new workhouse infirmary. The lack of involvement of the medical profession with these patients and the laxity of the attendants became apparent when new, younger medical officers were appointed at the North Evington Infirmary. However, the guardians supported the medical superintendent in this matter even though they were not confident of his ability, which confirms that the separation of infirmaries from workhouses resulted in greater administrative control by medical officers.

This thesis has offered insights into the care and treatment of different categories of patients. It has shown some instances of considerate treatment, yet it has also given many examples of the treatment of the elderly, the insane and infectious, which might be considered horrifying in the twenty-first century. The views of the majority of patients on their medical treatment and care are mainly unknown. Occasionally, this research has shown that patients were not always passive recipients: several patients wrote letters of complaint to the central authority, or to newspapers, or misbehaved and absconded. The medical officers also drew attention to deficiencies in the conditions and quality of the care and treatment of patients.

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<sup>2</sup> These Acts included the provision of free school meals in 1906, school medical inspection in 1907, the Old Age Pensions Act, 1908, the National Insurance Act, 1911, and the Mental Deficiency Act, 1913.

As with any piece of historical research, it is critical to judge these examples within the context of the medical knowledge and nursing standards of the time. The complexity of the treatment of different categories of pauper patients makes it necessary to avoid simplistic judgements on the poor law medical service. The stereotypical image has been confounded by some of the evidence offered here. The treatment of patients was not found to have been deliberately harsh. Yet because the deterrent poor law system was not formulated or implemented to provide medical care for paupers, and only gradually came to realise how significant ill-health was in engendering pauperism, circumstances were perhaps unintentionally but inevitably inappropriate for the patients.

## **Appendix 1**

### **Chronology of key events in relation to the Leicester union and workhouse.**

- 1836** The Leicester poor law union was officially established.
- 1838** Leicester union's new workhouse opened.
- 1843** Benjamin Goodman Chamberlain, aged 32 and a printer and bookseller and former guardian, was appointed as Clerk to the Leicester union. He remained in post for thirty-two years.
- 1847** Leicester union began to appoint paid nurses.
- 1851** The Leicester union workhouse was re-built.
- 1853** William and Elizabeth Dickisson were appointed master and matron of Leicester workhouse. Mr Dickisson was formerly a relieving officer of the union for seven years.
- 1856** Dr Bolton, the workhouse medical officer, resigned after being reprimanded for his treatment of a patient.
- 1857** Dr John Moore appointed as the workhouse medical officer.
- 1867** Leicester union workhouse school opened. Sick wards were added the following year.
- 1867** Dr John Moore resigned and Dr Julius St Thomas Clarke (Dr Moore's former deputy) became the new workhouse medical officer.
- 1869** The Leicester Borough Asylum opened.
- 1869** Leicester Anti-Vaccination League formed.
- 1870** Dr Clarke carried out several skin-grafting operations on workhouse infirmary patients suffering from ulcerated legs.
- 1871** Dr Edward Smith, a PLB inspector, recommended that the accommodation at the union's infirmary should be improved for all classes of the sick and that provision should be made for small pox cases.
- 1871** The Leicester Borough Fever Hospital opened.
- 1873** A new wing of the workhouse infirmary was completed.
- 1875** Dr Clarke reported on the insufficiency of female accommodation in the infirmary.

- 1876** Benjamin Chamberlain resigned as Clerk to the union due to ill health. His son, Lionel Percy Chamberlain succeeded him in the post.
- 1878** Dr Clarke reported on the need for an isolated infirmary for the children.
- 1879** Dr Mouat, an LGB inspector, reported that the school infirmary was inadequate.
- 1880** Dr Clarke resigned to take a post at the voluntary hospital, the Leicester General Infirmary, and Dr Bryan was appointed as the new Leicester workhouse medical officer.
- 1880** William and Elizabeth Dickisson retired. Charles and Sarah Gardiner replaced them as master and matron.
- 1884** Children at the Leicester workhouse were moved to the Cottage Homes at Countesthorpe. Orphan and deserted workhouse children were boarded-out with foster parents.
- 1886** The former children's workhouse school was converted into an infirmary for adult workhouse patients.
- 1886** Charles and Sarah Gardiner were asked to resign for 'misappropriation of wines and spirits'. They were replaced by Mr and Mrs Lambert.
- 1886** A shed was built for the vagrants' use in wet weather and a wall was built to divide the vagrants from the infirmary.
- 1893** Herbert Mansfield, solicitor, appointed Clerk to the guardians.
- 1895** The guardians appointed a midwife, Miss Lily Masters, to be solely responsible for parish midwifery cases, which caused considerable debate with the LGB.
- 1896** Miss Lily Masters resigned her post.
- 1889** Fanny Fullager was elected in All Saints Parish as the first women guardian at Leicester union. Miss Fullager was the daughter of a former district medical officer. She served on the board of guardians for fifteen years.
- 1891** The Leicester Extension Act was passed in which the municipal boundaries were extended to include the parishes of Aylestone, Knighton, Belgrave, North Evington and West Humberstone.
- 1895** The guardians' first proposal to purchase land at North Evington for the purpose of building additional workhouse accommodation.
- 1897** The LGB recommended that the maximum number of workhouse inmates should be limited to 1,078.

- 1897** The itch and venereal wards of the workhouse were severely criticised by the LGB. The wards were not improved until 1906.
- 1905** The Leicester workhouse infirmary at North Evington opened.
- 1906** Two scattered homes for twelve children in each were acquired by the union, and a house was rented to be used as a receiving home for children.
- 1907** There were now six female guardians on the board.
- 1907** Mr and Mrs Lambert retired as master and matron and were replaced by Mr H.E. and Mrs Mabel Lovell.
- 1912** The guardians made arrangements with the Leicester and Leicestershire Provident Dispensary for it to dispense drugs prescribed by the district medical officers.
- 1914** Dr Bryan died and Ernest Hadley took over as medical superintendent of the workhouse and the North Evington Infirmary.
- 1915** Patients at the North Evington Infirmary were transferred to the workhouse or the borough sanatorium. North Evington Infirmary was taken over as war hospital.
- 1918** Leicester workhouse patients were transferred back to North Evington Infirmary at end of 1918.

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