

THE MEDICAL PROFESSION IN MID-VICTORIAN LANCASTER

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The years between the 1850s and the 1880s were a time of transition for the British medical profession. In the first place, they saw the completion of the long trend away from the traditional tripartite division between physicians, surgeons and apothecaries, and towards the new world of specialist consultants and lower-status general practitioners. Secondly, they saw a clear dividing-line drawn between the "legitimate" practitioners and the rest through the Medical Act of 1858, which established a General Medical Council to oversee the establishment and upkeep of a register of practitioners with acceptable qualifications, consigning the rest to the outer darkness of "quackery". Thirdly, and as a direct result of the 1858 Act, the complaints which had echoed through the medical press during the 1830s and 1840s about medicine being an over-stocked profession were gradually stilled, as recruitment became more difficult and the profession expanded much more slowly than the population at large. This transition ensured that the treatment of working-class patients would fall much more generally into the hands of chemists and druggists, whose numbers increased substantially during the 1860s and 1870s; but it also made for growing prosperity for many of the doctors who benefited from being in short supply at a time when the prosperous middle classes were growing steadily in numbers and in affluence, creating a buoyant market for relatively expensive medical treatment from formally accredited practitioners.

The physicians had traditionally occupied the highest levels of the medical hierarchy. In the early seventeenth century they were claiming to mix on equal terms with the landed gentry, and two centuries later they still scorned the manual labour associated with surgery and especially midwifery, and regarded themselves as gentlemen (with a gentleman's education) first, and trained medical experts a long way second. They were advisors on medication, and preferred not to contaminate their exclusive status by embracing anything less cerebral and detached. The surgeons, on the other hand, were compromised by their early association with the barbers, and they found the triple taint of trade, manual work and training through apprenticeship (in many cases) difficult to shake off, although by the 1830s and 1840s leading surgeons in the London teaching hospitals were making as much money as the top physicians, claiming comparable status accordingly. More straightforwardly inferior were the apothecaries, who were relegated to the status of mere shopkeepers by virtue of their function of making up medicines and dispensing prescriptions. But in practice these lines of demarcation were blurring, as surgeons increasingly obtained licences to practise as apothecaries (although they were not always eager to reveal this to official investigators) and even physicians in country districts sometimes found it useful to keep apothecaries' shops on the

side. Despite the growing reality of the rise of general practice, however, the ruling councils of the Royal Societies of Physicians and of Surgeons systematically opposed a sequence of proposed Acts of Parliament which sought to regulate a unified profession in new ways and compel all practitioners to have demonstrated competence in both medicine and surgery. Even the famous Medical Act of 1858 did not achieve this, and it was not until 1886 that new recruits to the profession were obliged to be formally qualified in both kinds of expertise.

The 1858 Act itself has often been presented (not least by the General Medical Council which it created) as an essentially philanthropic measure, bringing not only progress towards a properly regulated medical profession but also protection to the purchaser and consumer of medical services, by distinguishing between qualified and unqualified practitioners and providing redress against the incompetent or malevolent. Recent social historians of medicine have been a little more sceptical. They argue that the Act, by creating a closed profession with the power to regulate numbers and restrain competition, was responsible for protecting the income and status of medical professionals and can be seen as self-serving and even monopolistic. Moreover, the state of medical knowledge at the time was not so self-evidently excellent and unassailable as to justify the exclusion of those who followed unorthodox systems or purely empirical methods. The sociologist Ivan Waddington provides a viewpoint which approximates to the current orthodoxy among historians of medicine:

... we may suggest that those writers who have argued that the 1858 Act was passed for the benefit of the public have offered at best a grossly oversimplified account of the significance of registration, for they have ignored not only the fact that the profession derived significant monopolistic advantages from registration but equally importantly the fact that these monopolistic advantages were clearly recognised within the profession from the very beginning of the campaign for registration.

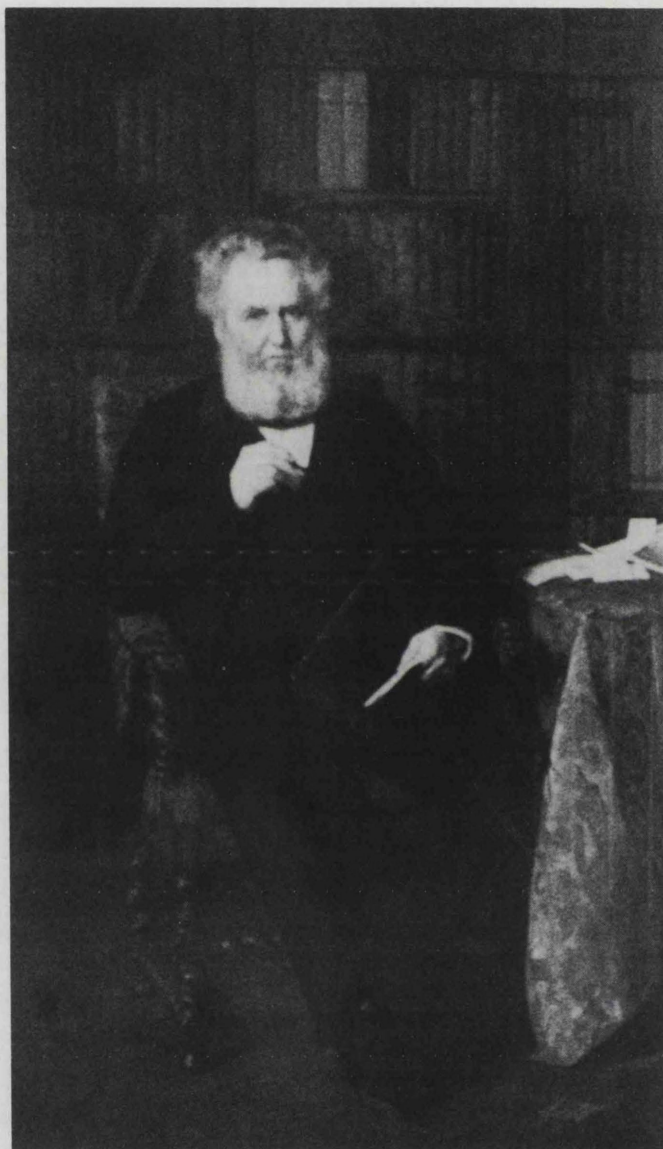
The mid-Victorian years were thus eventful and significant in the history of the medical profession. This was a period of flux, uncertainty, conflict and change, with power-struggles within the profession and angry demands for greater professional democracy from the general practitioners. But what was the impact of these changes on the structure of the medical profession in the provinces? And what other influences were brought to bear on the fortunes of doctors away from the world of the leading London practitioners and the great teaching hospitals? Before such questions can be answered with any confidence, we need detailed local studies; and what follows is a limited and tentative attempt to reconstruct the changing situation of the medical profession in Lancaster between the censuses of 1851 and 1881.

Lancaster itself was changing during these years. Its eighteenth-century heyday as importer of exotic goods from distant climes was long gone, and the port was already in terminal decline at mid-century. It was still a centre of polite society, however, as befitted the old county capital; and it was the administrative and servicing focus for a wide agricultural area. Its textile industries were suffering from competition from the burgeoning industrial centres further south, however, and the railways were doing little to remedy this, although the town's status as an important junction, already established in 1851, was generating new kinds of railway-related employment. The county asylum, which was in the throes of a major expansion programme at mid-century, was becoming an important employer, and the Grammar School and union workhouse added to the town's institutional importance. By 1881, significant changes had taken place. Lancaster's industrial economy had been re-made, with oilcloth, table baize and matting displacing cotton and silk, in a formula which was to bring employment if not prosperity to the local working class for generations to come. A railway wagon works, along with the expanded railway system itself, added to the opportunities. The county asylum had expanded further, and the Royal Albert Asylum had provided an additional captive market for the town's tradesmen. Population had stagnated during the 1850s and most of the 1860s, but growth was now beginning in earnest. The old "polite society" presence had not evaporated, but it was less in evidence and less important to the town's economy. The Lancaster of 1881 was much more an industrial town, and less of a traditional county town, than the Lancaster of thirty years earlier.

Slater's Directory for 1851 listed three physicians and thirteen surgeons in Lancaster. Two of the surgeons were father and son and two of the others were in partnership. Lancaster's level of medical provision, at about 1000 people per physician and surgeon, was somewhat higher than the national average, as befitted its social structure. As in most places, the title "apothecary" had disappeared as an occupational label: most apothecaries had been subsumed into the ranks of the surgeons since the Apothecaries Act of 1815. Here and there, as P.S. Brown found in his study of Bristol, one or two might cling to the old label, but the disappearance of the apothecary was almost complete generally by 1851. Their functions had been taken over by general practitioners who also made up and sold medicines, and by retail chemists and druggists. Ten of the latter were in fact listed in the directory, along with two dentists (who had not yet emerged as an organised profession) and a truss maker.

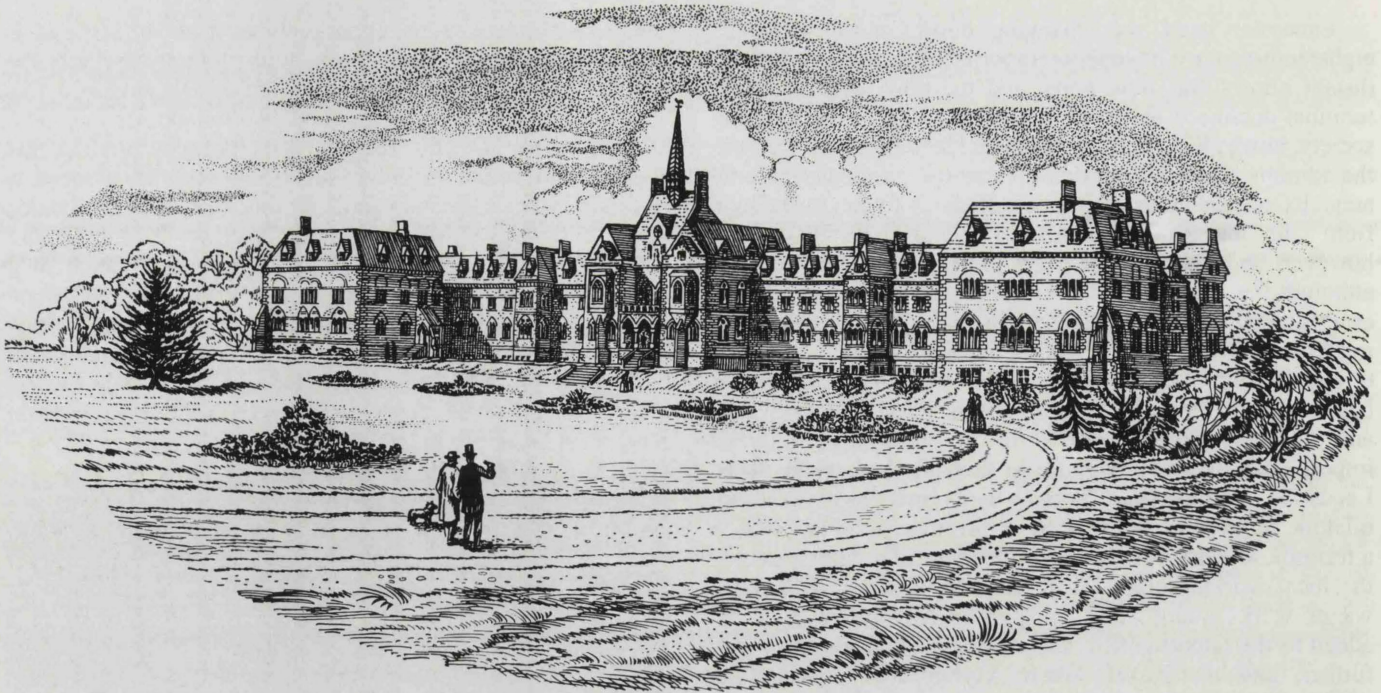
The directory listed all of Lancaster's medical men as either physicians or surgeons (leaving aside the "lesser" categories for the moment). But the census enumerators' books, which list every individual household by household, present a different picture. Almost all of the practitioners listed describe themselves as "general practitioner", the exceptions I can find being one physician, one surgeon and the two resident surgeons at the Lancaster Asylum. The self-described physician, James Johnson of Greenfield, was cast very firmly in the leisured, cultured gentlemanly mode which the Royal College of Physicians sought to preserve. He had a Bachelor of Arts degree as well as an M.D. and his Fellowship of the Royal College of Surgeons (the R.C.P. may have been too exclusive even for him). At 38 years of age he had seven children, kept four resident servants and seems to have retired from practice, for he also had income from land and investments and was a gentleman farmer on fourteen

acres. The surgeon, John Thomas Bateson of 98 Castle Hill, was a 48-year-old widower with four children between the ages of six and twenty living at home, and an aunt to act as housekeeper. He kept a groom and two female servants, and his failure to list any degrees does not compromise his obvious pretensions to rather superior status. Male servants were expensive, impressive and, by this time, unusual outside the ranks of the very substantial middle classes. A third figure of obvious importance was E. D. De Vitre, listed as a physician in the trade directory, a town councillor, M.D. and F.R.C.S., a substantial local property owner and visiting physician to the Asylum, where he had played a significant part in the reforms of the 1840s. He was well established in his profession at 45 years of age, and kept three resident servants at his house in Leonardgate.



ED De Vitre

The conventional wisdom of the time assumed that anyone claiming really substantial middle-class status and acceptance into polite society would need to keep at least three domestics, preferably with some specialisation of function between them, so that a neat housemaid would always be available to answer the door and a cook would ensure that hospitality could be offered in appropriate style. Nine medical households in all met this criterion in various ways. Samuel Harrison of Dallas Place, for example, with a wife and no resident children, made do with two experienced female servants and a gardener. So a majority of Lancaster's medical men in 1851 were able to live at a comfortable upper



*Royal Albert Hospital, Lancaster
Main Building, 1868*

middle-class level. They were concentrated into substantial Georgian residential streets, and Christopher Johnson of St Nicholas St. was a Justice of the Peace for the borough, his status no doubt boosted by his wife's income from landed property. Only two of this professional elite laid claim to medical degrees, and most combined membership of the Royal College of Surgeons with a licentiate from the Society of Apothecaries.

Those practitioners who did not meet these standards of apparent affluence and material comfort can be divided into two groups. Three were attached to institutions: the asylum superintendent and his deputy, and the house surgeon to the infirmary, who lived on the premises while also seeking to build up a practice of his own. The others were men in their mid-thirties and early forties who lived in less impressive parts of town and kept only one or two servants. One was a bachelor, one had a childless marriage and one had three children, so there is no pattern to the level of their outgoings in this respect. But in a profession whose median age in Lancaster was 36, all but one were at or below the dividing-line, suggesting that they were still striving to make their way in a competitive environment. They were as firmly rooted in the locality as their more affluent peers, for apart from De Vitre, who was Cumberland-born, no Lancaster general practitioner had been born outside the county. The most distant birthplaces recorded within Lancashire were Liverpool and Ulverston, and most of the town's medical men were born in Lancaster itself. The town provided a comfortable living for most of these native sons at a time when there was much complaint of the difficulty of making an adequate income in the medical profession elsewhere. But Lancaster was clearly neither an attractive nor a hospitable place for outsiders.

The patterns of medical provision had changed considerably by 1881. Twenty physicians and surgeons were listed in Kelly's Directory for this year: an increase of 25 per cent on 1851, which was much less than the town's rate of

population growth during these years. But five of the twenty, as opposed to three out of sixteen in 1851, were attached to institutions in posts which demanded most or all of their time: three at the Asylum, one at the Royal Albert, and the house surgeon at the Infirmary. So the rate of growth of general practice was just over 15 per cent. Even this was more than the national average, which had been held back sharply by the 1858 Act and the subsequent stricter policing of qualifications; but there were far more people per doctor in Lancaster in 1881 than in 1851.

Over the thirty years, the old style of gentlemanly practitioner had ceased to dominate the town's medical provision. Only a handful of medical men had the large households which prevailed in 1851. William Wingate Saul of 48 Market St. was the most prominent exponent of the older way of life. At 38 years of age, he had a wife and five small children, and kept four specialised female domestic servants. But he may well have benefited from property development as an additional source of income, and he was Medical Officer to the prison, which must have augmented his income in a reliable way. But – arrestingly – the most affluent lifestyles in terms of servant-keeping, apart from Wingate Saul, were displayed by the medical superintendents of the two great institutions. David Cassidy of the Lunatic Asylum had a Swiss governess and three other servants to care for his four children, although his bachelor assistants lived in less impressive style. And George Shuttleworth of the Royal Albert, with his young wife and infant daughter, kept a housemaid, cook and nurse on his comfortable salary.

The norm among those medical practitioners who could be traced in the census was much less affluent than this. Where they were not boarders or living in the parental home, Lancaster's doctors were now unlikely to keep more than one or two servants, and the old concentration into Castle Park and the Georgian houses of the old town centre was no longer apparent. Less opulent premises on Ulleswater Road, in the Stonewell and on King Street were beginning to feature in the

lists. These were, in general, better-qualified practitioners than in 1851, with more degrees in evidence; but the key difference, perhaps, is that they were significantly younger. The median age had fallen to 33, with five of the fifteen for whom ages have been recovered being in their twenties. And the Lancaster-born were now a small minority: only three of the fifteen were local, with only a single Mancunian to represent the rest of Lancashire. The rest were quite cosmopolitan, including two Scots, an Irishman and a South African as well as men from Leicester, Lincolnshire and Birmingham. This adds up to a complete transformation of important aspects of medical society in Lancaster. Instead of a cosy band of affluent locals offering their services to county town society and being well remunerated, we have a group of well-qualified, thrusting, competitive offcomers striving to make their way in a new environment, in a town which was much more working-class and coming to be dominated by manufacturing industry. There were some consolations, especially in the proliferation of institutions which offered salaries to top up incomes from general practice. But Metcalfe Johnson had scooped up three of the most lucrative of these: he was Poor Law and Workhouse Medical Officer and Medical Officer to the Barracks. John Harker had two more, being Corporation Medical Officer and holding a similar post with the Rural Sanitary Authority as well as being an Honorary Surgeon at the Infirmary. So there was nothing left, in the short run, for the struggling and aspiring newcomers.

Working-class patients paid less well and less reliably than their social superiors, and they were also more likely to go direct to the chemist and druggist for advice on treatment, or to purchase patent medicines, or to seek folk remedies from neighbours with a reputation for wisdom in these matters. Over much of industrial England Hilary Marland has detected an upward trend in the numbers of chemists and druggists over this period, while physicians and surgeons stagnated; and she suggests that this is how most of the medical needs of the working class were met. In Lancaster, this seems not to have been the case. Ten chemists and druggists were listed in the 1851 directory (one of whom was also a seedsman) but only seven in 1881, although the later

practitioners may have had larger businesses. On the other hand the number of dentists went up from two to four. There was also "Professor M. Moores, phrenologist and physiologist", who boarded in a house in Friar Street with his young son. But this evidence does not support the Marland thesis in the Lancaster context. Perhaps the local strength of traditional self-help medicine among the working class may help to explain the divergence; or perhaps the younger doctors were picking up more working-class patients than elsewhere. At the moment we can do no more than speculate.

By 1881, at any rate, the chemists and druggists were on a par with the younger doctors in terms of residential accommodation and servant-keeping, although they were older and most had families to support. This was quite a sharp contrast with 1851, when the doctors were a good deal better off, on this imperfect and value-laden measure; but it was the doctors' standards that had fallen, rather than the chemists' rising, during the intervening years. And the presence in the workhouse in 1881 of Jonas Rushworth, a 62-year-old chemist and druggist, is a stark reminder of the vulnerabilities of tradesmen in the mid-Victorian economy. Doctors were undoubtedly more secure in the long run; and the unexpected profile of the Lancaster medical profession in 1881, which goes against national trends and expectations, probably reflects a moment of transition between the generations rather than a long-term decline in the fortunes of Lancaster's doctors. More research would certainly produce interesting results.

FURTHER READING

Waddington I. *The Medical Profession in the Industrial Revolution*. Gill & Macmillan. Dublin. 1984.

Brown PS. The providers of medical treatment in mid-nineteenth century Bristol. *Medical History* 1980;24:297-314.

Marland H. The medical activities of mid-nineteenth century chemists and druggists, with special reference to Wakefield and Huddersfield. *Medical History* 1987;31:415-439.

Answer to quiz on page 163

1. Large bowel obstruction
2. Intramural bowel gas
3. Gas within the portal veins of the liver

Portal venous gas in adults is associated with mesenteric infarction and is almost always fatal.

The same finding in babies with necrotising enterocolitis is less sinister with recovery occurring in 50%.

Portal vein gas extends to the periphery of the liver, compared with the branching shadows from the hilum found with gas in the biliary tree.