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Introduction

During the last few decades the study of the history of medicine has begun to follow a number of interesting new directions. Previously the subject was regarded in extremely narrow terms. Method was based on a collection of facts arranged either chronologically or thematically;[1] emphasis remained with 'histories of technical achievement, of medical institutions, of progress of treatment against disease, and of the medical or allied professions'.[2] Most studies implied that medical developments took place in a vacuum, uninfluenced by wider social, economic, political or legislative changes. The process of moving away from studies of prominent medical practitioners, major medical institutions and theoretical and technical developments has now begun. There is a clearer understanding that scientific advances 'did not immediately translate into advances in medical practice',[3] and that 'great men' in medicine were by no means representative of (and in terms of impact and numbers probably by no means as important as) the medical profession as a whole. Prestigious voluntary hospital foundations tell us little about the sum total of medical facilities for the poor. Studies of institutional provisions as a whole leave out the large, 'grey' area of self-help medicine.

The field of the 'social history of medicine' still covers a great deal of uncharted ground, and much work needs to be done before a greater understanding is achieved concerning the relationship between medicine, history and society. Many areas suffer from neglect. Pioneering studies, such as Woodward's investigation into the voluntary hospital movement, undertaken in the early 1970s, have tended not to have been followed up.[4] Emphasis has remained with institutional provisions: in England, hospital and Poor Law medical services. Self-help agencies in the form of sick clubs and friendly societies, fringe and folk medicine and self-medication

have received much less attention. Even within the boundaries of institutional medicine, research has shown a clear bias; towards in-patient hospital facilities and medical services under the New Poor Law. The more informal medical service provided under the Old Poor Law, and the numerically more significant out-patient and dispensary facilities have been comparatively neglected. There is still a geographical bias in favour of London and other major population centres. Emphasis to some extent remains with the 'important', 'accessible' and 'famous', rather than with the 'typical'.

Perhaps one of the most serious defects of investigations into medical history has been a failure to examine medical men and services in the context of the community, although it is acknowledged that local studies could add much to our understanding of the development of agencies of medical care. In the words of George Rosen, for example,

> The social history of health and disease is . . . more than a study of medical problems . . . It requires as well an understanding of the factors – economic conditions, occupation, income, housing, nutrition, family structure and others – which create or influence health problems, and of the ways in which they operate.[5]

Medical services did not evolve in isolation. To take the setting up of hospitals, their establishment was determined only partially, often very partially, by perceived medical needs. Just as important were the motivations of the lay groups who financed these enterprises. As will be shown in Chapter 4, a wide variety of motivations could influence the setting up of these institutions: civic pride, a desire to control the labour market, fear of epidemic disease, social ambition, religious impulses and humanitarianism. All had more to do with social and economic rather than medical concerns, and with lay rather than medical groups.

P. Branca has suggested that the social history of medicine involves three layers: great medical personalities at the top, patients or prospective patients at the bottom, and the ordinary practitioner in the middle.[6] To this sub-division I would add a further layer, which also occupied something of an intermediate position: the interested layman. The importance of lay, usually middle-class, groups in directing medical services will be stressed throughout the following chapters. As suggested above, medical charities were just as dependent upon lay organisational and financial support as upon

the co-operation of local medical men. It was often laymen who campaigned for the establishment of these institutions, and invariably they provided the greatest proportion of financial support and determined policy-making, including admissions policies.

The influence of lay groups within medical charities had its parallels in other medical services. Poor Law medical relief was directed by lay overseers and vestries, and after 1834 by the Boards of Guardians, assisted by the lay relieving officer. Friendly society and sick club provisions were determined by the initiatives of their lay, this time usually working-class, membership. The survival, development and growth of various types of fringe medicine was influenced by the changing demands of the population for these forms of treatment. In a similar way, the growth of the 'regular' medical profession and changes in practice were not determined solely by intra-professional developments in training, qualifications and ethics. Rather, the evolution of the medical profession was influenced very much by changing demands for medical care and the creation of new posts, both emanating from lay groups, especially the middle classes. The middle classes not only produced a demand for the services of medical men, in particular the general practitioner; they also helped to fill it. As will be demonstrated in Chapter 7, recruitment of medical practitioners took place in most cases from middle-class groups.

In the past, medical historians have made a limited selection and use of available sources, and this explains in part at least the emphasis which has been placed on institutional medicine and eminent personalities. This survey has attempted to examine as wide a range of source material as possible, to include the records of the Poor Law administration, medical charities and friendly societies, census data, trade and medical directories, newspapers, parliamentary papers and miscellaneous data relating to both 'regular' and 'fringe' medical practitioners. The use of such a variety of data was found to give a clearer picture of the range of options available, and their relative importance, in particular throwing more light on friendly society facilities and fringe medical practices. The project attempted both to look at new sources and to examine old sources in a new way. For example, while hospital reports have been used quite extensively by historians, little use has been made of subscription lists, which were frequently attached to annual reports. These lists give information on the social and occupational compo-

sition of supporters of medical charities, data which are not normally available elsewhere. The value of subscription lists in providing this information and in giving clues as to the motivations of those funding these institutions will be emphasised in Chapter 4. Until recently, parish documents, in particular overseers' accounts, were not regarded as a viable source for the study of medical history. Here they were found to be a reliable and unique source of information on medical relief under the Old Poor Law. In the last few years, meanwhile, census enumerators' books have attracted 'legions of historians and social scientists seeking a long-term historical perspective for their studies'.[7] The Wakefield and Huddersfield census returns proved to be valuable (especially when used in conjunction with trade and medical directories) in giving data on the numbers and social composition of medical men. They also provided, albeit in a limited form, information on various groups of fringe practitioners, an aspect of medical history for which data are extremely scarce. More details on sources and the problems implicit in the use of different forms of evidence are given in the appropriate chapters. But it should be emphasised here that the suggestion of R. S. Roberts that 'it is no longer appropriate to rely on any one sort of evidence or any one sort of approach'[8] in the study of medical history has been taken very much to heart. While an effort has been made to be selective, and to achieve a balance between qualitative and quantitative data, a wide range of primary source material has been utilised.

The selection of Wakefield and Huddersfield, two medium-sized communities, as subjects for the study was in part determined by the methodological approach. It was felt to be possible to look at a large number of sources relating to medical provisions and agencies only within the context of two 'manageably-sized' communities. This also facilitated an analysis of the towns' social and economic developments. Other factors also influenced the selection of Wakefield and Huddersfield. The choice was determined in part by the need to readjust the balance of studies towards the provinces and smaller communities.

Detailed studies of the evolution of medical facilities in urban settings provide information for comparison with other nineteenth-century communities with diverse economic and social backgrounds. But Wakefield and Huddersfield also provide us with an interesting comparative study in their own right. Wakefield, a

traditional market and service centre, which experienced only a slow rate of population growth and a retarded industrial development during the nineteenth century, responded in a very different way in the provision of medical care compared with Huddersfield, a fast-growing and dynamic textile town. The diverse experiences of the two communities in terms of population growth, industrial development, town functions, political, social and civic activities will be discussed in Chapter 2, and throughout the following chapters we will return to the issue of how these factors influenced medical services and personnel in Wakefield and Huddersfield.[9]

One aim of this project was to sum up the relative importance of the different medical services and providers of medical treatment which emerged during the late eighteenth and nineteenth centuries. This comparison will be returned to in the concluding chapter (Chapter 9). Primarily, it will be suggested that the bias in the amount, quality and accessibility of source material, and, leading on from this, a bias in the selection of data, has resulted in the least important forms of medical provision being emphasised: that is, institutional forms, hospitals and Poor Law (especially post-1834) medical services.

Chapters 3 and 4 will examine the main forms of institutional provision in Wakefield and Huddersfield. Chapter 3 will look at official provisions, created through the medium of the Poor Law. Under the Old and New Poor Law administrations, medical relief was provided on a very small scale in both communities, although Wakefield, faced with a shortage of other forms of institutional medical relief, moved with greater rapidity towards the setting up of some form of basic health service for the poor. Similarly, only a small proportion of the populations of the two communities gained admission to hospitals and dispensaries. Statistically, the percentage taken as in-patients was negligible. Numerically, out-patient and dispensary facilities (comparatively neglected provisions) were of far greater importance, and their relative significance will be examined in Chapter 4. But it is not on the amount of medical relief offered that Chapter 4 will mainly focus. Rather, emphasis will be placed on the motivations of those setting up medical charities in the two communities: the social composition of support, the pressures leading to the establishment of these facilities, what their supporters hoped to achieve and their success in fulfilling their ambitions.

As already suggested, institutional provisions were perhaps of

less significance than self-help and 'alternative' sources of relief, which will be focused on in Chapters 5 and 6. Chapter 5 will look specifically at the type and amount of medical relief provided by friendly societies in the two communities during the nineteenth century. A wide variety of fringe forms of medical treatment were utilised by the populations of Wakefield and Huddersfield, and not just the poorer inhabitants. In Chapter 6 it will be demonstrated how older forms of fringe practice, self-medication, folk healing and the utilisation of midwives, for instance, were bolstered in the nineteenth century by a wide range of new alternatives and personnel, including medical botanists, chemists and druggists, hydropathy and an ever-increasing range of patent medicines. During the nineteenth century, use of these alternatives did not, as we might expect, diminish. Rather, they flourished, and apparently provided a large proportion of the population with sources (possibly for many the only sources) of medical relief. Chapters 5 and 6 will switch the emphasis to self-help medicine, but throughout the study an effort will be made to give some emphasis to the role of patients and potential patients in and their reactions to the various medical services.

Each chapter will look in passing at the providers of the different forms of medical treatment. But it is only in Chapters 6, 7 and 8 that a detailed analysis will be made of these groups. Chapter 6 will look at those on the periphery of medical life, the unqualified fringe practitioners, who included not only the traditional healers, but also predominantly 'commercial' groups, the 'market place' quack, the spa doctor, and the chemist and druggist. The 'regular' medical profession will be examined in some detail in Chapters 7 and 8. Emphasis has been placed on examining the 'medical community' as a whole, rather than any eminent practitioners who might have emerged during the nineteenth century. Chapters 7 and 8 will not only look at intra-professional developments, but also at the relationship between supply and demand, expressed in terms of practice-building opportunities and posts. The social position of medical men will also be examined, together with their efforts to improve both their professional and social status.[10]

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Wakefield and Huddersfield: aspects of their economic, civic and social activities, circa 1780 to 1870

Wakefield and Huddersfield, while both situated in the West Riding woollen district at a distance of only thirteen miles from each other (see Map 1), developed in very different ways during the eighteenth and nineteenth centuries. By the late eighteenth century Wakefield had evolved into a regional market and service centre of some importance, and was,

> . . . considered as one of the handsomest and most opulent of the clothing towns, being inhabited by several capital merchants, who have costly and elegant houses. It is large and populous, and possesses a considerable share of business.[1]

By early in the nineteenth century it could be described as being 'in many civil matters, the capital of the West Riding',[2] having the principal court for the election of Members of Parliament, a registry of deeds and wills, a prison, the office of the Clerk of the Peace, and, after 1818, the County Lunatic Asylum, all institutions utilised by the whole region. While Wakefield reached something of a peak in its material prosperity by late in the eighteenth century, the nineteenth century ushered in a period of 'gradual decline'.[3] The stagnation of the clothing industry was perhaps the most serious aspect of this decline, but it was paralleled by a more general quiescence in the community's other economic activities, institutions and social and cultural life.

For Huddersfield, by contrast, the nineteenth century, particularly the first decades, was a period of remarkable expansion and increasing prosperity (at least for a small proportion of the community). The basis for this growth was the woollen industry. Huddersfield (whose involvement in the woollen industry dated back to the thirteenth century) was just as much a product of the textile industry as Bradford and Leeds and the classic cotton mill

towns of Lancashire, situated just over the Pennines. Huddersfield's massive population growth and its apparent upsurge in civic pride (reflected in a spate of church building, the foundation of numerous voluntary societies, and the initiation of local government and public health reform early in the nineteenth century) was linked closely to the development of, and the wealth produced by, the woollen industry. Wakefield's demise and Huddersfield's fruition were noted as early as the 1830s. In 1832 it was remarked that while Wakefield was still noted for its markets and commercial interests, '. . . as a town for manufactures it has declined, . . .'.[4] Five years later Huddersfield was described as '. . . a populous, flourishing, and handsome market town, which has more than doubled its magnitude, and greatly improved its appearance, since the year 1811'. While

> Little more than a century ago, the population and wealth of Huddersfield did not amount to more than one-half of either Halifax or Wakefield, . . . now it is equal, if not superior, to the larger of them, ...[5]

In 1849 an article in the *Morning Chronicle* remarked that Huddersfield

> has sprung up entirely within the last sixty years. Previous to that time it was but an insignificant cluster of irregularly built lanes. The town of Huddersfield is a species of minor capital of the broad and fancy cloth-working districts of Yorkshire; . . . .[6]

Wakefield and Huddersfield differed in many other aspects. While Wakefield remained a bastion of Tory/Establishment interests, Huddersfield developed as a centre of Liberalism and Non-Conformity during the late eighteenth and nineteenth centuries. The formation of governing bodies in the two communities also followed very different lines of development, Wakefield being incorporated in 1848, Huddersfield not until twenty years later. Both towns experienced upsurges of working-class discontent during the late eighteenth and nineteenth centuries, but they tended to be more severe and protracted in Huddersfield, largely due to structural changes in the textile industry. During this period there were 'fewer explosions of popular violence'[7] in Wakefield than elsewhere in the West Riding.

These differing patterns of development will be looked at more closely in the following pages. This chapter will concentrate on those aspects of civic and economic activity which would appear

to have had an influence upon the development of medical provisions (as suggested in Chapter 1). Section 2.1 will examine the population growth and economic evolution of the two communities, Section 2.2 aspects of their civic life (local government, voluntary society activity, religion and politics), Section 2.3 activities in the field of public health and disease prevention, and the final Section (2.4) manifestations of distress and popular discontent.

2.1 Population growth and economic development

The West Riding experienced a remarkable increase in population during the late eighteenth and nineteenth centuries. Between 1700 and 1801 the estimated population per square mile of the Riding more than doubled from 91 to 212.[8] In the next thirty years the population increased from just over half a million to a little under one million.[9] By 1831, only two counties, Middlesex and Lancaster, had more inhabitants than the West Riding. The story of the massive growth of individual towns within the Northern manufacturing districts is well known. In the decade 1821 to 1831, for example, the population of Leeds increased by 47.7 per cent, that of Sheffield by 40.5 per cent and that of Bradford by 65.5 per cent. By 1831, Leeds had 123,000 inhabitants compared with 53,000 in 1801. Bradford, the fastest growing city in the first half of the nineteenth century, increased its population eightfold between 1801 and 1851. By 1851 Bradford had 103,778 inhabitants.[10]

Wakefield and Huddersfield shared in this phenomenon, Huddersfield in particular experiencing very spectacular growth rates. Between 1700 and 1800 Huddersfield grew from a sprawling and 'miserable' village with a population of less than 1,000 into a town of 7,268 inhabitants. In the first decades of the nineteenth century the town continued to expand significantly. Natural increase was boosted by migration into Huddersfield from neighbouring parts of Yorkshire and Westmorland, and to a lesser extent Ireland, in the 1830s and 1840s, the migrants being attracted by the Huddersfield textile industry.[11] The population of Huddersfield grew by over 30 per cent in every decade between 1801 and 1851. Between 1811 and 1821 it increased by 37.4 per cent; in the following decade by over 43 per cent (see Table 2.1). In the first seventy years of the nineteenth century Huddersfield's population increased fivefold (or by an average of 27.5 per cent per decade).[12]

Table 2.1. *The population of the Wakefield and Huddersfield Townships, 1801–1871.*

	Wakefield		Huddersfield	
Date	Population	Percentage increase over preceding decade	Population	Percentage increase over preceding decade
1801	8,131		7,268	
1811	8,593	5.7	9,671	33.1
1821	10,764	25.3	13,284	37.4
1831	12,232	13.6	19,035	43.3
1841	14,754	20.6	25,068	31.7
1851	16,989	15.1	30,880	23.2
1861	17,611	3.7	34,877	12.9
1871	21,076	19.7	38,654	10.8
Average percentage increase 1801–1871		14.8		27.5

Source: W. Page, *The Victoria History of the Counties of England. A History of the County of York*, Vol. III (1913), Table of Population, 1801–1871, p. 525.

Wakefield's population growth was rather less remarkable. Unlike Huddersfield, which underwent considerable spatial expansion during the century, Wakefield's population growth was largely contained within the town boundaries which were in existence at the end of the eighteenth century. By the turn of the century Wakefield with 8,131 inhabitants was larger than many of its neighbours, including Huddersfield. But failing to profit by either its late eighteenth-century leadership position in the woollen trade or from the coming of the 'railway age', its population increased just two and a half times (an average of 14.8 per cent per decade) between 1801 and 1871. Its growth amounted to half that experienced by Huddersfield.[13]

The population growth of the two communities was linked closely to their very different economic developments during the nineteenth century. By the late eighteenth century the livelihoods of both towns were tied very much to the clothing industry. However, while the story of Huddersfield's economic development