Patients, Power, and the Poor in Eighteenth-Century Bristol

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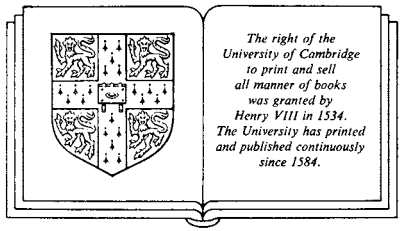

CAMBRIDGE UNIVERSITY PRESS

CAMBRIDGE

NEW YORK PORT CHESTER MELBOURNE SYDNEY

PUBLISHED BY THE PRESS SYNDICATE OF THE UNIVERSITY OF CAMBRIDGE
The Pitt Building, Trumpington Street, Cambridge, United Kingdom

CAMBRIDGE UNIVERSITY PRESS
The Edinburgh Building, Cambridge CB2 2RU, UK
40 West 20th Street, New York NY 10011-4211, USA
477 Williamstown Road, Port Melbourne, VIC 3207, Australia
Ruiz de Alarcón 13, 28014 Madrid, Spain
Dock House, The Waterfront, Cape Town 8001, South Africa

http://www.cambridge.org

First published 1991
First paperback edition 2002

A catalogue record for this book is available from the British Library

Library of Congress Cataloguing in Publication data
Fissell, Mary Elizabeth.
Patients, power, and the poor in eighteenth-century Bristol / Mary E. Fissell.
p. cm. – (Cambridge history of medicine)
Includes bibliographical references.
ISBN 0 521 40047 3 (hardcover)
1. Medicine – England – Bristol – History – 18th century. 2. Poor – Medical care – England – Bristol – History – 18th century. 3. Poor – England – Bristol – Social life and customs. 4. Bristol (England) – Social life and customs. I. Title. II. Series.
R488.B78F57 1991
610'.92423'9309033–dc20 90-28169 CIP

ISBN 0 521 40047 3 hardback
ISBN 0 521 52693 0 paperback

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Introduction

This study started life as an examination of a local system of health-care provision in early modern England. I was interested in the patient's perspective on medical care, not merely that of the unusual sufferer who left details of his or her encounter with illness, but that of the ordinary person.[1] It seemed to me that patients as well as practitioners structured and shaped medical practice. My focus on the patient provoked questions about how and why individuals made choices among different health-care providers; no simple equation of medical science with "better" health care could be made when a wide variety of different practitioners flourished. Instead, the provision of health care in early modern England resembles some of today's African medical systems, replete with "traditional" healers as well as high technology Western medicine, in which family needs and wishes, religion, and economic factors shape patient choice.[2]

The ordinary, non-elite patient's view is particularly significant for the early modern period because the institutions now central to modern medicine – hospitals and clinics – had their origins, not in provision for the wealthy, but for the poor. Historians of medicine have overlooked the charitable dimension to the origins of institutional health care, and by focusing on practitioners have ignored not only the patients but also the patrons who founded and ran hospitals. By neglecting the meanings of hospitals for those who built and used them, some historians have reduced the significance of hospital utilization to the merely medical, creating a progressivist and noncontextual vision of the institution. Patients' choices of medical care, albeit constrained by poverty, were influenced by their understanding of the hospital's charitable nature as well as the contingencies of ill health.

By examining how patients made choices, how medicine appeared when viewed from the sickbed, an emerging health-care

system can be understood not only as a product of altered patterns of charitable provision and attitudes toward poverty, but as the result of a fundamental shift in attitudes toward the body itself. Over the course of the eighteenth century, the very ways people understood and interpreted their bodies altered. What had been a set of shared assumptions, a belief system held by high and low alike in the seventeenth century, became the purview of the poor by the early nineteenth century. But the waning of vernacular medicine was a complex process; to align it with class formation, with modernization, with commercialization, is at once to say all and to say nothing. Certainly as the ties that bound men and women together moved from the vertical chains of hierarchy and patronage to those we construe as the horizontal ones of class, so too did the bonds of a shared understanding of the body crack and break. This gradual process was punctuated by specific moments in which the cultural differences between rich and poor were articulated with special clarity, and those moments owed as much to the expressions of political and religious tension as they did to primitive forms of class conflict.

In other words, the making of modern health care was a part of a more general process of cultural and social change. The respect granted by society's elites to ordinary people's interpretations of their own bodies diminished as a series of reforms of manners in the latter half of the eighteenth century served to isolate and denigrate "popular" medicine. Within this broader shift, the functions of welfare and charity institutions – hospitals, workhouses, dispensaries – became medicalized as ideas about charity were recast. A new style of medical practice was established, increasingly oriented toward modes of diagnosis and therapy alien to vernacular medicine. Medicine was now able to use the charitable institution to emphasize its distance from lay beliefs. But medicine did not create the hospital nor the disparagement of popular culture.

Rather, hospitals and reforms of manners were expressions of the relationship between society's elites and those less fortunate. Historians have usually defined *the poor* in one of two ways. Swayed by the availability of charity and relief records, some have identified the poor as those who were in receipt of funds, from private or municipal coffers;[3] others use the term more vaguely, including most of the laboring classes.[4] But neither usage provides a fully satisfactory analysis. Those based upon records of institu-

tions are seductive; they provide snapshots of individuals, and can illuminate attitudes toward the poor. Such analyses, however, rely upon one group's definition of another, upon benefactors' notions of the "deserving" poor (however constituted) and their recipients' attempts to meet – or subvert – those criteria of worthiness.

This study defines the poor as those who might have been at risk of dependency; rather than basing an analysis on vaguely defined economic criteria, it explores the potentials for poverty, the chances that an individual might become dependent on friends, neighbors, patrons, or institutions. Such an approach derives from demographically inclined historians who have shown that early modern poor relief was very closely linked with life-cycle.[5] For example, recently married couples, with two or three young children, were extremely hard put to pay the bills. The wife's wage earnings were of necessity small, the children too young to earn, the father unlikely to experience a rise in wages sufficient to meet increased expenses. But at other points in the life-cycle, such a family might not be in need of help. Given inferential problems of length of observation in relation to life-cycle, an inclusive definition of poverty is useful.

In addition, the closer one studies the lives of the poor, the more one is struck by the creativity of the economies of makeshift. Distinctions between charity and relief, as well as between receipt of funds and independence, ultimately blur. What to make of an elderly widow who received a loaf of bread a week from a parish-based charity? One loaf a week was obviously not sustaining this woman. Yet such gifts were sought after, and many made do with combinations of charity, relief, use rights, barter, and earnings, details of which will always elude the historian. Rigid definitions of poverty seem inapplicable to the multitude of ways in which the poor managed to keep body and soul together.

Not that the rich are particularly easy to define. In some ways, they are self-identified, the institutions of urban charity and welfare providing a theater for the articulation of social difference.[6] Just as surely as a workhouse distinguished the poor by forcing them to wear badges, so too it denoted middle and upper sorts through their governance of the institution. Both rich and poor defined one another through their interactions, potential and actual, their relationships always those of realization and realignment.[7]

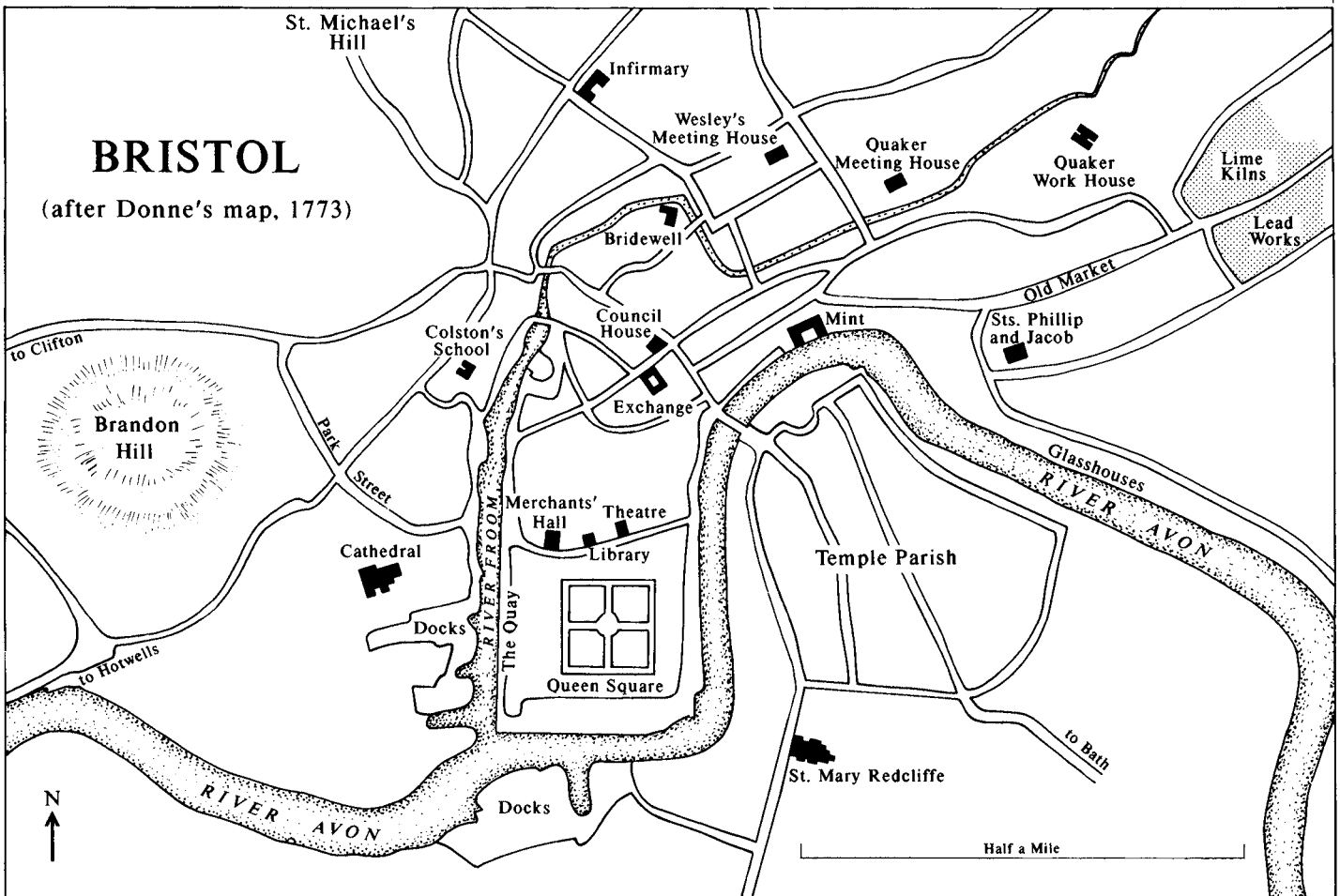
This analysis of welfare and health care is based on a study of Bristol (see Map 1), in the South-West of England.[8] Two rivers –

the Avon and the Frome – flowed through the city, but wealth came from a third: the Severn. Visitors who came by water from the west were treated to the beauty of St. Vincent's Rocks and the deep gorge through which the Avon river linked the Severn to the city. For many, Bristol appeared a city of steeples. For others, it was the small crowded medieval streets and the hills that left an impression. Narrow streets were made narrower by the old-fashioned houses whose upper stories overhung the lower, enclosing noisome streets with open gutters. Daniel Defoe was not the only observer to comment on the odd but necessary custom of transporting goods on sledges within the city; the hills made such measures necessary. The city was only slowly becoming geographically differentiated; it was centered on commercial and residential parishes that housed warehouses, the Exchange, and merchants' houses. Over the course of the eighteenth century, as in many other cities, new socially segregated spaces were created by developers. Thus, Bristol saw Queen's Square, a typical late eighteenth-century large green square surrounded by elegant houses at variance with older cramped dwellings. So too, by the turn of the century the outlying areas of Clifton and the Hotwells were beginning to assume their identities as affluent suburbs.

Bristol's merchants considered themselves second only to those of the metropolis, and until northern cities burgeoned in the latter part of the century, they were probably correct. Almost all of the English trade with the West Indies and with Newfoundland, for example, came through Bristol. The city dominated the African slave trade, although Liverpool overtook Bristol in this regard by the 1770s. However varied and exotic was her long-distance trade, Bristol's economy rested equally on shorter voyages, both to Ireland and inland, the Severn functioning as an important artery to the Midlands in the era before canals.

Bristol's port meant more than just ships and warehouses; local manufacturing was linked to overseas trade. Sugar, for instance, was the most significant manufacture in the city; there were as many as twenty refineries operating in the city at that time. The city served as an entrepôt, distributing wine and sherry from Spain, exchanged for Newfoundland fish in one of the many transatlantic triangular trades. So too, Bristol brass, Bristol glass (some-

Map 1. Bristol


BRISTOL
(after Donne's map, 1773)
St. Michael's Hill
Infirmary
Wesley's Meeting House
Quaker Meeting House
Quaker Work House
Lime Kilns
Lead Works
Bridewell
Old Market
Sts. Phillip and Jacob
Mint
Council House
Colston's School
Exchange
to Clifton
Brandon Hill
Park Street
Glasshouses
RIVER AVON
Merchants' Hall
Theatre
Library
Cathedral
Temple Parish
RIVER FROME
The Quay
Docks
Queen Square
to Horwells
to Bath
St. Mary Redcliffe
RIVER AVON
Docks
N
Half a Mile

times containing Bristol water), lead, woollen cloth and numerous other products featured in both distribution and production networks centered on the city's port.

Although contemporaries loved to portray eighteenth-century Bristolians as dull traders thinking only of profit and return – they were reputed to sleep with one eye open so as not to miss an opportunity – the city's residents laid claim to participating in a polite and leisured urban culture. Did not the city have its own spa at the Hotwells? Did not the *bon ton* enjoy a fashionable round of theaters, horse races on Durdham Down, balls, and assemblies? It was from this realm that charity drew one of its inspirations. Like the mayor's installation, the feasts of the City Council, or plays at the Theatre Royal, the annual Infirmary sermon and banquet was a moment of civic show in which the authority and benevolence of the city's ruling elites were on display.

While Bristol had those whose importance and power equaled London's so-called "big bourgeoisie," one of the city's defining characteristics was its extent and range of middling men.[9] Although historians disagree as to the significance of these groups, there was a certain fluidity and openness to the power structures in Bristol, which meant that the "small" bourgeoisie had important civic roles to play. At the most basic level, Bristol had a wide-open electorate; as many as 80 percent of the city's male heads of households voted in the parliamentary elections of 1696. Although middling sorts were unlikely to become one of the city's forty-three councillors or a member of the Society of Merchant Venturers, they participated in parish vestries, city companies, and after 1696, the Corporation of the Poor. On occasion, Bristol's elites deferred to the city's middling men, courting their allegiances in an attempt to present a united and prosperous face to the city.

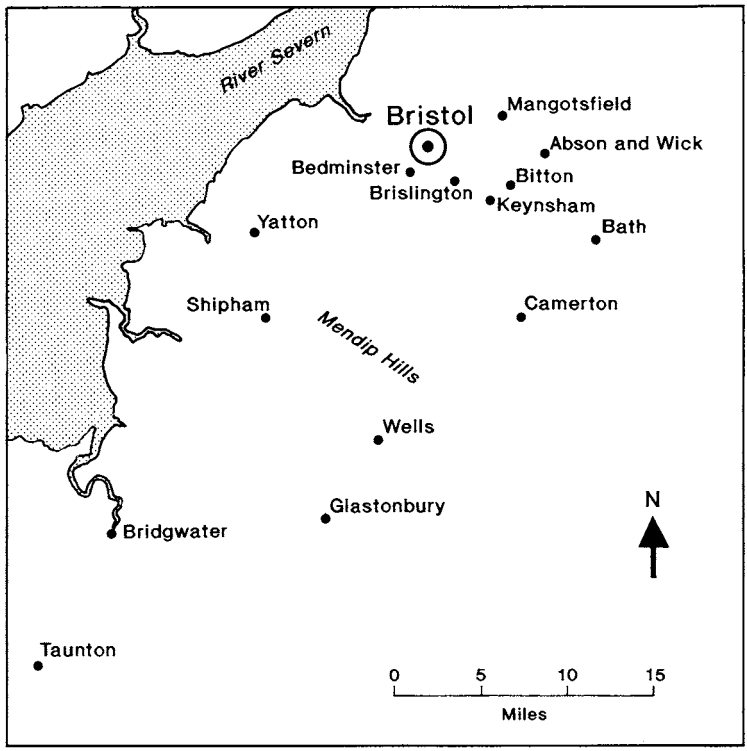
But the city was far from united. The other key to Bristol's charitable munificence lay in the bitter sectarian divisions that characterized much of the city's civic life. Both church and party divided the city, but the fracture lines created by religion probably ran deepest. Bristolians' penchant for religious deviance is sometimes traced back to the Lollards, and by the latter half of the seventeenth century, the city was renowned for its variety and extent of religious difference. Baptists, Independents, Presbyterians, and Congregationalists all had their followers. The city's population included the highest percentage of Quakers anywhere in England,

and harsh fines and imprisonments had characterized the Friends' experiences of the 1670s and 1680s. Even after the 1689 Toleration Act, memories were far too grim to permit any deep or long-lasting unity in the city. Indeed, the Society of Merchant Venturers, the center of the trading community, did not admit its first Quaker until 1720.

In a place so marked by difference, charity could scarcely be neutral; institutions were quickly characterized by factional interest, even if founded in a spirit of unity. For example, the city's workhouse, founded in 1696 by amalgamating all seventeen city parishes into a single corporation for poor relief, was soon perceived as the tool of Whig and dissenting interests, although alliances subsequently shifted. Such an equation was not difficult to make, because the ideological roots of the project lay in Interregnum approaches to poor relief and in the Low Church interest in the reform of manners.

But Bristol's unusual workhouse owed something to the city's expansion as well as to the politics of religious difference. For as in London (which tried to imitate Bristol's Corporation of the Poor), the rich and poor were becoming geographically distinct. Prior to the foundation of the workhouse, the rich and tiny inner-city parishes had already been turning over some of their funds for poor relief to the larger and much poorer parishes, because the industrial populations of St. James, SS. Philip and Jacob, and Temple parishes were growing faster than their relief mechanisms, based upon Elizabethan statute, could respond.

Although Bristol's foundation of a hospital in 1737 was less exceptional than her Corporation of the Poor, it too was quickly subsumed within urban rivalries. Historians of British hospitals have focused on their role in polite culture, with various provincial cities emulating one another's new foundations. But analyses of Continental institutions suggest that hospitals also served as sites for the negotiation and mediation of power by local elites.[10] Bristol's Infirmary represented a place where individuals could maintain networks of patronage, the recommendation from a hospital supporter required by a prospective patient a form of social exchange in a face-to-face society.[11] The hospital provided an arena for the mediation of social power, both directly through individual patronage, and symbolically through civic ritual and display.



Map 2. Bristol's environs

But there is another side to these charitable institutions. For it was not just their founders who made them; clients used institutional health care in ways unforseen by their benefactors.[12] This study focuses on two parishes, one rural and one urban, in order to delineate the factors shaping institutional populations. Abson and Wick, the rural parish, was seven miles from Bristol, just to the north of an imaginary line drawn between Bristol and Bath (see Map 2). It was made up of four hamlets and had a mixed industrial and agrarian economy. It was tiny compared to its urban counterpart, SS. Philip and Jacob. Like Abson, Philip and Jacob housed many industrial workers. But if a poor person fell ill in the city, he or she had a wider range of options than did a rural denizen. As in the country, there was the Poor Law, but in the city, this might mean incarceration in the workhouse, which had a medical staff, rather than so-called out-relief, payments for medical attendance,

rent, food, heating, and other necessities. The urban worker might also try to get a recommendation for a lengthy stay in the infirmary, or the equivalent of out-relief in the outpatient department of the hospital or a dispensary.

In the city parish, an individual was also more likely than in the country to be without family or friends for support. Patterns of local desperation, of family economies gone wrong, of immigrant isolation, led people to make use of new institutional resources. So too, connections with urban elites provided the means by which individuals sought help, so that institutional utilization was mediated by the circumstances of neighborhood, of workplace, of church or meetinghouse.

Just as charity has most often been discussed from the perspective of its benefactors, so too has medicine been understood as the creation of its practitioners. Recent years have seen the study of eighteenth-century British medicine reinvigorated as a focus of scholarly attention. Often, however, this new intellectual vitality has been granted through attempts to integrate British medicine into a Continental, especially Parisian, model.[13] But British infirmaries never aspired to be the Hôtel-Dieu, and the search for the Paris model of medicine – accomplished through the bodies of thousands upon thousands of destitute patients as well as a revolution – seems to have led some historians to a narrow perspective on British medicine.

Instead, the vitality and strength of local traditions of medical practice were far more significant to experiences of illness and infirmary growth than any developments across the Channel.[14] In Bristol, barber-surgeons' and apothecaries' companies provided a structure for urban practice that integrated their members into the city's civic rituals and functions. The leaders of these companies commanded high apprentice fees and trained the sons of merchants and gentlemen. Only as patterns of apprenticeship changed did the infirmary come to adopt an educational function similar to that of Parisian hospitals. A local focus on medicine as it was practiced, rather than on the national and supranational construction of the identity and bureaucratic structures of a profession, presents an alternate view of early modern medical practice to those based upon Continental models.

However, the patient's view reveals that even these formally trained practitioners represent only a fraction of the city's health-

care providers. Many understood how to maintain health and treat illness; medical knowledge was a part of everyday discourse. There were wig-makers, blood-letters, inoculators, itinerant venereal disease doctors, druggists, and "cunning women," purveying health care which competed with domestic medicine provided by patients themselves. As Roy Porter and Irvine Loudon have shown, health care was an economic free-for-all, an open market, an exemplification of the consumer revolution.[15] But such openness was not solely predicated on a cash economy; in a world in which most people were capable of practicing the rudiments of domestic medicine, the utilization of protoprofessionals needs to be explained on a deeper level than mere emulation of others' consumption.

In a local study such as this, some of the dimensions of the relationship between healer and healed can be traced out in detail. For instance, some of Nicholas Jewson's schematic views of an eighteenth-century medicine dominated by the desires of the patient rather than the practitioner can be supported with examples from Bristol.[16] But over the course of the century, the relationship between healer and healed shifted as the cultural role of lay medicine altered.

In the late seventeenth century, vernacular medical knowledge was extensive and tenacious. For lay practice, interpretations of the causes and precipitants to illness were as significant as therapeutics. These interpretive frameworks owed much to religion, be it Anglican orthodoxy or dissent. One of the keys to these belief systems was the importance placed on signs inscribed on the body's surface. Such concepts were congruent with cultural norms about signs and wonders, from the appearance of monsters to the healing virtues of plants; the outside reflected the inside, and interpretation was open to all.

Later in the century, the shared basis of these beliefs was attacked by those who would impose a rationalistic and class-specific order upon belief and behavior.[17] But the persistence of a supernatural component to these vernacular healing practices calls into question the seventeenth-century replacement of magical beliefs by a more rational, secular outlook.[18] Nor was this process gradual and imperceptible; it was punctuated and stimulated by specific issues and debates. Thus, in the 1740s and 1750s, concerns about Jacobitism and dissent were voiced in terms of the opposi-

tion between "polite" and "vulgar" beliefs and behaviors. In the 1780s and 1790s, a new wave of reformers attacked cultural expressions associated with an emergent working class. In both periods, modes of interpretation of the body that emphasized signs visible to all came under particular attack as they were easily associated with forms of deviant "enthusiastic" popular religion.

Medical men were not prominent in any of these reevaluations of the body. And yet such processes served to augment medical authority by denying poor patients' abilities to interpret illness in ways sanctioned by dominant cultural norms. Within the hospital, parallel processes denied patients a voice as medical men closed ranks and defined themselves as the products of a dissection-oriented anatomical training. No longer were patients' own narratives of illness and interpretations of external signs the key to diagnosis; no longer were the moral meanings of illness central to medical as well as vernacular practice. Instead, truth lay deep inside the body, accessible only to the trained observer, sometimes apparent only at the postmortem dissection so loathed by patients.

Medical men were able to take control of the process of illness interpretation within the hospital because the authority of the infirmary's benefactors devolved upon them in an unexpected way. As hospital governors slowly abandoned their direct day-to-day control of the institution, surgeons inherited the apparatus of management. But medical men did not create the hospital; they medicalized it.

Such an analysis serves, of course, as comment on and critique of Michel Foucault's *The Birth of the Clinic.* Other historians have tried to map Foucault's discussion of French Enlightenment medicine onto Britain, without great success.[19] But Foucault's analysis is suggestive on a deeper level. His perception of the ways in which power can be inscribed on the body, however schematic, is a model for understanding some of the means by which English medical men came to dominate their patients. But this domination comes at the end of our story; control over the hospitalized body had already been derived from the infirmary's origins in the workhouse. Perhaps it is Foucault's *Discipline and Punish,* which illuminates how early modern institutions contained and concealed deviance, to which historians of English medicine must turn. Like bridewells, workhouses, and prisons, hospitals were designed to reform their inmates and engage them in the world of productive

labor – in this case, by mending their bodies, making them fit for work. Medical men's power over their patient's bodies depended upon incarceration; only slowly was such power mediated through medical knowledge as the hospital became central to medical thought and practice.[20]

This is a book about Bristol, but it is also intended to have more general relevance. Thus, for example, Chapters 2, 3 and 9 discuss aspects of English medicine, often relying on examples from the South-West, but making a larger argument. Although Bristol's wealth and size may make it atypical of English provincial cities and towns in this period, the city experienced much in common with its smaller counterparts. The pattern of infirmary development was similar to that in other old cities, and there were connections to other hospitals through figures such as Alured Clarke and Sir James Stonhouse (associated with the Winchester and Northampton infirmaries). Given the paucity of historical work on English provincial medicine and welfare in this period, it is also instructive to compare Bristol with Continental and American cities. Certain themes link Montpellier and Philadelphia and Turin with Bristol, suggesting commonalities to ancien régime experiences of medicine and urban welfare.

One of the most apparent features of charity and poor relief in eighteenth-century Bristol was its commitment to moral reform. So too in other cities; the poor were to be brought to godliness as well as protected from starvation. Thus, for example, in Montpellier (home of the leading French provincial medical school), poor-relief institutions, including the Hôtel-Dieu, emphasized their roles in transforming the shiftless into the saved. As a member of the board of Montpellier's Hôpital Général declared, *"cette maison a toujours été regardée comme un azille pour les moeurs aussi bien qu'une ressource contre la misère."*[21]

As in many other cities, the key to Montpellerian reformation lay in work and in community. Colin Jones has illustrated how the regular life of the community in poor-relief institutions was intended to reform inmates, however perennially subverted by them. Similarly, Philadelphia's responses to poverty emphasized work and community. Thus, for example, the so-called Bettering House was founded in 1766, a combination almshouse and workhouse whose name indicated its reforming function. Like its European counterparts, it housed a range of individuals, the

invalid, the beggar, even the petty criminal. Although England was rapidly losing faith in the ability of the workhouse to cope with poverty, Philadelphians looked back to English models, to the ideal communities of John Bellers, in their attempts to improve the poor.[22] Not surprisingly, their experience echoed Bristol's: managers of the workhouse found that inmates could not earn sufficient through their labor to offset running costs. But work was more than just wage earning; its functions in inculcating discipline and godliness were equally significant. Inmates were kept picking oakum or spinning wool for reasons far beyond finance.

If institutions provided reformation as well as relief to their inmates, so, too, they performed a range of functions within the city. As Sandra Cavallo has shown for Turin, hospitals and workhouses served as centers for the negotiation and exercise of patronage.[23] Such power was manifested in public display. Thus, for instance, in Catholic countries the remnants of baroque piety promoted funerals ornamented by large numbers of paupers in attendance, while in Protestant England charitable institutions stage-managed public processions to anniversary sermons and the like. The public role accorded philanthropy mirrored the private power which it conferred upon donors who could use their control of institutional admissions to support their own clients. The recommendation system was in wide use on both sides of the Atlantic and the oft-distinguished "worthy" poor were validated through their connections with local patrons.

In cities with more than one institution, this system could mean a certain level of differentiation. Thus, for example, in Philadelphia, a three-tier system separated the most worthy (who could make use of the Dispensary founded in 1786) from those who utilized the Hospital. Both were preserved from the elderly and infirm in the Bettering House who were in turn distinguished from the beggars and vagrants in that same institution. However, as Colin Jones has pointed out in his analysis of Montpellier, segregation and differentiation did not occur along modern medical lines, but in accordance with social dictates.[24] So too, in Bristol, even within the city workhouse there are hints that the respectable elderly enjoyed medical out-relief while those less fortunate in acquiring local patronage only received medical care as inmates.

Thus the ancien régime institution, often old, almost always multifunctional, looks back to a tradition of moral reform and