

# Health, disease and society: Scottish influence in the 19th century



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# Introduction

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This course examines the roles of Scots who contributed to the comprehensive transformation of medicine in the nineteenth century. It begins by observing how laboratory practices led to improved techniques of medical diagnosis. This is followed by assessing how Scots contributed to the emerging collective identity of medical practitioners, as well as the improvements in licensing that led to reform of the medical professions. Many new developments in medical education also enabled women to qualify and practise medicine for the first time.

Finally, using many Scottish examples, the last section of this course presents information about how healthcare institutions, namely asylums, were again influenced by social, economic, political and cultural contexts.

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# Learning Outcomes

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After studying this course, you should be able to:

- describe the Scottish contributions to the history of medical thinking and practice in the nineteenth century
- give examples of many medical advances that were influenced by wider social, economic, political and cultural contexts
- understand how developments in medical education permitted women to qualify and practise as doctors
- appreciate that the laboratory had a limited impact on medical practice until the twentieth century
- describe the status of medical practitioners in Europe during the nineteenth century.

# 1 The rise of laboratory medicine

## 1.1 Transforming practice

'Laboratory medicine' represented a fundamental shift away from the established view of the body and disease. Where hospital medicine saw disease as a collection of symptoms in life, which related to changes in body structure discovered at post-mortem examination, laboratory medicine sought to explain the structure of the body at the cellular level and to describe its function as a complex series of dynamic processes. Within this medical cosmology, the laboratory usurped the hospital as the locus of research, and the laboratory scientist claimed a greater authority than the clinical practitioner. The diagnosis of particular infectious diseases now relied on tests on tissue samples performed at the lab bench, not simply on the subjective analysis of patterns of symptoms.

At the time Nicholas Jewson published his article 'The disappearance of the sick-man from medical cosmology, 1770–1870' (1976), few historians would have questioned *how* the laboratory acquired this central role within medicine. In an area when 'high tech', scientific medicine seemed to supply an endless stream of new theories and better therapies, the laboratory was assumed to have won its place simply on the grounds of utility.

While laboratory research undoubtedly revolutionised understanding of body function and disease, its impact on medical practice is less clear-cut. Laboratory medicine did lead to improved techniques of diagnosis, but research produced few new therapies until the twentieth century. Even when new diagnostic methods and new therapies did become available, practitioners did not rush to adopt them.

## 1.2 The laboratory in diagnosis

Different fields of laboratory research offered a range of new diagnostic techniques. Bacteriological research into the identity of disease-causing microorganisms provided practitioners with a new and accurate means of diagnosing cases of infectious disease. By the 1890s, specimens from patients suspected of suffering from tuberculosis or diphtheria were routinely cultured to confirm a diagnosis made on the basis of symptoms (Worboys, 2000, pp. 211–16, 252–7). Laboratory equipment used to explore physiological function in the healthy body was applied to reveal underlying physiological dysfunction and thus to diagnose disease. The electrocardiograph, for example, which was devised to explore the function of the heart, became a standard piece of hospital equipment used to diagnose heart conditions. It also helped to establish cardiology as a new specialty. Hospitals began to set up small biochemistry laboratories to analyse blood and urine samples taken from patients suffering from physiological diseases such as anaemia or diabetes. In new pathology departments, histological analyses were performed to check whether or not tissues removed during surgery were cancerous (Howell, 1995).

In the article mentioned in Section 1.1, Jewson assumes that clinical practitioners simply accepted that laboratory scientists – with their new and detailed knowledge of body function – possessed a special authority. Research on British medicine around the turn of



the century, however, shows that there was conflict between the two groups, with some practitioners resisting the introduction of laboratory methods of diagnosis. Christopher Lawrence has shown how a group of elite London clinicians built their careers around a model of a gentleman practitioner, broadly educated, versed in the classics and with finely honed clinical skills. Such practitioners relied on attracting patients from the upper classes who shared this type of education and outlook. Far from being scientific reductionists inclined to see their patients simply in terms of diseased organs, these clinicians, like the eighteenth-century practitioners described by Jewson, saw the patient as a sick man, suffering from a unique and individual case of a disease, its course affected by lifestyle and environment. They prided themselves on their skills in clinical diagnosis based on observation and simple physical examination. Not surprisingly, they saw no value in bringing to the bedside the skills and knowledge acquired in the laboratory. One of the staff of St Bartholomew's Hospital was reported to have told his students, 'When you enter my wards your first duty is to forget all your physiology. Physiology is an experimental science and a very good thing no doubt in its proper place. Medicine is not a science, but an empirical art' (quoted in Lawrence, 1999, p. 426). Science was equated with specialism, and specialism with a narrow approach that might lead the practitioner to overlook clinical signs (Lawrence, 1985).

Resistance such as this was typical of a particular cohort of practitioners. Later generations of practitioners who had received training in laboratories as part of their medical degree were more willing to accept that there was a role for science at the bedside. In 1908, Thomas Horder (1871–1955), a distinguished clinician and a member of the London elite, wrote:

Though the days are past when the student entering the wards often received the superfluous advice to 'forget his physiology', the physiologist is still regarded a little suspiciously at the bedside. Perhaps he is in part himself to blame for that, for he is sometimes inclined to forget that observations made in the laboratory are not infallible, and are not necessarily more correct than clinical evidence ... [P]hysiology can only come to the aid of medicine with becoming modesty, and without overweening dogmatism. There is no finality about either.

(Lawrence, 1999, p. 428)

Horder and other practitioners of his generation tried to strike a balance between the role of science and the clinical art. For them, observation still laid the groundwork for diagnosis. Measurement could then ascertain the severity of the condition. For example, a practitioner should be able to diagnose anaemia by observation and questioning: a blood count could measure the severity of the case and help to guide treatment. At all times, the laboratory and the bedside should be linked. The clinician should perform diagnostic tests, and thoroughly understand the implications of the results. Students and practitioners should not become so immersed in the specialised disciplines of the biomedical sciences that they lost sight of the patient as a person (Lawrence, 1999). There is good evidence that by the early twentieth century general practitioners working among the middle classes used laboratory tests to help their diagnosis. Similarly, the development and marketing of small 'kits' containing all the equipment necessary to perform simple analyses of blood and urine suggests that some general practitioners applied to their practice the skills learned in the medical-school laboratory.

Research has suggested that other practitioners were equally cautious about pathological examinations carried out in the laboratory. The first reading, by L.S. Jacyna, is taken from his case study on the role of the pathologist in Glasgow Western Infirmary, 1875–1910.

### Exercise 1

Read 'The role of the laboratory in the hospital', linked below. How do practitioners use the laboratory in their practice, and how does their use of the laboratory compare with that of the elite practitioners described by Lawrence?

Click to open [The role of the laboratory in the hospital](#).

Jacyna's account is about the use of a different sort of laboratory science: where Lawrence's practitioners are using physiological measurements, to judge the severity of cases, Jacyna's practitioners want a diagnosis based on a tissue sample. However, the Glasgow practitioners seem to share the London elite practitioners' feeling that the proper role of the laboratory should be strictly limited, and should come after an initial diagnosis has been made: the lab is used to confirm the cancerous nature of a tumour, or to decide which of the possible diagnoses of inflammation, tuberculosis and so on is correct. While practitioners accept that the laboratory has the technology, and that the pathologist has special skills which they lack, they do not immediately use the laboratory for diagnosis; nor do they use it to determine the course of treatment. The laboratory therefore has a strictly limited role – to refine or confirm an existing diagnosis. It assists practitioners in their clinical practice when dealing with a limited number of conditions.

While clinicians might be suspicious of the laboratory, practitioners working in laboratories actively promoted their skills as a means of serving local medical communities, and thus helping to build a niche for the laboratory. In Sheffield, for example, the established medical school added laboratories to its other teaching facilities in the 1890s. These were primarily intended to attract students, who might otherwise go to better-equipped schools for their training. However, the laboratories also provided services to the local medical community. The bacteriology laboratory conducted tests for local hospitals and the local authority, identifying cases of infectious disease. The physiology laboratory worked with local hospitals in carrying out research into occupational diseases linked to local industries, and into goitre – enlargement of the thyroid glands – which was prevalent in the area. The laboratory staff acquired a prominent position among local practitioners, and were seen as experts on particular conditions. General practitioners were therefore willing to refer on more difficult cases to these local experts, who could provide better diagnosis (Sturdy, 1992).

## 2 The emergence of a modern profession?

### 2.1 Introduction

In the late eighteenth and nineteenth centuries, fundamental and sweeping changes took place in medical training and practice. Apprenticeships, which were once the most



common form of medical training, gradually disappeared, and a university education became the norm for all practitioners. Responsibility for licensing practitioners shifted from the old medical guilds and colleges to the state and then back into the hands of medical men. The last remnants of the division of practitioners into physicians, surgeons and apothecaries were swept away. Instead, medical men were split into general practitioners and consultants. At the same time, medical practitioners developed a new collective identity, seeing themselves as members of a single occupation, with common interests and conforming to common standards of behaviour. A clear differentiation emerged between members of the regular and orthodox profession, who had gone through recognised forms of training, and those who were considered irregular healers and unorthodox practitioners.

## 2.2 Unity and conflict

In the nineteenth century, licensing reform and developments in medical education brought a new unity to the profession. Students had a similar education, trained in large groups and developed a strong sense of allegiance to their institutions and to their teachers (see Figure 1). Links formed at medical school were maintained after graduation, with former students keeping in contact, calling on each other for help with operations and consulting each other or their former teachers on difficult cases.



Figure 1 A clinique of the Royal Infirmary of Edinburgh, c.1895. A 'clinique', or 'firm' as it was known in England, was made up of the students working with the staff of a particular hospital ward. Photographs like this appeared at the end of the century and are a visual representation of the new allegiances of medical students to their classmates, the schools and hospitals where they trained and their teachers. Such pictures were often taken by commercial photographers and sold to students as a memento of their studies.

(Lothian Health Services Archive/SCRAN)

Lothian Health Services Archive/SCRAN

This sense of a collective identity – of belonging to a body of practitioners with similar patterns of work and common interests – was greatly strengthened by the many new medical societies and journals founded in the nineteenth century. Medical journals were most popular in Britain, where more than 400 new titles were launched during this period. One of the first and most successful was the *Lancet*, founded in 1823 by Thomas Wakley (1795–1862), a general practitioner with a real flair for firebrand journalism. The *Lancet* served as a model for many other journals, including the *London Medical Gazette* (1827) and the *Provincial Medical and Surgical Journal* (1849), which became the *British Medical Journal* in 1857 (Bynum *et al.*, 1992). Medical journals were founded in rather smaller numbers in Europe at the same time – in France, Germany and Belgium, where the *Scalpel* (surely in homage to Wakley's *Lancet*) appeared. Even in Russia, twenty-three new journals were established around the middle of the century.

Nineteenth-century medicine had a form and character that was unique to its time. By the end of the century, there is a stronger case for seeing medicine as a profession. Practitioners formed a more cohesive group, sharing the same forms of education, qualifications and codes of ethical behaviour. They enjoyed the status of experts, and had greater (though by no means total) control over licensing. However, they still had no monopoly of practice.

Did these changes come about through a process of professionalisation or reform? There is no clear answer. On the one hand, nineteenth-century practitioners wanted to be seen as members of a profession, distinguished by gentlemanly codes of behaviour. This may have encouraged the development of medical ethics. On the other hand, change was also driven by economics. The key attribute of modern professions – the possession of a body of specialist knowledge – was also a means by which individual students could ensure that they would succeed in practice. However, as the experience in many European countries shows, governments also had an interest in driving up educational standards in order to ensure that their populations had access to well-trained practitioners. The role of social, cultural, economic and political contexts in shaping the development of the medical profession remains poorly understood. Professionalisation occurred right across Europe – from Russia and Norway to Britain, France, Holland, Belgium and Germany – and in each nation, licensing standards were pushed up, practitioners developed a strong collective identity and they were concerned with their low status. Why this should have happened at the same time under widely differing political regimes and against different cultural backgrounds remains a puzzle for future historians.

## 3 Women in medicine: doctors and nurses, 1850–1920

### 3.1 Introduction

Women have always cared for the sick. They have nursed family members within the home and worked as nurses, healers and midwives within the community. In the eighteenth century, a few women worked as 'doctresses' and 'surgeonesses', having

received some form of training similar to male practitioners. However, when formal medical training began to be developed in hospitals and medical schools in the early nineteenth century, women were not admitted. Thus they were excluded from the ranks of the medical profession. It was not until the late nineteenth and early twentieth centuries, after a long and often bitter struggle, that women gained access to formal medical training. But even after this barrier had been crossed, women still encountered difficulties in pursuing a career as a doctor.

## 3.2 The push for – and opposition to – women in medicine

In Britain, the campaign for access to the medical profession began at Edinburgh University in 1869, and was led by Sophia Jex-Blake (1840–1913). Influenced by the feminist movement of the time, Jex-Blake had a wide-ranging education and was keen to earn an independent living. She fought a relentless battle with the Edinburgh University authorities. Initially, the university refused to admit a lone female student, so Jex-Blake recruited a small group of women. Once admitted, the women were denied access to the university's medical classes so they made their own arrangements for learning these subjects, organising separate classes with professors sympathetic to their cause and attending courses taught outside the university. They were then denied access to clinical training at Edinburgh's Royal Infirmary, and were only admitted after a long battle with the hospital authorities. Finally, they were denied the right to graduate. Jex-Blake eventually qualified in Bern, Switzerland, and received her licence through the Irish College of Physicians (Blake, 1990, pp. 97–155).

Female medical students also faced physical violence. Despite medical students' growing reputation for studiousness, Jex-Blake and her fellow female students were roughly handled by the male students. During a 'riot' in Edinburgh, Jex-Blake and her companions were jeered at and had the gates of the medical school slammed in their faces. Later, a live sheep was pushed into their classroom, and on leaving the lecture the women had mud thrown at them and were pushed and jostled (Blake, 1990, pp. 125–8). Across Europe, similar resistance was shown to women who wanted to study medicine. In Spain, a group of female medical students passed their examinations but were refused a full degree. And one Spanish student, Pilar Tauregui, was attacked by her male classmates when she attended medical school in 1881 (Anderson and Zinsser, 1988, p. 189).

Why were medical men so violently opposed to women becoming practitioners?

### Exercise 2

Read 'The impact of women doctors'.

- 1 Why is the author of this editorial so worried about the prospect of women qualifying as doctors?
- 2 What arguments are used to oppose the entry of women to the profession?
- 1 The author is deeply concerned about the effect that women will have on the medical profession. As he boldly states towards the end of the extract: 'the profession is overstocked'. Such claims were used to justify raising the requirements for medical licensing in order to reduce the number of male

practitioners. Competition from women doctors will mean that the income of each will further decline, and fewer men of ability will be attracted to the profession. The presence of female doctors also threatens the status of the profession. At this time, medical men were trying to raise the status of their occupation by emphasising the need for practitioners to possess highly specialised knowledge. If women, who were thought to have very limited intellectual capacities, could qualify, then this devalued medical knowledge.

- 2 The editorial reiterates the argument that women are not physiologically suited to a career in medicine. They lack the physical stamina, they would be overcome with emotion at the sight of a patient in pain and they cannot be trusted to respect patient confidentiality. (The author here assumes a biological tendency to 'gossip'.) If women do complete a medical training, they run the risk of losing their natural female qualities of compassion and kindness. The author also introduced some new arguments. While denying that women patients are demanding female physicians (the author suggests that a 'thoughtful' woman regards the idea of a female medical attendant as repulsive), he seems to assume that female doctors will concentrate on midwifery. Such specialism is equated to quackery and poor standards of practice, and is seen as a backward step. Doctors have only recently saved obstetrics from the practice of untrained wise-women. The author claims that female practitioners who work only in obstetrics will not acquire, and are not capable of acquiring, a full medical education – another sign of the quack doctor. This will further devalue all medical training, resulting in a reduction in the quality of service, and will threaten the status of the whole profession.

The idea that women could not become competent practitioners was not confined to the medical press. It was also the subject for cartoons in the popular press (Figure 2).



Figure 2 The caption to this cartoon, entitled *The Coming Race*, reads: 'Doctor Evangeline: "By the bye, Mr Sawyer, are you engaged tomorrow afternoon? I have rather



a ticklish operation to perform – an amputation, you know.” Mr Sawyer: “I shall be very happy to do it for you.” Doctor Evangeline: “O, no, not *that!* But will you kindly come and administer the chloroform for me?” The humour rests on the way the cartoon turns on its head the stereotype of the helpless woman and strong man. It portrays a ‘comic’ situation – where a fashionably dressed, small female doctor claims greater surgical competence than a man. At the same time, it accurately captures the way doctors did ask each other for help in administering anaesthetics. The cartoonist reflects the ambiguous views held of women doctors. In the 1870s, when only a few women were training as practitioners, they were depicted as small, elaborately dressed feminine figures. By 1900, when a small number of women were practising successfully, a more ‘mannish’ stereotype emerged, wearing a plain skirt and masculine jacket. She was often the butt of the joke.

(From *Punch*, 14 September 1872, p. 113)

From *Punch*, 14 September 1872, p. 113

### 3.3 The reasons for – and emergence of – women working in medicine

Why in the face of such resistance did women wish to become doctors at all? Until recently, many authors have argued that women pursued a medical career as a form of service and for altruistic reasons. Women doctors claimed to be serving the public (one of the features of a profession) by preserving the modesty of women patients and ending their suffering at the hands of male doctors who did not understand the female body. This idea of women being called to serve for the betterment of others is a common feature of many autobiographies written by pioneer women doctors and contemporary biographies. However, recent scholarship suggests that women may have constructed narratives of their lives in ways that would be acceptable to society.

Given the obstacles that had to be faced, the fact that women doctors often told their stories in terms of having received a calling, or having been possessed by a mission is scarcely surprising. To have felt possessed by forces outside one's own control was probably easier than owning up to one's own driving ambition.

(Dyhouse, 1998, p. 324)

#### Exercise 3

Read ‘Motives for medical training’. According to this account, what motivated Mary Murdoch to qualify as a doctor?

This account suggests that Mary Murdoch (1864–1916) (Figure 3) was bored by the life of a ‘lady of leisure’ and did not want to waste her years in the ‘small activities’ of a country town. As the only daughter left at home, she cared for her mother until her death and was then left with the problem of how to support herself. With a small legacy and no husband she had to find a career. The family physician clearly had some influence. Thus her career choice might have resulted from changes in her family life and from a desire for freedom.

In the second passage, Murdoch is shown as offering herself to medicine in a way similar to that of a novice offering herself to God. Murdoch was a deeply religious woman, and her Catholicism seeps through the piece as she justifies her choice of

career. Her medical career is presented as a life of self-sacrifice. While loving her chosen profession, Murdoch presents it as a life of service and devotion to the detriment of other pleasures, as medicine has taken away her liberty.



Figure 3 Portrait of Mary Murdoch in her writing room. Like many male contemporaries, Murdoch is portrayed without any sign of her occupation, but is shown as a woman of culture – note the paintings, statue and books.

(By permission of the British Library, shelfmark: 010855.cc.8)

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Murdoch's biography hints at the role played by male supporters in encouraging women in their chosen path. While women did face fierce opposition, mainly from elite practitioners who made up the staff of the largest medical schools and teaching hospitals, they also received help and advice from individual men. At Edinburgh, for example, Jex-Blake had invaluable support from two men. Alexander Russel was editor of the *Scotsman* newspaper and did much to publicise the unfair treatment meted out to the female medical students. David Masson was professor of English at Edinburgh University, and a strong supporter of education for women.

Having been denied access to established medical schools, some British women were determined to found their own training courses. This was quite possible in Britain where there were many private medical schools set up by practitioners. Opinion was divided on the matter among medical women. Garrett Anderson and Blackwell opposed the idea of a separate education for women, fearing that it would be regarded as inferior to that received by men. After she failed to graduate from Edinburgh, Jex-Blake moved to London in 1874 and began to plan a women's medical school. The London School of



Medicine for Women (LSMW) was opened in October 1874 and received the support of some men, including the Earl of Shaftesbury, and some intellectual radicals, including lawyers (for example, William Shaen, who acted as solicitor to the school) and politicians (for example, James Stansfeld, who supported women's suffrage). The LSMW did not provide a way into medicine for all women: the founders limited admission to the very brightest and charged high fees of £200 per annum. Lectures were given by male and female doctors already in hospital posts and, from 1877, the female students were able to gain clinical experience at the Royal Free Hospital (Blake, 1990, p. 186). While the LSMW offered opportunities for education to women when other routes to medicine were blocked, it did not provide the same springboard to a medical career as a 'male' education could do. Its staff did not belong to the medical elite and could not offer their graduates entry to junior posts in prestigious hospitals. Without support from distinguished hospital staff when seeking posts, many of the LSMW's students worked in lowly positions within the medical hierarchy – as medical missionaries for instance.

### 3.4 War and women in medicine

Until 1914, the number of women attending medical schools grew slowly (Figure 4). In Britain, even after the 1876 Enabling Act allowed medical examining boards to grant licences to women, universities could still legally exclude women from their medical schools. By 1881, there were only twenty-five women doctors in England and Wales – a total of 0.17 per cent of the profession. By 1911, there were 495 women on the register, comprising just under 2 per cent of the profession (Harrison, 1981, p.51). In Germany, there were only a total of 138 women physicians in the entire Reich by 1913. It was in Russia that female medical students were the most numerous. By the First World War more than 1,600 had qualified and were practising – more than the combined number of qualified women throughout the rest of Europe (Bonner, 1992, p.78).



Figure 4 Women medical students, Royal Infirmary, Edinburgh, 1897–8. Women students were finally admitted to Edinburgh University in 1892, but they were taught separately from the men. This group photograph was taken in front of the main door, exactly where the male classes were photographed. Note the all-male teaching staff seated in the front row.

(Lothian Health Services Archive/SCRAN)

Lothian Health Services Archive/SCRAN

The First World War is often portrayed as a watershed for women, opening up many new employment opportunities. The war certainly gave medical schools an incentive to open their doors to women, as the number of male applicants fell and the call up of male doctors offered increased opportunities for women to practise on the home front. Some women were able to work close to the battlefield itself, in the Scottish Women's Hospitals (SWH). Funded through charitable donations, the SWH saw service under French command (the British Army refused the services of the women) on the western front and in Serbia. However, the idea that the war irrevocably improved the situation for women wishing to pursue a career in medicine is overstated.

Many medical schools persisted in their opposition to women, and, at the end of the war, limits were once again put in place.

One by one the London teaching hospitals again closed their doors to female students. University and King's College Hospitals retained limited places, but

otherwise the Royal Free was the only London hospital offering them clinical induction.

(Leneman, 1994, p.176)

At St Mary's Hospital Medical School in London (which had supported the admission of women from 1916), male students and staff started to complain about the female students. The arguments reached a crisis point in April 1924, when ninety-six male students signed a petition for the removal of the female students (Garner, 1998, p.83). The hospital discussed the matter and decided that from 1925 no more women would be admitted. Although St Mary's chose to exclude women, in other medical schools the backlash against female students was dying away. The number of women studying in British medical schools increased during the late 1920s and 1930s. By 1931, there were 3,331 qualified women, accounting for about 10 per cent of the medical profession (Cherry, 1996, p.33). This was not the case throughout Europe, however. In Germany, for instance, the proportion of women in medical schools actually fell by 17 per cent between 1923 and 1928 (Bonner, 1992, pp.162–5).

The inter-war period was also characterised by gains and setbacks in the career paths of individual women. Male practitioners were still able to push women into the margins of the profession – just as they had marginalised practitioners who practised unorthodox forms of medicine – by denying them access to research opportunities and prestigious posts. For some, such as Mary Walker (1888–1974), barriers remained to their career progression. Walker spent much of her career working in London Poor Law hospitals (regarded by most practitioners as a low-status post) despite a clear aptitude for research. Her doctoral thesis won the Edinburgh Gold Medal in 1937, but she did not take up the offered post at the Elizabeth Garrett Anderson Hospital to pursue research in neurology. Whether this was a consequence of male opposition, lack of desire or the impact of marriage and a family is unclear. Others, such as Letitia Fairfield (1885–1978), were able to have careers which mirrored those of their male colleagues. From an intellectual family (her sister was the novelist Rebecca West), Fairfield took a post with the London County Council in 1911, and eventually became its first female senior medical officer. She served in a medical capacity in both world wars and had interests in maternal, child and geriatric medicine (Hall, 1994, pp.194–5).



Figure 5 Nurses on a ward, Leith Hospital, Edinburgh, 1917. This image encapsulates the order and cleanliness of the hospital ward, with its rows of beds and polished floor. This picture is unusual in that it does not show the medical staff, only the nurses, some of whom are tending to a patient. The trolley of dressings and bottles is visual evidence of how the role of nurses had expanded from providing care to undertaking medical treatment.

(By courtesy of the Trustees of the National Museums of Scotland/SCRAN)

By courtesy of the Trustees of the National Museums of Scotland/SCRAN.

Women's access to the medical profession was thus fraught with difficulties, which even by the 1920s were not completely removed. As Porter has noted, women faced two obstacles to entry into the medical profession: first, medicine was a 'chummy male monopoly' (1999, p.356) and second, it required a university education which was largely denied to women. Biological arguments about women's suitability for medical work were utilised in specific ways to maintain and protect existing professional structures and to prevent equal access and progression for women well into the inter-war years.

## 4 The rise of the asylum

### 4.1 Introduction

In the nineteenth century, the asylum became – as never before – the accepted place for the care and treatment of insanity. Until that time, people suffering from mental disorders were mostly cared for at home. Of the few institutions that offered care, most were rather



small. They were funded by a combination of fees charged to patients and charitable donations or subscriptions. From the early nineteenth century, the number of asylums increased all over Europe as governments accepted a responsibility to care for the mentally ill via various (but strikingly consistent) means and timescales. Most importantly, by the 1840s and 1850s, most European governments required local authorities to build asylums. Yet this shift was not directed solely by central government. From the later eighteenth century, local Poor Law boards, regional departments, townships and other local authorities, as well as a range of private benefactors, individual social reformers and charitable agencies, were agitating for the establishment of larger-scale, purpose-built asylum accommodation. While significant opposition to asylum-building persisted at national and local levels, there was an increase in both the number and the size of such institutions. British Victorian asylums were massive complexes of buildings. County and borough asylums were catering, on average, for over 800 patients by 1890, and some were accommodating over 1,000 inmates, with growing (but often inadequate) numbers of staff to see to their needs. The rise of the asylum was not just about bricks and mortar: governments created regulatory bodies to oversee the care offered by institutions, and comprehensive bodies of lunacy legislation. (This complex of institutions, laws and agencies is referred to as *asylumdom*.)

## 4.2 Social factors in the growth of the asylum: industrialisation, urbanisation and migration

Many historians link the rise of the asylum with the huge social changes of the nineteenth century. Some link the rise to industrialisation and urbanisation, pointing to the fact that asylums grew up in industrial regions and large cities. Frank Rice, for example, argues that in Scotland the great majority of asylums grew up if not within urban centres, then at least servicing urbanised communities, in the central belt of Scotland (Figure 6). Only two of twenty-three Scottish private mad-houses identified as being in existence in 1855 'were situated outside the central belt', and demographic research suggests that after 1811 there was never less than 81 per cent of the Scottish population concentrated within the urbanised central regions (Rice, 1985, p.44). Rice emphasises (but fails to offer specific statistics on) the chronological correlation between the size of Scottish towns and the number of institutions erected within them. Many cities appear to have embarked on new and enlarged asylum programmes out of a recognition of the inadequacy of existing, mainly urban-sited, provision for the insane in hospitals and poorhouses. Furthermore, Rice argues, these new asylums were built just as urban communities were attaining the peak of their industrial and demographic growth rates.

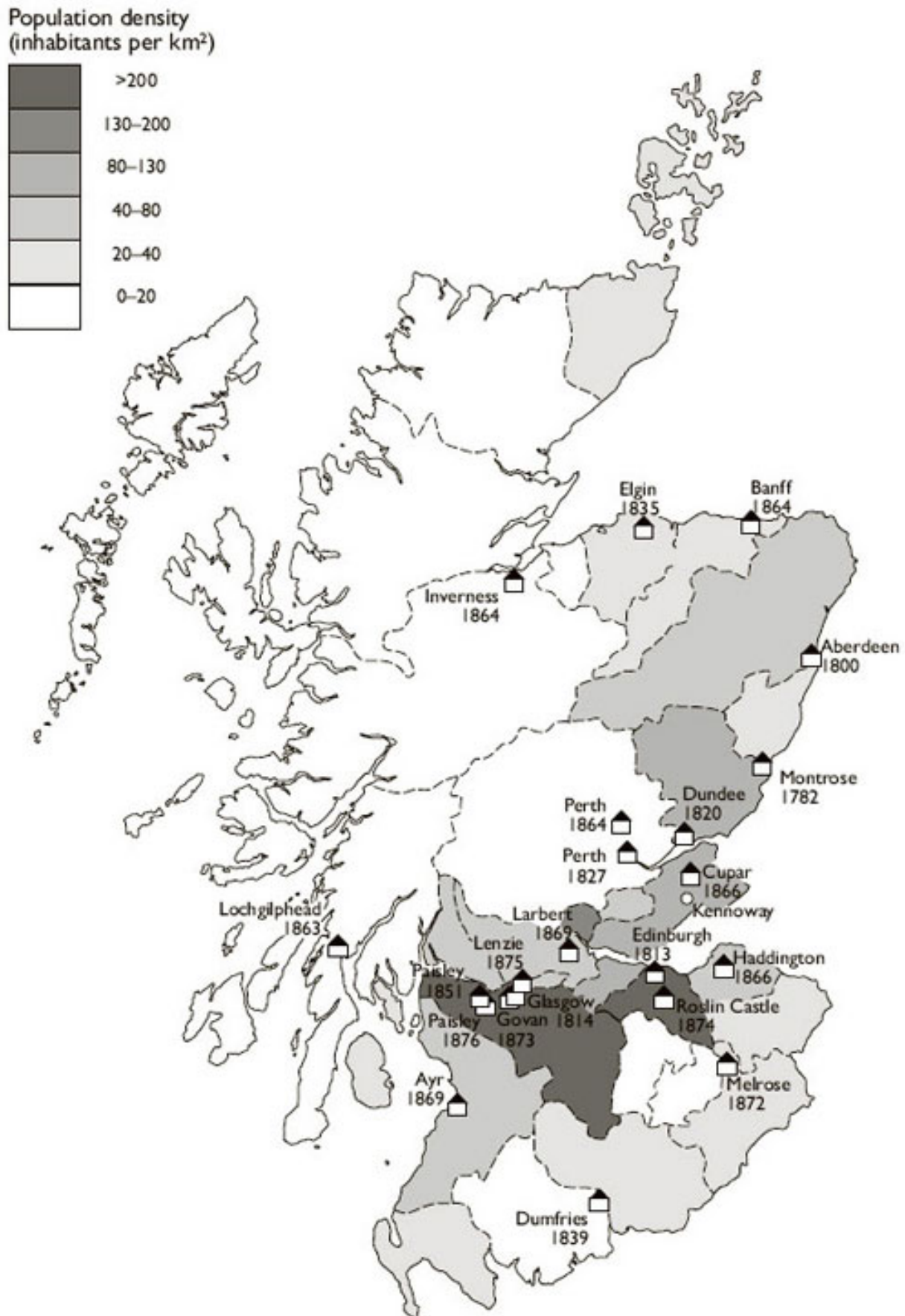


Figure 6 Map showing early asylums in Scotland and population densities of counties. This map shows the location of public, pauper, district and 'idiot' asylums built before



1880, and Kennoway, Scotland's most famous village centre for the boarding-out of lunatics. The map reveals the difficulty of relating asylum-building to industrialisation and urbanisation. While the concentration of asylums around Scotland's populous central belt is quite clear, a significant number of institutions were located in thinly populated areas

However, other historians have questioned the simplicity of the link between the new cities and the asylum. They point out that asylums were in many cases sited in rural areas that had little, or limited, industrial and urban growth. The first Victorian asylums were characteristically sited at some distance from towns and cities. The archetypal model of the nineteenth-century asylum, the Quaker York Retreat, opened in 1796, was a 'retreat' offering 'asylum' from the strains and stresses of everyday life (Figure 7). Early prints emphasised the idyllic situation of asylums, in expansive grounds with sheep and cattle grazing nearby (Figure 8). Many asylums' physician-superintendents emphasised the rural nature of their catchment areas, and the easy recruitment of staff from among the servants and farmworkers of the surrounding country. In England, as Scull argues, while rural communities enthusiastically built public asylums from the 1780s onwards, few of the counties in England's most industrial, urban Midlands and northern regions built asylums until obliged to do so by the 1845 Lunacy Act (Scull, 1979, p.29). Even in Scotland, it would be stretching the point to characterise Montrose (1781–2) and Dumfries (1839), the sites of two of the earliest asylums in Scotland, as highly urbanised and industrialised regions. Elgin, the site of Scotland's first district asylum for paupers only (1835), was even further distant from the central belt. The industrialisation–urbanisation theory also fails to explain why poor-houses with lunatic wards attached grew up in rural areas like Stranraer or Irvine. My own studies of the catchment area for Glasgow Asylum (later Glasgow Royal Asylum) during the first decades of the nineteenth century show how broadly the institution spread its net outside Glasgow and the more industrialised regions of Lanarkshire and Renfrewshire, with significant numbers of patients coming from the more rural regions of Argyllshire, Ayrshire and Fifeshire. Unfortunately, we still lack enough detailed surveys of the origins of Scottish asylums and their demographic profiles to attempt an overall model.



Figure 7 Perspective view of the north front of the York Retreat, opened in 1796 and run by William Tuke (1732–1822), a retired tea merchant, and his family. It was intended primarily for members of the Society of Friends (Quakers), although as time went on it became increasingly multi-denominational. The engraving shows the plain edifice of the Retreat, and its leafy site, removed from the bustle of York. The inspiration for the foundation of the Retreat was the Tukes' disgust at the ill treatment and death of a Leeds Quaker, Hannah Mills, in the York Asylum. This image is taken from the frontispiece of *Description of the York Retreat* (1813), written by William's grandson Samuel, which did more than any single publication to broadcast and popularise the virtues of the Tukes' distinctive approach to madness, known as 'moral therapy'

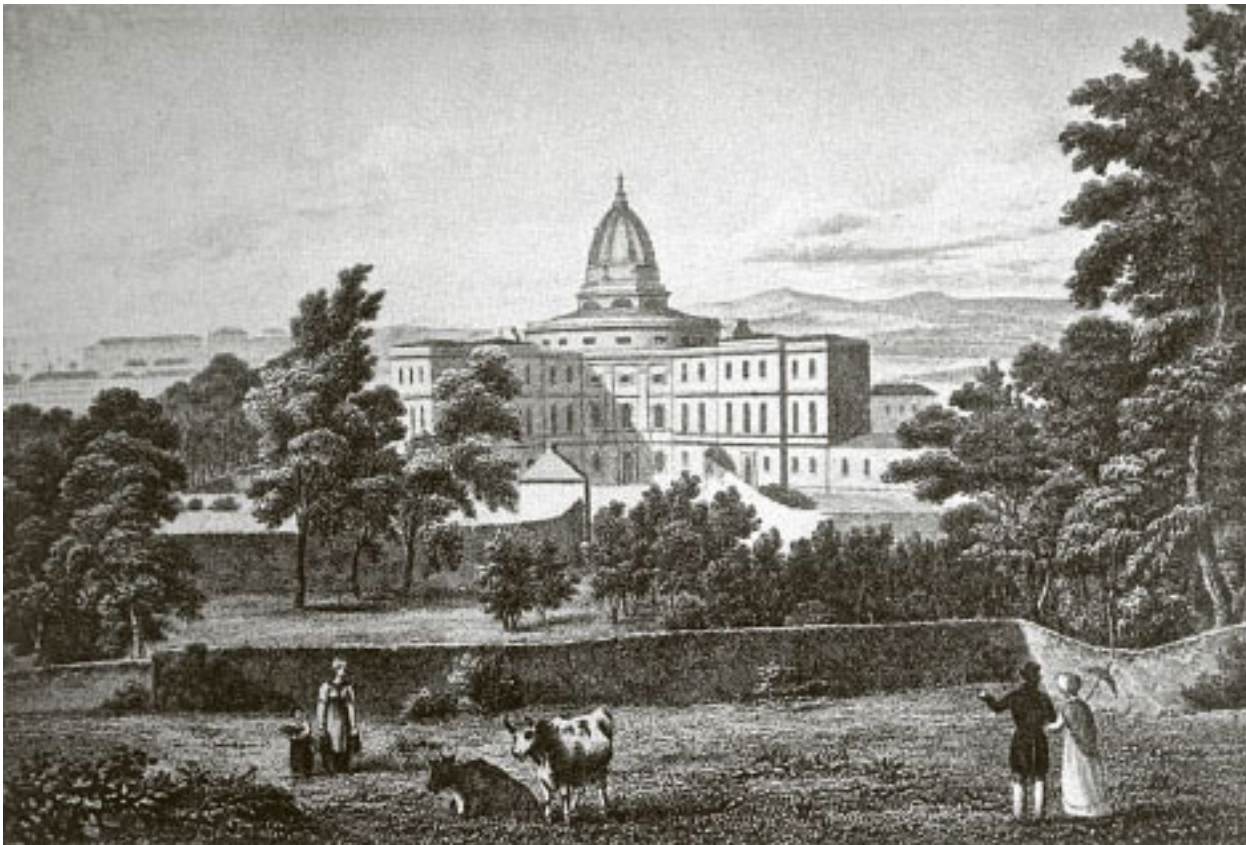


Figure 8 The first Glasgow Asylum for Lunatics, at Parliamentary Road, Dobbie's Loan, opened in 1814 and renamed the Glasgow Royal Asylum after it acquired a royal charter in 1824. This engraving underlines the representation of the asylum as a rural retreat. Clearly, the site was selected because of its appreciable remove from the urban sprawl of Scotland's rapidly expanding second city. The architect, William Stark, and its directors and staff, certainly claimed common ground with the ethos of the Retreat. This engraving was reproduced repeatedly to publicise the asylum, even after it had been rebuilt in Tudor-Gothic style on a new site at Gartnavel, Glasgow (where it remains to this day)

Another issue in question is whether or not the growth of asylums occurred at the same time as the growth of cities. Andrew Scull argues that the main growth of asylums took place before Britain was truly urbanised. While more than half of the populations of England and Wales lived in cities or towns by the middle of the nineteenth century, most of these communities were small. Only around one-third of the population lived in cities of 20,000 or more people. By this time, the asylum movement was well established, with all the major pieces of legislation in place and large numbers of asylums founded.

However, recent historical research has produced new evidence in two areas that challenges Scull's assertion that asylum-building preceded urbanisation and industrialisation. This work has shown that there was a significant phase of proto-industrialisation which preceded and laid the foundations for larger-scale industrial, urban and commercial growth. There was no radical divide between urban and rural areas in terms of industrial development, with many factories (especially textile works) and proto-industrialised crafts growing up within urban networks but closely linked to rural economies. Recent surveys of English urbanisation have emphasised the dramatic nature of the shift away from rural dwelling-places into townships and cities in the period c.1780–1850, and suggest that towns of 5,000 ought to be ranked as urbanised in contemporary terms (King and Timmins, 2001).



Scull and other historians have pointed to capitalism and the rise of an economy based on the payment of wages, rather than urbanisation or industrialisation, as important factors in the growth of institutional care for the insane. The next reading, from Scull's book *The Most Solitary of Afflictions: Madness and Society in Britain, 1700–1900*, reviews the debate over whether urbanisation or capitalism drove the increase in asylum populations.

#### Exercise 4

Read 'The impact of industrialisation'.

What aspects of capitalism does Scull believe contributed to the rise of the asylum?

Scull argues that capitalism and the emergence of a commercial society in the late eighteenth and early nineteenth centuries, which occurred *before* large-scale industrialisation, destroyed the old ways of dealing with insanity within a domestic setting. A money-based, highly competitive economy broke the old social bonds between upper and lower classes that had helped poorer families to care for a mentally disordered person. In cities, where housing costs were high, families were unable to support an unproductive member, or to care for them, especially as their wages rose and fell dramatically during periods of boom and bust.

This is a very appealing argument. However, recent work by a number of historians suggests that we need to treat it with a certain degree of caution. This new research is built on a different approach: rather than trying to link a broad asylum movement with major social change, it focuses on particular institutions and the experience of individual patients, and forms part of the movement to study 'history from below'. It uses hitherto neglected sources such as medical certificates, family members' descriptions of patients' behaviour prior to admission, and patient records from asylums. This provides a quite different perspective on the asylum, one that highlights issues of demand and need as well as supply. On the question of why patients were admitted to asylums, studies of accounts provided by the friends and families of the mentally disordered lend only qualified support to Scull's view that economic strain was the main trigger for seeking admission. Families and friends occasionally spoke of loss of income to the household through the expenses associated with nursing and managing a mentally disordered individual, through their own, or that individual's, inability to get employment. But there is little evidence yet from these sources that such rationales for committal figured any more prominently than they had done in previous times (Adair *et al.*, 1998; Walton, 1981, 1985; Wright, 1998).

Similarly, detailed work on the geographical origins of asylum patients has also questioned the portrayal of the link between urban migration, social dislocation and the asylum. We might assume that the migration of families into towns in search of work would have loosened networks of support, and ultimately led to families placing members in asylums. The story is not that simple, however. My research on Glasgow Royal Asylum shows that although there were recent migrants to the city among the inmates, they were not a conspicuously large group. An extensive survey of the route to the asylum in the Devon region during the second half of the nineteenth century by Adair *et al.* (1997) has argued that the relationship of migration to asylum admission was actually the reverse – at least in some areas. They find that it was not the migrants who were more prone to end up in the region's asylums. On the contrary, it was 'from the deeply rooted, physically less mobile and more socially entrenched families that the bulk of ... patients came', and thus from those sectors of society where kinship and household ties would be expected to be

more resilient (Adair *et al.*, 1997, p.393). Longer distance migration in Devon was actually associated with *lower* admission rates. The key factor here seems to be that insanity (like other forms of illness) prevented families from being mobile and moving into the cities.

## 4.3 Social factors in the growth of the asylum: social control, the family and the asylum

Both contemporary commentators and historians have argued that the pressures of capitalism resulted in families being not only less capable of supporting family members but also less tolerant of unruly behaviour. In Scull's phrase, the asylum became a dumping ground for 'inconvenient people'. It is clear from contemporary admission documents, including private correspondence and diaries, that caring for a mentally ill relative put all sorts of emotional strains on families. Many strove in vain to keep the problem within doors. They struggled to cope with the verbal incongruities and indiscretions of people with florid delusions, or with the often frightening and wearing behavioural anomalies of those who were destructive, violent, despondent and self-harming. Most felt the strain of dealing with the associated problems of compromised working lives and interrupted sleep. Most admission records dwell on the troublesome, bizarre and traumatic nature of the behaviour of the mentally disordered. Such behaviour was likely to bring the insane into contact with the police and other authorities engaged in maintaining good social order. This is the basis of another explanation for the growth of asylums: that these institutions were used for the social control of deviancy. This thesis sees the asylum as an instrument for the (bourgeois) establishment of norms and social order, via the incarceration of those defined as socially, morally, politico-religiously and physically deviant and dangerous (Doerner, [1969] 1981; Goffman, [1961] 1990; Rothman, 1971). Ireland, where the insane and mentally disabled were confined (and conflated with the criminal) in accordance with the Dangerous Lunatics Act 1838, seems to provide particular evidence for the intensification of representations of insanity as 'dangerous in this period' (Walsh, 1999).

So were asylums geared to dealing with Scull's 'inconvenient people' or were they about confining disorderly persons who threatened bourgeois property and livelihoods? John Walton has made a detailed study of admissions to Lancaster County Asylum which presents some useful evidence for deciding between these two viewpoints.

### Exercise 5

Read 'Getting rid of "inconvenient people"?'.  


- 1 What does Walton conclude about the reasons for admission of persons to the Lancaster Asylum?
- 2 How does his work challenge the claims made by Scull?
- 1 Walton dismisses the idea that the asylum is used in any systematic way to deal with the 'disorderly poor' – although a small number of asylum admissions did come through the law courts. He also finds little substantial evidence that asylums served the function of quelling political or religious dissent: only a handful of patients seem to have been admitted on such grounds without other signs of mental disorder. He suggests that the machinery of asylum admission was simply too complex to make it an effective method of social control.

- 2 Walton argues that people admitted to the asylum were not the 'inconvenient people' of the Scull thesis but were, rather, 'impossible people'. Drink and violence, especially violence towards other family members, as well as deep depression and suicidal behaviour figured in over half of the admissions. There is little evidence that any failure to contribute to family income was a reason for incarceration. Walton argues that families did not dump their relatives in the asylum: institutional care was a last, not a first, resort. Family bonds and social networks were resilient under the pressures of hardship and destitution.

Other studies back up Walton's conclusions by showing that the police were rarely involved in committing lunatics. My study of Gartnavel Royal Hospital (Glasgow Lunatic Asylum) reveals that as many as 10 per cent of committals had some kind of police involvement, but that a large proportion of these patients came voluntarily to police stations, or exhibited highly delusive, dangerous or disruptive forms of behaviour. Others were sent to asylums at the behest of their families after getting into trouble (often repeatedly) with the police. Such findings do not entirely fit with the idea of close social control through intensified policing of Victorian societies.

There seems no doubt that, as Walton puts it, 'the roots of most asylum committals clearly lay in domestic troubles, as families at the end of their tether sought succour even though it meant the Poor Law and the asylum' (Walton, 1985, p.139). Does this mean that we should accept the views of contemporary commentators that families' increased willingness to confine individuals was the result of the availability of asylum accommodation? Was the growth of the asylum a result of the supply of places, or a real demand for such care? Given Walton's argument that families did look after mentally ill relations until the situation became difficult or even dangerous, and the way in which asylums were constantly forced either to expand, to rebuild or to refuse large numbers of applicants, the answer seems to be that there was a genuine demand for places, and not that working-class families were cynically exploiting a resource to deal with awkward family members. Almost invariably, the number of applicants exceeded the available accommodation, and the mounting waiting lists for admission suggest that the demand increased ahead of supply.

## 4.4 Outside the asylum walls: limits to the primacy of the asylum as a solution

Although historians have written about the asylum as the only response to insanity, there was in fact a widely used alternative. *Boarding-out*, or 'family care' of the insane, offered a genuine alternative to asylumdom. The exact form of boarding-out differed from one national and regional context to another, but basically it supported patients within domestic and often rural settings, generally with guardians or relatives in single dwellings and cottages. The practice had long been used by local authorities, but after the middle of the nineteenth century it was subject to much wider centralisation and official oversight. Boarding-out was widely used, from Gheel and Liemeux in Belgium to Dun-sur-Auron in France, and to Massachusetts in the USA. In Scotland, the Fifeshire village of Kennoway, where children had been long boarded by local parishes, was the best known and most touted of the Scottish initiatives (see Figure 6 in Section 4.2).



The practice was not without its critics. It was alleged that boarding-out was only practicable for a minority of the harmless, chronic insane and demented, and that patients were sometimes exposed to ill treatment. Yet there is evidence that by the 1870s many patients fared well in such settings (Parry-Jones, 1981; Sturdy and Parry-Jones, 1999). In Belgium and Scotland, and in some areas of France, boarding-out can be characterised as a mainstream solution to the problem of harmless chronic and imbecile patients who accumulated in asylums. While strong and growing fears about the propagation of the unfit meant that women were often boarded-out only post-menopause, and harmless female patients might be retained in asylums until past the age of fertility, the embracing of boarding-out as a policy under centralised supervision by the Scottish Lunacy Commissioners, in collaboration with local authorities, won plaudits and esteem from a wide range of international commentators and observers. In this context, a British approach to lunacy significantly influenced other contemporary international initiatives with family care of the insane, lunatic colonies and cottage asylums.

In addition, we know that a whole host of alternatives to asylums were tried for the convalescent, the nervous and even the more seriously mentally troubled among the middle and monied classes. Such alternatives ranged from home-based regimen and exercise routines, to visits to spas and hydropathic establishments, and to travel at home and abroad. These options were increasingly available to the lower middling classes by the end of the nineteenth century (Andrews, 2000; Oppenheim, 1991; Wright and Bartlett, 1999).

## 4.5 Section summary

This section has given some of the sense of how historians work – by developing explanations of historical events, which are in turn challenged by new research that re-examines these ideas. In the case of the nineteenth-century asylum, much of the research carried out since the 1980s is based on new sources and detailed case studies which test old explanations for the timing and causes of the growth of asylums. In part, this reflects a trend in other areas of medical history and in the broader field of social history.

The result has been to challenge the nature of the link between the growth of asylums and the forces of broader social change – urbanisation, industrialisation and capitalism.

Detailed work suggests that links between urbanisation and asylums are not straightforward: asylums did not grow up in large cities (which were thought to be inappropriate sites for such institutions), and their patients came from both urban and rural areas. Urban life did not necessarily undermine the social bonds within the family that helped to support a mentally disordered family member – families facing such a strain tended to stay put.

Admission to the asylum was not merely, and often not directly, a response to economic difficulty, but was also closely bound up with the longer-term emotional strain of dealing with violent and difficult family members. Its meanings were wider and more variable than has formerly been postulated in terms of the socio-economic and life-cycle pressures on families in variously configured industrialising, commercialising regions and societies.

Such findings suggest the need to recognise and explore personal experiences of dealing with insanity in different regions before patterns of resort to the asylum in the Victorian age can be explained.

It is difficult to pin down how changes in the treatment of the insane and the rising status of doctors specialising in mental disorder may have fed into the growth of asylums. While reforms within asylums – the replacement of physical restraint with moral therapy, and the domestication of asylum architecture, amenities and furnishings – undoubtedly made the

asylum seem a more pleasant place to the families of the insane, these reforms seem to come too late to explain the growth in asylum numbers. Similarly, improvements in the status of doctors dealing with asylum patients (which owed little to their ability to cure patients) came in the second half of the century, when the asylum had already achieved its place as an important (although as we have seen, not the only) means of dealing with the insane. New research on the roles of the legal and welfare authorities also suggests that we should not place too much weight on the role of medical men in driving change.

## Conclusion

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Exercise 1 Jacyna, L.S. (1988) 'The laboratory and the clinic: the impact of pathology on surgical diagnosis in the Glasgow Western Infirmary, 1875–1910', *Bulletin of the History of Medicine*, vol.62, pp.389–90 and pp.391–4. © The John Hopkins University Press.

Exercise 4 Scull, A. (1993) *The Most Solitary of Afflictions. Madness and Society in Britain, 1700–1900*, New Haven and London: Yale University Press.

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