‘A Lowly Sort?': Cardiff’s Medical Men, 1836-1858

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ABSTRACT

After the passing of the 1834 New Poor Law Act in England and Wales and despite any central planning, a nationwide network of doctors was established to provide medical care to the many destitute who, notwithstanding the new regulations, were still forced to fall back on the public purse. Most current scholars are of the opinion that these first state doctors were not members of society’s elite and were treated with disdain by their employers. However, the studies upon which this view is based have focussed entirely on the not inconsiderable number of complaints and scandals which came to the attention of a national audience. There is, therefore, a need for local studies to see whether, within the medical profession, the level of dissatisfaction documented by historians was truly representative.

The setting for this particular local study is the Cardiff Poor-Law Union in the first two decades following the implementation of the act. Analysis of contemporaneous newspaper accounts, the minutes of the meetings of the board of guardians and their correspondence with the Poor Law Commissioners in London, has allowed the documentation of the lives of all the poor-law medical officers working in Cardiff at the time. This research has revealed a much more nuanced picture than that depicted by the current historiographical consensus. For example, several doctors were already pillars of society when appointed to poor law roles and few, if any, seem to have been simply using the post as a stepping-stone to a more lucrative private practice. Grievances over pay and lack of respect were certainly present but it would be unwise to assume that this was the view of all poor-law practitioners since the study showed that disparities could be as great within as between unions. Indeed, it is even possible to challenge the widely held view that medical practice at the time was ineffective. Thus, evidence exists that, through the adoption of public health initiatives, Cardiff’s union doctors saved the lives of some of its poorest citizens which would otherwise have been lost to infectious disease.
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I declare that this dissertation is my own, unaided work and that no part of it has previously been submitted for a degree at The Open University or any other university or institution. Parts of this dissertation are built on work I submitted for assessment as part of A825.

ACKNOWLEDGMENTS

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1

Introduction

In May 1834, the second reading of the Bill for the Amendment and better Administration of the Laws relating to the Poor in England and Wales was passed in the House of Commons by an overwhelming majority of 319 votes to 20.¹ The New Poor Law, as it came to be known, arose out of the findings of the 1832 Royal Commission to assess the workings of the Old Poor Law but particularly reflected the political philosophy of just two men, Edwin Chadwick and Nassau Senior, who wrote the summary for the Commission. Chadwick and Senior believed that welfare payments from ratepayers were effectively subsidising lower wages. Once freed from this yoke of dependency, they argued, the benevolent hand of the market would intervene and secure higher wages for labourers. To encourage the poor to participate in this social experiment the new legislation sought to establish a ‘hostile environment’ in which fewer able-bodied men were eligible for relief and the conditions in the workhouse were so draconian that only the destitute would seek refuge there.²

Considering that poverty and sickness are inextricably linked, the New Poor Law was remarkably reticent about engaging with the medical profession.

¹ ‘Amendment of the Poor Laws (England)’, Hansard, 9 May 1834.
The only reference to doctors was to define them as one of the ‘officers’ that could be employed by a poor-law union, a list which included, amongst others, assistant overseers and vestry clerks. Chadwick, a lawyer, certainly shared this dismissive attitude to medical practitioners, believing there was no more justification for a Medical Commissioner on the Poor Law Commission than there was for a Bakery Commissioner to advocate on behalf of the men who supplied the bread to the workhouses. Most modern historians believe that Chadwick’s opinions set the tone for the respect afforded to medical officers appointed in the wake of the New Poor Law. Thus, Englander describes them as ‘lowly-sorts, overworked and underpaid’. This dissertation will investigate whether this perception was an accurate one.

The time period under consideration will be 1836-1858. Although the New Poor Law was enacted in 1834, 1836 was the year when the measures it contained initially took practical shape and the first new poor-law medical officers were appointed. 1858 is also seen as a significant year in the history of British medicine, marking, as it did, the foundation of the General Medical Council and the acknowledgement that the doctors on its register could call themselves members of a true profession. In practice, though, 1858 was not a landmark year for those already earning a living in medicine but it will

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3 House of Commons Parliamentary Papers (PP.), 1834 (581) Bill for the Amendment and Better Administration of the Laws relating to the Poor in England and Wales, p. 58.
serve as a useful time-point to denote the end of approximately the first two decades of medical services under the New Poor Law.

To date, most of the scholarship about the life of doctors working in the early years of the New Poor Law regime has been based on the research of historians surveying the national landscape. To assess the universality of the conclusions drawn by these authors, this study seeks to harness the power of local history with its added ability to follow the lives of individual practitioners over time. The local area chosen is that covered by the Cardiff Poor-Law Union and the research methodology employed is to meld together the differing perspectives of three readily available resources, local newspaper records, minutes of the Board of Guardians and correspondence with the Poor Law Commissioners (available online from the National Archives).

It is worth providing, here, a brief account of nineteenth-century Cardiff, not just as background, but because its social history is so intrinsically interwoven with its medical story. In 1801, there were 1,870 residents in the town, representing just twelve per cent of the 15,325 inhabitants of the territory which would later be incorporated within the Cardiff Poor-Law Union. By 1861, whilst the population of the rural areas had increased somewhat, rapid urbanisation meant that the then 32,954 town-dwellers constituted a fourfold greater proportion of the union’s 68,575 inhabitants. Insofar as any one man can be held single-handedly responsible for such enormous population growth, it was the second Marquess of Bute who was

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custodian of the family’s Glamorgan estate between 1814 and his death in 1848. He, it was, who, constructed the capacious Bute Docks, the first of which opened in 1839. This proved to be an opportune time as it coincided with the development of the Glamorganshire coal fields and set in train the expansion which, by the end of the century, would make Cardiff the busiest coal-exporting port in the world.  

People flooded into Cardiff seeking work building the docks and rail connections to the mining valleys, none more so than the Irish, driven from their homeland by the Potato Famine of 1847. As passengers, they were an attractive prospect for the ships’ captains plying their trade across the Irish Sea since they provided more readily unloaded ballast material than the usual shingle or lime. Once settled in Cardiff, many of these destitute individuals were forced to live in dreadful conditions. One of the best contemporaneous descriptions of the poorer quarters of the town was provided by the person sent to investigate the town’s sanitation requirements. Thomas Webster Rammell bemoaned the fact that ‘unassisted by science or prudence...floods, swamps, filth, miasma, ague and other disorders occur in fearful abundance’.

The dichotomy between the rural areas and the rapidly growing town, then, provides the context for this study into the lives of Cardiff’s medical men between 1836 and 1858. Chapter 2 considers what sort of person was

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9 Morgan, p. 164.
selected to be a union doctor and analyses what factors influenced the union’s board of guardians in making these appointments. Chapter 3 outlines the many causes for complaint identified by historians about the working conditions of poor-law medical officers and research is presented on whether these complaints held true in Cardiff. The question of whether the medical profession actually improved the health of the poor is addressed in chapter 4 and chapter 5 discusses the status of union doctors in civic society and the relationships between them and medical colleagues working in other care settings.
The Appointment of Poor-Law Medical Officers

*Background*

One of the more interesting observations from chapter one was the paucity of provision for medical services in the 1834 New Poor Law. Despite, or perhaps because of, this failure to produce precise legislation, almost all the newly formed boards of guardians divided their unions up into districts and appointed a medical officer for each. This new structure represented a consolidation of services since, prior to 1834, medical practitioners employed to attend the poor, where they existed at all, had been appointed by the overseers of individual parishes, of which there were many more than the newly created districts. Far from the new provision representing overkill, the wider availability of doctors merely served to highlight the unmet need under the previous arrangements. By 1844, there were over 2,800 district medical officers in England and Wales delivering in a few short years what one commentator has described as ‘one of the more remarkable social developments of the Victorian period.’

This burgeoning in the number of doctors employed essentially by the state does not mean the actual appointment process was without controversy. It was not unusual for medical men to have to submit tenders for a district

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medical officer’s job and for the post to go to the person who simply offered their services for the least amount of money.\(^2\) Moreover, as renowned Pathologist, Thomas Hodgkin, observed, a doctor who already had a large private practice could agree to take on poor-law work for nothing because he could sub-contract it to assistants who would even pay him for the privilege of doing so.\(^3\) In order to understand the extent of this ruthless application of market forces, it is, therefore, of interest, to see what situation pertained in Cardiff.

**The Medical Appointment Process in Cardiff**

The Cardiff Board of Guardians launched the Union on September 13\(^{th}\), 1836 and a fortnight later decided to combine the union’s forty-four parishes into four districts of roughly equal area (see map 2.1). The parishes of St. John’s and St. Mary’s, which comprised the town of Cardiff itself, were the most populous with the remainder of the union being largely rural (see table 2.1). Each district was to have a medical officer and the first salaries were agreed in advance (see Table 2.1).\(^4\) Amendments to split the Cardiff District in two and for the appointments to be subject to a tendering process were rejected.\(^5\) This arrangement held for four years but, in 1840, the Cardiff district was eventually sub-divided and a new medical district of Llandaff created. The

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\(^3\) Thomas Hodgkin, *On the Mode of Selecting and Remunerating Medical Men for Professional Attendance on the Poor of a Parish or District* (Lindfield: W. Eade, 1836), p. 4.

\(^4\) The National Archives (TNA), MH 12/16246/17, Letter from Thomas Watkins, Clerk to the Guardians of the Cardiff Poor Law Union to the Poor Law Commission (PLC), 27 September 1836.

\(^5\) Glamorgan Archives (GA), UC/2/1, Minutes Book of the Cardiff Poor Law Union (CPLU), 22 September 1836.
St. Nicholas district was also divided in two to form the West and East St. Nicholas districts (see map 2.2).

**Map 2.1 Configuration of the Medical Districts in the Cardiff Poor-Law Union, 1836**

Since the base map is of the Glamorgan parishes the three Monmouthshire parishes in the Cardiff Union, Rumney, St. Mellons and Vaen are not shown.

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Map 2.2  Configuration of the Medical Districts in the Cardiff Poor-Law Union, 1840

= Llantrisant  
= Caerphilly  
= Cardiff  

= East St. Nicholas  
= West St. Nicholas  
= Llandaff

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7 TNA, MH 12/16246/174 and MH 12/16246/181, Watkins to the PLC, 28 December 1839 and 4 April 1840.
Just three days after the districts were first agreed in 1836, an advertisement addressed to ‘Medical Gentlemen’ appeared in the major South Wales newspaper inviting anyone ‘wishing to undertake the duties of either district’ for the pre-determined remuneration to send a sealed application.\(^8\) At the next weekly meeting of the Board of Guardians, the Cardiff and Caerphilly posts were filled following a unanimous vote and a proposal to accept the successful candidates for the Llantrisant and St. Nicholas jobs carried by a majority. It is not clear whether there was more than one applicant for any of the roles or whether the voting was simply to decide whether to accept the applications or to re-advertise them.\(^9\)

**Table 2.1 First Medical Officer Appointments of the Cardiff Poor-Law Union** \(^{10}\)

<table>
<thead>
<tr>
<th>Medical District</th>
<th>Area (Miles(^2))</th>
<th>Doctor’s Salary</th>
<th>Population (1831 Census)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiff</td>
<td>36</td>
<td>£70</td>
<td>9837</td>
</tr>
<tr>
<td>St. Nicholas</td>
<td>36</td>
<td>£45</td>
<td>4507</td>
</tr>
<tr>
<td>Llantrisant</td>
<td>40</td>
<td>£60</td>
<td>5346</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>32</td>
<td>£45</td>
<td>5300</td>
</tr>
</tbody>
</table>

This, Cardiff Union’s very first exercise in employment, provides information which is highly pertinent to the historiography of poor-law medical officers. The lack of any guidance from the central state clearly meant that boards of guardians across England and Wales were making up the

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\(^8\) Cardiff Union, *The Cambrian*, 1 October 1836, p. 2.
\(^9\) GA, UC/2/1, CPLU Minutes, 8 October 1836.
\(^{10}\) TNA, MH 12/16246/174, Watkins to PLC, 28 December 1839.
rules as they went along. Thus, neighbouring unions were free to take a
different approach and did so. The Neath Union, for example, chose to
accept the services of a doctor prepared to do the work for the lowest
salary.11

It would be premature, however, to assume that the Cardiff Guardians always
showed doctors the respect of fixing their salary in advance since, for their
next appointment in 1840, they, too, used the tendering process.12 In fact,
this led to the dismissal of the incumbent medical officer when his previous
district was sub-divided. The clerk to the board was too discreet to record in
the minutes whether this was due to his asking for too high a salary!13

Overall, the approach of the Cardiff Guardians to the appointment of their
medical officers appears to have been pragmatic rather than doctrinaire.
When, within the year, the doctor who had won the tender mentioned above
became ill, they re-appointed the former holder of his office and when this
gentleman in turn became too ill to continue, the young man who had been
deputising for him for over a year, simply stepped up. By this time the Poor
Law Commissioners were also looking to abolish the discredited tendering
system, urging all boards of guardians to ‘make their selection of the officer
with reference to his qualifications and the place of his residence’.14 Despite
this injunction, in 1843, the Cardiff Guardians offered the West St Nicholas
job to the one applicant who did not possess the necessary dual qualification

12 ‘Cardiff Union’, The Cambrian, 29 February 1840, p. 2
13 GA, UC/2/2, CPLU Minutes, 12 March 1840
14 House of Commons Parliamentary Papers, 1841 Session 1 (327) Seventh Annual Report of the Poor Law
Commissioners, p. 5
of both the Licentiate of the Society of Apothecaries (LSA) and the Membership of the Royal College of Surgeons (MRCS). The Poor Law Commissioners would not wear this but when, four years later, the dual-qualified applicant stepped down, the Cardiff Union quietly appointed the unqualified (and hence hitherto unsuccessful) candidate to replace him. The guardians justified this U-turn on the grounds that the new appointee at least resided close to the district. Indeed, so adamant did they become that residency overrode all other factors that, by 1847, they were happy to advertise the Llantrisant district post with the specific clause that ‘preference will be given to any gentleman in or near the town of Llantrisant’.

In summary, appointment of medical officers for the Cardiff Poor Law Union did not follow a set pattern. If the job was advertised at all, the pre-conditions for each post varied depending on local priority and the imperatives that were uppermost in the Poor Law Commissioners’ minds at the time. One consistency is striking, however. No attempt was made to attract talent from further afield than Glamorgan and Monmouthshire. How ironic, then, that at a time when poor-law medical services were looking to appear increasingly professional, the one advertisement by the Cardiff Union that looked to cast its net wider than South Wales was for a nurse at a salary of a mere ten pounds per annum.

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15 Price, p. 30
16 Cardiff and Merthyr Guardian, 26 June 1847, p. 2.
The Poor-Law Medical Officers Appointed

The appointments made for each of the medical districts between 1836 and 1858 are shown in figure 2.1.

Figure 2.1 Poor-Law Medical Officers Employed in Each District of the Cardiff Union. 1836-1858

| District       | 1836 | 1837 | 1838 | 1839 | 1840 | 1841 | 1842 | 1843 | 1844 | 1845 | 1846 | 1847 | 1848 | 1849 | 1850 | 1851 | 1852 | 1853 | 1854 | 1855 | 1856 | 1857 | 1858 |
|----------------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| Caerphilly     |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |
| Cardiff        |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |
| Llandaff       |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |
| Llantrisant    |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |
| St. Nicholas   |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |
| East St Nicholas|     |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |
| West St. Nicholas |   |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |


The district of Llandaff did not exist until 1840 and the St Nicholas district ceased to exist after this date because it was split in two.

The first feature to note is that, in Cardiff, contrary to most historiographical accounts, by no means all the poor-law medical officer appointments were stop-gaps taken only to provide some income until a more lucrative private practice could be established. Of the twenty practitioners who worked for the Cardiff Poor-Law Union between 1836 and 1858, nine were union doctors for at least five of those twenty-two years. Another two, W.T. Edwards and Joseph Lewis, were appointed after 1854 so could not have fulfilled the criteria anyway and a further three, J. Prichard Thomas, Richard Jenkins and Thomas Woodwell Davies only relinquished the post because they were terminally ill.

If further evidence was needed that historians should be wary of the generalisation that a poor-law medical officer was a recent graduate trying to
find any work in an overcrowded market, it comes from the biographical data in table 2.2.

### Table 2.2 Age and Qualifications of Doctors who Served at Least a Year for the Cardiff Poor-Law Union between 1836 and 1858

<table>
<thead>
<tr>
<th>Doctor</th>
<th>L.S.A.</th>
<th>M.R.C.S.</th>
<th>M.D.</th>
<th>Age at First Post</th>
<th>Years Qualified on Appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bates, Edward</td>
<td>√</td>
<td>-</td>
<td>-</td>
<td>27</td>
<td>2</td>
</tr>
<tr>
<td>Davies, Daniel W.</td>
<td>√</td>
<td>√</td>
<td>-</td>
<td>39</td>
<td>10</td>
</tr>
<tr>
<td>Davies, Thomas W.</td>
<td>NK</td>
<td>NK</td>
<td>-</td>
<td>NK</td>
<td>NK</td>
</tr>
<tr>
<td>Davis, Evan</td>
<td>√</td>
<td>-</td>
<td>-</td>
<td>27</td>
<td>2</td>
</tr>
<tr>
<td>Edwards, Daniel I.</td>
<td>√</td>
<td>√</td>
<td>-</td>
<td>24</td>
<td>2</td>
</tr>
<tr>
<td>Edwards, Evan</td>
<td>Pre-1815</td>
<td>-</td>
<td>-</td>
<td>46</td>
<td>23</td>
</tr>
<tr>
<td>Edwards, W.T.</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>32</td>
<td>11</td>
</tr>
<tr>
<td>Evans, Edward</td>
<td>√</td>
<td>√</td>
<td>-</td>
<td>27</td>
<td>7</td>
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<tr>
<td>Leigh, John</td>
<td>√</td>
<td>√</td>
<td>-</td>
<td>24</td>
<td>1</td>
</tr>
<tr>
<td>Lewis, James</td>
<td>Pre-1815</td>
<td>-</td>
<td>-</td>
<td>45</td>
<td>24</td>
</tr>
<tr>
<td>Lewis, Joseph</td>
<td>√</td>
<td>√</td>
<td>-</td>
<td>26</td>
<td>5</td>
</tr>
<tr>
<td>Llewellyn, John</td>
<td>√</td>
<td>√</td>
<td>-</td>
<td>38</td>
<td>21</td>
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<tr>
<td>Paine, Henry</td>
<td>√</td>
<td>√</td>
<td>-</td>
<td>26</td>
<td>3</td>
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<tr>
<td>Sloper, Charles E.</td>
<td>-</td>
<td>√</td>
<td>-</td>
<td>30</td>
<td>4</td>
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<tr>
<td>Sloper, Richard</td>
<td>-</td>
<td>√</td>
<td>-</td>
<td>28</td>
<td>3</td>
</tr>
<tr>
<td>Thomas, J. Prichard</td>
<td>NK</td>
<td>NK</td>
<td>-</td>
<td>26</td>
<td>1</td>
</tr>
<tr>
<td>Williams, Edward</td>
<td>√</td>
<td>-</td>
<td>-</td>
<td>50</td>
<td>16</td>
</tr>
<tr>
<td>Wood, William H.</td>
<td>√</td>
<td>√</td>
<td>-</td>
<td>29</td>
<td>7</td>
</tr>
</tbody>
</table>

General Practitioners who had qualified prior to the introduction of the Licentiate of the Society of Apothecaries (L.S.A.) degree in 1815 were accepted as poor-law medical officers on a grandfather clause. 19

M.R.C.S. = Member of the Royal College of Surgeons

It can be seen that, whilst some of the poor-law posts were taken by men in their twenties who had just graduated, there were several who were born in the eighteenth-century and who, presumably, had been making a living out of medicine for at least a decade before they decided to apply to heal the pauper sick. There is also little evidence of medical graduates migrating from English or Scottish medical schools because they had spotted opportunities.

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18 Data assembled from censuses of 1841, 1851 and 1861 and UK and Ireland Medical Directories, 1845-1855, Ancestry <www.ancestry.co.uk> [accessed October – November 2021].

for employment in the rapidly expanding town of Cardiff. Sixteen of the men above were born in Glamorgan or Monmouthshire and Daniel Ithiel Edwards was only born in Middlesex because his Glamorgan-born father was as a doctor in London at the time.

**Conclusion**

The experience of Cardiff suggests that it would be wrong to assume, as some have done, that there was a consistent philosophy underlying the appointment of union doctors. At one time the post could be filled, without advertisement, by a local candidate known to have the right experience for the post, at another, the hated tendering process could be employed and the job given to the person prepared to do it for the least amount of money. At no time, though, did Hodgkin’s worst-case scenario of a doctor with a flourishing private practice taking on the role for nothing come into play.

Overall, if you were a doctor in the Cardiff area in the early Victorian era it was likely that you wanted to take up a poor-law appointment and there appear to have been few obstacles in your way other than waiting for the post to become vacant. That did not necessarily mean, however, that you would then be content with your lot and the possible sources of friction will form the basis of the next chapter.


Grievances

The previous chapter presented evidence that, when appointing its doctors, Cardiff generally avoided the worst excesses of some of the other poor-law unions. This chapter discusses whether the Cardiff union also bucked the trend when it came to dealing with issues which plagued the lives of poor-law medical officers in other parts of the country.

Chapter one introduced the idea that doctors of the time were seen as tradesmen rather than professionals. As Chadwick’s biographer put it, their contribution was regarded ‘as no more important than the supply of any other commodity’. Most modern historians believe that this perception was all pervasive and ensured that the first poor-law medical officers were seriously under-valued. Indeed, Flinn maintains that doctors only applied for poor-law posts in the first place because ‘the profession was often over-stocked’. The anonymous author of The Song of the Union Doctor would have had no argument with this analysis:

It’s O to be a slave  
To Poor-law Guardian’s rule;  
The day I first put on their yoke  
I was an egregious fool.

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There were two systemic issues which bred particular resentment amongst poor-law doctors in the first two decades of their existence. The first, unsurprisingly, was pay. Just two years after the first union doctors were appointed, the Select Committee of the House of Commons examining the implementation of the New Poor Law were left in no doubt that inadequate remuneration was a major cause of dissatisfaction amongst their number. Giving evidence in his capacity as President of the British Medical Association, George Webster, who also happened to be the Old Poor Law medical officer for Dulwich, reported that the new union doctor was to be offered a salary of just £30 a year for doing the same job for which Webster had previously been paid £80. Indeed, Webster revealed that, even though he had continued to provide the medical service for Dulwich’s paupers after the New Poor Law came into force, he had not been paid anything at all for about fifteen months.\(^5\)

His lobbying may have had some effect since some of the worst aspects of the poor law medical service, for example the tendering system and lack of remuneration for specialist procedures such as midwifery and fracture setting, were ameliorated by the General Medical Order of 1842.\(^6\) Inadequacy of salaries, however, remained a running sore. In 1848, the Committee of the Medical Officers of Unions in England and Wales petitioned the Home Secretary to improve the administration of medical relief to the poor. In their words, ‘amongst the grievances most generally

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\(^6\) PP. 1842 (389) *Eighth Annual Report of the Poor Law Commissioners*, pp. 75-78.
complained of are the low rate of pay...and the anomalous and unequal manner in which the payments are distributed’.\(^7\)

The other bone of contention for union doctors was a disrespect for their professional status. Their disquiet began early when the Poor Law Commissioners’ ruled that the decision as to whether a pauper could seek medical attention was to be taken by a layman, the union relieving officer.\(^8\) Even if a consultation was sanctioned, any medication required still had to be paid for out of the doctor’s own pocket.\(^9\) Perhaps most disrespectful of all was the readiness of the authorities to scapegoat doctors when deficiencies of the system reached the attention of politicians and the wider public.

Historians have become particularly interested in exploring this topic in recent years. Samantha Shave, for example, has reported on cases which were sufficiently notorious to come to the attention of parliamentary select committees in the decade or so after 1834. One such study, of the Fareham Union in Hampshire, recounts the story of three very young boys who were denied food by the workhouse-master as a ‘punishment’ for incontinence despite the regulations stipulating that only a medical man could alter dietary regimes. When this distressing story came to light, however, it wasn’t the master who was heavily censured but the workhouse doctor, Mr Blatherwick, who was said to have known the boys were ‘in a filthy state but made no

\(^7\) PP. 1854 (348) Report from the Select Committee on Medical Relief, p. 245.
\(^9\) Flinn, p. 49.
inquiry as to the cause of their infirmities’. Believing himself to be the victim of unjust attacks, Blatherwick felt compelled to resign.10

Kim Price has attributed an even greater degree of cynicism to some boards of guardians than trying to protect their own backs by blaming others. He argues that hardly any poor-law doctor could ‘plausibly carry out their duties effectively’ and that, in such circumstances, non-attendance when called out to the patient’s home was widespread and inevitable.11 Price, therefore believes it was commonplace for the authorities to turn a blind eye to such criticism only to revive the complaint as a weapon against the doctor if he had the temerity to ask for a pay rise.12

It can be seen, then, that a good case can be made for believing that all poor-law doctors had multiple reasons for seething with resentment. There is, however, an obvious flaw in accepting unquestioningly this version of history and that is that the starting point for the above-mentioned studies was always a problem or a complaint. In short, if it existed at all, the voice of the contented practitioner would not have been heard, either at the time or subsequently. Thus, to determine whether the stereotype of the downtrodden poor-law doctor is truly representative, studies are needed which look at the lot of all practitioners not just the disaffected ones. Such ‘bottom-up’ research has not been widespread but there are indications that the picture of doctors lacking support from their employers may not have been universal.

In 1840s Durham, for example, the board of guardians, far from being at loggerheads with its medical officers, actively lobbied the Poor Law Commissioners to increase their salaries. 

Likewise, in Bromsgrove, the jury at the inquest into the death of a child being treated for scabies found that the union doctor’s conduct had been injudicious and negligent but the guardians, knowing the doctor to be of previous good service, merely admonished him.

As noted in the introduction, the ready availability of primary sources makes Cardiff fertile territory for its own ‘bottom-up’ study. The two most contentious employment issues outlined above, low pay-rates and lack of support from the authorities will be considered in turn.

**Pay**

The Medical Officers Organisation may have complained about the arbitrary nature of their pay structure but, to better understand how this disadvantaged some individuals, it is worth considering the Cardiff payment structure in some detail. In chapter two, it was noted that the very earliest appointments made by the Cardiff Poor-Law Union were those of its four medical officers. Their salaries and workloads are given in Table 3.1.

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Table 3.1  Cost of Medical Services in 1839 in each District of the Cardiff Poor Law Union

<table>
<thead>
<tr>
<th>District</th>
<th>Doctor</th>
<th>Area (acres)</th>
<th>*Population</th>
<th>Cases 16 (per annum)</th>
<th>Salary (£ per annum)</th>
<th>Payment per Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caerphilly</td>
<td>Evan Edwards</td>
<td>20,480</td>
<td>6,304</td>
<td>104</td>
<td>45</td>
<td>8s 8d</td>
</tr>
<tr>
<td>Cardiff</td>
<td>James Lewis</td>
<td>23,040</td>
<td>13,103</td>
<td>352</td>
<td>70</td>
<td>4s 0d</td>
</tr>
<tr>
<td>Llantrisant</td>
<td>Evan Davis</td>
<td>25,600</td>
<td>7,094</td>
<td>120</td>
<td>60</td>
<td>10s 0d</td>
</tr>
<tr>
<td>St. Nicholas</td>
<td>Daniel Davies</td>
<td>23,040</td>
<td>4,527</td>
<td>132</td>
<td>45</td>
<td>6s 10d</td>
</tr>
</tbody>
</table>

* Population in 1839 calculated by assuming even growth between the 1831 and 1841 censuses

Even before comparing the Cardiff salaries with the national picture, it is clear from the table that the ‘anomalous and unequal’ pay-rates could apply within, as well as between unions. James Lewis’s slightly higher overall remuneration in no way compensated for his having more than twice the workload of his close neighbours. To make things worse, doctors who appeared before the select committees made much of the greater travel involved for practitioners in rural districts such as Llantrisant and St. Nicholas, not least because of the inevitable extra expense of keeping a horse or horses, but, even on this basis, Lewis seems to have been unfairly treated. 17 Whilst he could have walked the short distance from his house in the affluent part of Cardiff to many of his pauper patients, the distance from

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15 The National Archives, MH 12/16246/17, Letter from Thomas Watkins, Clerk to the Guardians of the Cardiff Poor Law Union to the Poor Law Commission, 27 September 1836.
16 TNA, MH 12/16246/174, Watkins to PLC, 28 December 1839.
17 PP. 1837-38 (518) Select Committee on NPL, p. 146.
Radyr in the north of his district to Lavernock in the south was still some fourteen miles.\textsuperscript{18}

The disparity between districts enacted at the very first meeting of the Cardiff Guardians set the template for the next twenty years. Even when more districts were created, care was taken to maintain the overall medical bill at roughly the same level which meant that salaries of existing medical officers were reduced if their district decreased in size and population. From time to time, the union doctors submitted individual requests for an increase in salary but these could be rejected as often as they were granted.\textsuperscript{19} At other times, in fairness, the guardians seemed to have increased pay of their own volition. The end result for the Cardiff Union was that, in total, the salary costs of doctors increased from £220 in 1836 to £305 in 1858, an outcome made slightly more acceptable by the fact that this was a time of zero inflation.\textsuperscript{20} What was far more significant, however, is that this was also a time when the population of the Cardiff Union increased very rapidly. Thus, on average, the financial rewards per head of population for a Cardiff Union doctor actually fell by over thirty per cent over this period (see figure 3.1).

\textsuperscript{18} ‘The Late James Lewis Esq.,’ \textit{Cardiff and Merthyr Guardian}, 31 March 1855, p. 3.
\textsuperscript{19} Glamorgan Archives, UC/2/2, Minutes of the Cardiff Poor Law Union, 27 March 1841 and UC/2/7, 3 October 1857.
\textsuperscript{20} GA UC/2/1 to UC/2/7, CPLU Minutes, 1836-1858; Measuring Worth<measuringworth.com> [accessed 7 November 2021].
Figure 3.1: Medical Salary Costs of the Cardiff Poor Law Union

Salaries taken from the minutes of the meetings of the Cardiff Board of Guardians, 1836 to 1857. Population assumes even growth in the years between the decennial censuses of 1831, 1841, 1851 and 1861.

Another way to contextualise this information is to observe that medical relief constituted just 2.2 per cent of the total relief bill. In this, Cardiff was below the Welsh average of 2.8 per cent but, in practice, there was nowhere where paying its doctors make a significant dent in a union’s expenditure.

Perhaps an even starker picture of the poor return for treating the poor comes from the realisation that the typical costs of medicine for each patient (which the doctor had to provide out of his own pocket) was 2s 6d. On that basis, James Lewis’s net income for treating one patient amounted to just 1s 6d (£6.75 at today’s prices).

Doubtless, there was some resentment within the union about the failure of pay to keep pace with the increased workload but the doctors would have

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21 GA, UC/2/1 to UC/2/7, CPLU Minutes
22 PP. 1844 (589) Appendices to Tenth Annual Report of the Poor Law Commissioners, pp. 308-311
been equally aware of the situation in the rest of England and Wales. William Farr, himself a doctor but by the 1840s effectively the government’s chief statistician, was particularly energetic in assembling the data with which to substantiate the poor-law medical officers’ claim for better treatment. In table 3.2, the Cardiff statistics have been interpolated within the tables which Farr produced for the 1838 Select Committee.

**Table 3.2 Medical Costs of the Cardiff Poor-Law Union Compared with Some English Areas**

<table>
<thead>
<tr>
<th>County/Union</th>
<th>Average Salary (£)</th>
<th>Average Population per Medical District</th>
<th>Salary Costs per Head (Pence)</th>
<th>Pauper Cases (% of Population)</th>
<th>Payment per Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dorset</td>
<td>57</td>
<td>3,514</td>
<td>4.2</td>
<td>11.0</td>
<td>3s 2d</td>
</tr>
<tr>
<td>Devon</td>
<td>37</td>
<td>3,332</td>
<td>2.8</td>
<td>7.3</td>
<td>3s 2d</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>42</td>
<td>5,550</td>
<td>2.4</td>
<td>4.2</td>
<td>4s 8d</td>
</tr>
<tr>
<td>Lancs/Cheshire</td>
<td>39</td>
<td>5,523</td>
<td>1.9</td>
<td>2.8</td>
<td>5s 6d</td>
</tr>
<tr>
<td>Norfolk</td>
<td>50</td>
<td>4,530</td>
<td>3.4</td>
<td>6.9</td>
<td>4s 1d</td>
</tr>
<tr>
<td>Wiltshire</td>
<td>63</td>
<td>4,050</td>
<td>4.5</td>
<td>19.4</td>
<td>1s 11d</td>
</tr>
<tr>
<td>Metropolitan</td>
<td>105</td>
<td>15,207</td>
<td>1.7</td>
<td>10.0</td>
<td>4s 7d</td>
</tr>
<tr>
<td>Cardiff</td>
<td><strong>55</strong></td>
<td><strong>7,757</strong></td>
<td><strong>1.7</strong></td>
<td><strong>2.3</strong></td>
<td><strong>6s 3d</strong></td>
</tr>
</tbody>
</table>

The first thing of note is that the Cardiff doctors had salaries broadly in line with those in English rural counties. However, because their districts were more populous (only St. Nicholas had a population similar to their English counterparts, see Table 3.1), their payment per head of population was lower than anywhere other than metropolitan London. This is in keeping with Poor Law practice.

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24 PP. 1837-38 (518) Select Committee on NPL, pp. 140-142.
Law Commissioner, George Cornewall Lewis’s data which put Glamorgan as second only to West Yorkshire as the county with the least well-funded poor-law medical services.25 It is, therefore, somewhat of a paradox that Cardiff’s payment per case is the most generous in the above table. To some extent this paradox is readily explained by how few cases the Cardiff Union doctors dealt with. However, this is only to push the problem one stage further back because it seems impossible to find a medical cause of Wiltshire, say, having a case-rate over eight times that of Cardiff. Two explanations, not mutually exclusive, seem possible. First, hard though Farr worked to provide persuasive information for the select committee, his efforts may have been undone by a failure to provide a uniform definition of what actually constituted a case. Second, in Cardiff, there may have been readier access to medical care through charitable and insurance-based schemes (for more detailed discussion see chapter 5). Such provision would have lessened the need for the poor to seek medical relief through the stigmatising mechanisms of the New Poor Law.

It should be recognised that a medical salary wasn’t the only source of income from public funds that was available to the union doctor. In Cardiff, it was accepted practice for poor-law medical officers to have first refusal on becoming the Registrar of Births and Deaths for their district. At 1s 6d a registration, this could add as much as £40 to the Cardiff district medical officer’s annual pay.26 If the public were alarmed by the thought that their

25 PP. 1844 (531) Third Report of Select Committee on Medical Poor Relief, p. 77.
26 GA, UC/2/2, CPLU Minutes, 18 December 1841.
doctor might have a financial incentive to hasten their demise, it was not recorded!

The fee for a smallpox vaccination was also initially 1s 6d but, in 1857, the Cardiff Board of Guardians accepted the national directive that a further shilling could be paid if the vaccinator had to travel more than two miles to deliver the inoculation. Partially as a consequence, in that year, Henry Paine earned £112 as a vaccinator, considerably more than the £75 he earned as a poor-law medical officer. However, in the rural areas with less inward migration, the financial benefits of being a vaccinator were less spectacular with an extra £20 - £25 being the typical reward.\(^{27}\)

Finally, the General Medical Order of 1842 had promulgated the idea that union doctors should be paid on a case-by-case basis for surgical and complex obstetric procedures. It wasn’t until 1848, however, that such payments were first recorded in the minutes of the meetings of the Cardiff Board of Guardians. Although not specified, this work was clearly not carried out solely on the basis of its occurrence in one’s district. Thus, although he was medical officer for the lightly populated East St. Nicholas district, Henry Paine often received over sixty per cent of the union’s total ‘extra medical fees’, adding another £60 to his earnings.\(^{28}\) It seems highly likely that, for surgical procedures, Paine replaced the Cardiff district doctor, James Lewis who, by 1848 was almost sixty years old and had entered the medical profession before qualifications in surgery even existed.

\(^{27}\) GA, UC/2/7, CPLU Minutes, 1 August 1857.

\(^{28}\) GA, UC/2/5, CPLU Minutes, 24 November 1849.
Although these extra sources of income clearly supplemented the pay of union doctors, they did little to assuage the sense of grievance at the inadequacy of the basic salary. When Richard Griffin launched his campaign to rectify this injustice, support from his fellow poor-law medical officers was widespread.29 The Cardiff fraternity were no exception and were among the first to commit to paper a pledge to support ‘the movement commenced by Mr. Griffin for an improved system of remuneration to poor-law officers’. 30

Support from the Authorities

When addressing the issue of whether the Cardiff Guardians created a supportive environment for their medical employees, it should be recognised that the board was not a monolithic structure and the guardians in different districts often took different approaches. Inevitably, their views were coloured by both their own backgrounds and, doubtless, the personality of the particular medical officer in their district. On the positive side, the town-based gentry and clergy who formed, in practice if not in statute, an executive group within the Board of Guardians, acknowledged that the union doctors could contribute experience and expertise to their meetings and extended a standing invitation to them to attend.31 This willingness to listen to its medical officers could result in far-reaching strategic changes, the decision in 1839 to divide the St. Nicholas district in two being made, not to

29 Richard Griffin, ‘The Weymouth Board of Guardians and Poor-Law Medical Officers’, Association Medical Journal, s3-3 (1855) 1097-1099
30 Henry Paine, ‘Meeting of Medical Officers of the Cardiff Union’, Association Medical Journal, s3-4 (1856) 372.
31 GA, UC/2/2, CPLU Minutes, 28 March 1840.
shorten the paupers’ journeys to see the relieving officer, but solely because the medical officer was struggling to reach the most distant parishes on his patch. 32

This constructive engagement between doctors and the board was not, however, seen in the largely rural district of Llantrisan where the predominantly farmer-guardians appear to have orchestrated a series of patient complaints against Evan Davis, the district’s medical officer. 33 The underlying problem was not so much Davis’ competence but his decision to live in Pontypridd just outside the Eastern border of the district rather than in Llantrisant town itself, which was some eight miles away on the district’s Western edge. 34

On top of these mixed signals from the board of guardians as to whether its doctors were to be treated as tradesmen or professionals, Cardiff’s doctors must have remained concerned that they would be scapegoated were there to be any external criticism of the poor-law medical services. Analysis of the only two cases where such complaints featured prominently in the local press suggests that these concerns might have been misplaced. The first series of allegations was made by a George Reece, himself a doctor but not a poor-law appointee, who ‘created much local excitement’ by insisting that the body of a young Irish woman, Margaret Flemming, be exhumed following her death in childbirth. At the subsequent inquest, the coroner’s jury returned a verdict

32 GA, UC/2/2, CPLU Minutes, 28 December 1839.
33 TNA MH 12/16246/256, William Day, District Commissioner to Cardiff Union to PLC, 1 May 1842.
34 TNA MH 12/16246/272, RF Rickards, Llantrisant to PLC, 3 Aug 1842
that ‘the deceased died in childbirth by the visitation of God’ and wanted it noted that ‘there does not appear the slightest ground for attributing any blame to Mr. Paine, who attended for the Union Surgeon, but on the contrary, his prompt and constant attendance in this case was most praiseworthy’.

Thwarted in his attempt to have Paine’s obstetric management censured, Reece then turned his fire on James Lewis, the union surgeon and Cardiff District poor-law medical officer who had asked Paine to deputise for him. The charge was one of ‘fraud practised on the ratepayers’ for receiving a fee from the Board of Guardians whilst actually paying a midwife to attend all the women in the workhouse who were in labour.

At their next meeting, the Board of Guardians’ response to these events was twofold. They noted their ‘great satisfaction’ that Paine had been exonerated but felt the allegations against Lewis should be addressed at a higher level by asking William Day, the Poor-Law Assistant Commissioner, to investigate. Far from scapegoating Lewis, Day seems to have accepted the necessity for a protocol for workhouse births which required the midwife only to seek medical assistance if complications arose. Moreover, he noted that the procedures put in place by Lewis’s predecessor (who happened to be George Reece’s uncle, Richard Reece) had been improved by Lewis who was now informed when a mother was in labour rather than only when the birth had taken place. Whilst accepting Day’s judgment, the Poor Law Commission did, however, stress that they could not permit the practice of a midwife

36 ‘George Reece, ‘The Late Inquest at Cardiff’, The Cambrian, 12 February 1842, p. 3.
37 GA, UC/2/2, CPLU Minutes, 19 February 1842
deputising for a medical officer, *except in the case of unavoidable absence* (my italics) and, consequently, they issued Lewis with a caution.\(^{38}\)

As alluded to earlier, the other Cardiff Union doctor to be the subject of allegations of medical neglect between 1836 and 1858 was the Llantrisant District Officer, Evan Davis. Although the Poor Law Commissioners dismissed these initial claims, they were concerned that Davis was also a poor-law medical officer for the adjoining Merthyr Union. Their instruction to the Cardiff Board of Guardians was unequivocal. ‘He cannot continue to hold two large districts in two adjoining unions.’\(^{39}\) The Cardiff chairman responded to this injunction by first ignoring it and then, nearly a year later, disputing the Llantrisant guardians’ evidence that their district, at 26,000 acres, was already much larger than the 15,000 acres recommended as a maximum in the General Medical Order of 1842.\(^{40}\) This was somewhat audacious as the clerk had, a few years earlier, submitted evidence to Somerset House that supported the larger estimate.\(^{41}\) Nevertheless, perhaps because he was noted to be ‘a large proprietor in this district’, the chairman was able to persuade the Commissioners that the citizens of Llantrisant were mistaken and Davis retained both his posts.\(^{42}\)

However, the complaints against Davis kept on coming. In February and March 1845, there were several allegations of failure to make home visits to patients despite an order to do so from the relieving officer. This time,
the executive of the Cardiff Board of Guardians was less sympathetic, writing to the Poor Law Commissioners that they ‘regret to find repeated complaints to the same effect’. 43 On this occasion, however, it was the Poor Law Commissioners who came to Davis’s rescue. Perhaps influenced by Davis’s assertion that ‘that there is some conspiracy against authority in his area’, they were prepared to concede that some of the complaints could not be substantiated. 44

Despite his chequered history, Davis’s association with the Cardiff Union continued for another two years. The final parting of the ways was caused by his role in the death of a travelling seller of trinkets, William Smith, when a coroner’s jury expressed the opinion that ‘the deceased’s case did not receive that degree of attention at the hands of Mr. Evan Davis, surgeon, which its urgency so evidently required’. 45 Davis was summoned to appear before the Board of Guardians the following week and, after hearing that the board concurred with the jury’s observation, he tendered his resignation. 46 Even now, though, the Commissioners allowed Davis to retain his post in the Merthyr Union; this despite Smith’s widow claiming that, when she had complained to Davis that ‘it was hard for a poor afflicted person to die of hunger’, he had replied ‘he may die; I can’t help it’. 47

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43 TNA, MH 12/16247/210, Watkins to PLC, 10 March 1845.
44 TNA, MH 12/16247/211, Watkins to PLC, 19 March 1845.
45 ‘Death Accelerated by Ill-Usage’, *Cardiff & Merthyr Guardian*, 12 June 1847, p. 3.
47 ‘Death Accelerated by Ill-Usage’. 
Conclusion

This chapter began with the observation that, because much of the history of the poor-law medical service has been written from a ‘top-down’ perspective, it is almost inevitable that examples of worst practice predominate, thereby creating the impression that a union doctor’s lot was grim across vast swathes of England and Wales. The bottom-up story, at least of the Cardiff Union, reveals a more nuanced picture. Salaries were commensurate with those in other parts of England and Wales but, because the doctors were responsible for districts with a higher population than the national average, their per capita payments seem rather miserly. On the other hand, if the data submitted by the union was accurate, their poor-law workloads were relatively light. Perhaps the most salient finding, though, is that inequitable remuneration could exist within, as well as between, unions, which should introduce a note of caution for historians seeking to make generalisations across regions.

There was, also, little consistency of approach within the union when it came to respecting the status of medical officers. In the rural districts, the relationship seems to have been rather more that of employer and employee whereas in the town of Cardiff itself there was greater recognition of the doctors’ professional standing. At national level, far from leaping to dismiss their medical staff at the earliest opportunity, the evidence of the Evan Davis case suggests that the Poor Law Commissioners sometimes retained people in post long after they should have accepted the veracity of complaints against them.
Improving the Health of the Poor

Previous chapters have dealt primarily with the difficulties of being a poor-law medical officer but this chapter addresses the question of whether, despite their tribulations, Cardiff’s doctors could also point to real achievements from their calling. Put simply, did the health of the poorer residents of the town and its surroundings improve between 1836 and 1858 and, if so, were the medical fraternity responsible? Before attempting to answer this specific question, though, it is worth reviewing the historiographical debates which surround a more wide-ranging and challenging question, viz, did any doctors in the U.K. contribute to the increased life expectancy enjoyed by the Victorians as the nineteenth-century progressed?

For many years, historians believed the answer to this question was largely no. This consensus sprang from the seminal conclusions of McKeown and his colleagues who carried out a painstaking analysis of the Decennial Supplements to the Annual Reports of the Registrar-General. McKeown calculated that the annual standardised mortality rate dropped from 22,000 per million to 17,000 per million between the 1850s and 1900s and presented persuasive evidence that much of the increased life expectancy could be attributed to a reduction in infectious diseases. Thus, about fifteen per cent of the reduction in mortality was due to the eighty per cent reduction in
deaths from scarlet fever. However, it is now generally believed that this was due to the scarlet fever bacterium mutating to a less virulent strain rather than to better health measures. ¹ Another half of the reduction in mortality from infectious diseases came from the improvement in the outcome for a single condition, tuberculosis (TB).² McKeown argued that the only explanation for this advance was the gradual improvement in the poor’s nutritional intake over the course of the century. Since neither the reduced mortality from scarlet fever or TB owed anything to medical intervention, McKeown concluded that ‘specific preventive or curative measures could have had no significant influence on mortality before the twentieth century’.³

This conclusion was not seriously challenged for nearly thirty years. In 1988, however, Szreter questioned whether the life expectancy of the Victorians really did increase in the continuous manner one would have predicted from a gradual but sustained rise in nutritional intake. Of special relevance to the timeframe of this dissertation, was Szreter’s assertion that TB mortality, in particular, did not decline consistently until after 1866-7.⁴ It would therefore be unrealistic to expect any noticeable impact on this disease in Cardiff between 1836 and 1858. Furthermore, whilst agreeing that pharmacological treatment was virtually non-existent in the mid nineteenth century, Szreter also criticised McKeown for being too ready to dismiss the doctor’s

² McKeown and Record, p. 104.
³ McKeown and Record, p. 94.
contribution to reducing mortality from infectious disease through his involvement in public health improvement.⁵

There were two specific pieces of legislation enacted during this period which potentially empowered the medical profession to play a significant part in the prevention of fatal illness. The first of these saw the state, for the first time, assume responsibility for delivering a nationwide vaccination programme, albeit that, at the time, smallpox was the sole disease for which such a preventative strategy was possible. The only ubiquitous infrastructure through which the government could fulfil this ambition was a local board of guardians so, after 1841, the poor-law doctors were in the vanguard of ensuring the successful roll-out of the programme. Thus, this was also the first time in British history that a medical intervention was offered to pauper and non-pauper in equal measure.⁶

The second parliamentary edict which paved the way for doctors to have a role in preventing as well as treating disease was the Public Health Act of 1848, the impetus for which had come from Edwin Chadwick’s Sanitary Report in 1842. The act enabled a town or borough to commission a public enquiry into its sanitation if sufficient ratepayers requested one or if the death rate was greater than 23 per 1000 living over a five-year period. Tellingly, it also allowed for the appointment of a Medical Officer of Health

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⁵ Szreter, p. 16.
though it was to be more than twenty years before such a post became mandatory.\textsuperscript{7}

\textit{Overview of Cardiff’s Mortality Statistics}

The rest of the chapter addresses the question of whether 1840s Cardiff used the above acts of parliament to its advantage and whether, by doing so, its experience validated Szreter’s contention that Victorian medicine was indeed capable of reducing mortality. However, before looking in greater detail at the effects of vaccination on smallpox rates and sanitation on infectious diseases, it will be helpful to identify the challenges facing the medical practitioners of the era. Cardiff’s mortality data between 1847 and 1866 are plotted in figure 4.1. Whilst this period extends beyond that strictly covered by this dissertation (1836-1858), this is thought to be a valid exercise because measures put in place before 1858 might not have shown any effect for some years.

With regard to the crude mortality data, the first thing to note is that mid nineteenth-century Cardiff was not a healthy place to live. For the first five years of the twenty, the average mortality rate was 36.7 per 1,000 living. To put this in context, the all-Wales mortality rate in 1851 was only 24.7 per 1,000 and even in a major city like London the rate was only 29.1 per 1,000.\textsuperscript{8} By the last five years of the two decades, Cardiff’s average mortality rate had


\textsuperscript{8} House of Commons Parliamentary Papers, 1851 (1416) \textit{Twelfth Annual Report of the Registrar-General for Births, Deaths and Marriages}, p. 10.
fallen to 23.2 per 1,000, a level actually below the Welsh average for 1861 of 24.1 per 1,000.\textsuperscript{9}

**Figure 4.1 Cardiff Mortality Rates, 1847-1866** \textsuperscript{10}

63\% of deaths in the ‘other’ category were accounted for by four conditions: convulsions (a non-specific diagnosis confined almost exclusively to children under the age of 5 which probably included some infectious deaths), ‘atrophy/debility’, old age and inquests or unknown causes.

The apparent improvement in death rates may be more illusory than real, however. No data is available prior to 1847 and that year and the four subsequent ones saw two epidemics of infectious disease in the town. The first was an outbreak of typhus imported by the starving Irish fleeing the Potato Famine. Overcrowded living quarters onboard ship or once they arrived in Cardiff merely accelerated the disease’s spread.\textsuperscript{11} The second major factor contributing to an increase in mortality was the cholera outbreak

\textsuperscript{9} PP. 1866 (3712) Twenty-seventh Annual Report of the Registrar-General for Births, Deaths and Marriages, p.94.
of 1849, of which more later. Taken together, these two epidemics almost certainly mean that the very high rates of mortality between 1847 and 1851 were a statistical outlier, not wholly representative of the true background levels of sickness before that time.

The Municipal Response to Cardiff’s Ill-Health

Despite these reservations about the long-term trend in Cardiff’s mortality rates, the data for the late 1840’s were such that, under the 1848 Public Health Act, a sanitary inspection could have been imposed on the town. In fact, driven by the coroner, the authorities were pro-active in trying to improve conditions. In May 1849, ‘the alderman, burgesses and inhabitants of the town of Cardiff’ petitioned the General Board of Health, ‘praying that a Superintendent Inspector be directed to visit them’.

Next month, a Local Board of Health was convened which was to go on to have substantial medical representation, albeit that the doctors were eligible for the committee in their other capacity as aldermen or town councillors. It wasn’t until 1853, though, that the decision was made to appoint a Medical Officer of Health. The board then had the added good fortune of finding a doctor who was so convinced that the role would allow him to improve the lives of Cardiff’s poorer citizens that he had even been prepared to do the job for nothing. As the position was now official, though, Henry Paine was at least

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12 The National Archives, MH 13/48/83, Petition to the General Board of Health from R Lewis Reece, Coroner, May 1849.
13 Cardiff Board of Health’, Cardiff and Merthyr Guardian, 28 September 1850, p. 2.
given a small salary of £30 per annum. He was to be Cardiff’s Medical Officer of Health for the next thirty-three years.

*Airborne Epidemic Diseases*

Encapsulated neatly in Paine’s own writings, the consensus view of the public health experts of the day was that eight interventions existed which could lessen deaths due to communicable disease. They can be précised as removal of noxious smells (from stagnant water, sewage and decomposing animal and vegetable matter), provision of a clean water supply and reduction in domestic overcrowding. Armed with our current understanding of the mode of transmission, only the last of these measures could conceivably have impacted on airborne pathogens but were Paine’s efforts successful in this regard? It has already been noted that no progress was made in reducing endemic respiratory diseases such as TB till later in the century but, to answer the question for other airborne microbes, it will be instructive to see whether there was any impact on diseases which presented as epidemics. Two of the most virulent were measles and scarlet fever and mortality rates in Cardiff due to these causes are shown in figure 4.2.

It can be seen that, although the death rate from measles was generally low, on occasion it could be a significant killer. In 1854, for example, the 96 deaths which it caused put it second only behind cholera as a cause of death and this was a year in which there was a major cholera outbreak. Scarlet fever, too, occurred in outbreaks and could wreak a high death toll. In 1863,

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14 ‘Cardiff Board of Health’, *Cardiff and Merthyr Guardian*, 16 April 1853, p. 3.
15 Paine, 1866 Report, p. 23.
it was easily the major single cause of death, its 158 victims accounting for 18 per cent of total Cardiff deaths that year.

Figure 4.2 Deaths of Cardiff Inhabitants due to Scarlet Fever and Measles

It is clear that no measures adopted before 1858 prevented outbreaks of either measles or scarlet fever but Paine could claim, with some justification, that lack of local autonomy had thwarted his attempts to tackle overcrowding. He wanted to set his own standards for the amount of sleeping and living space each occupant had to be granted but the Poor Law Board pointed out that, whilst the law authorised actions like removal of pigs on finding a dwelling-house in ‘a filthy and unwholesome condition’, such drastic measures did not

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16 Paine, 1866 Report, p. 2.
extend to its human occupants. Paine experienced resistance, too, from the supposed beneficiaries of the new public health medicine although his disparaging attitude may not have helped. When trying to enforce the ‘proper amount of privy accommodation’, he couldn’t help remarking that ‘the filthy habits of the lower class of Irish labourers’ necessitated constant inspection to maintain the sanitary standards to which he aspired.

The other most feared epidemic spread by respiratory and/or contagious transmission was smallpox but, as mentioned above, this was also the one disease for which a specific prophylactic procedure, vaccination, was available. With the exception of the town of Cardiff’s union doctor, James Lewis, all the district medical officers became public vaccinators. Despite the legislation being passed in 1841, the Poor Law Commissioners did not request information on infant vaccination numbers until 1845. As figure 4.3 demonstrates, when they did, they found that, initially, over eighty per cent of the children born in the Cardiff Union in the previous year had been vaccinated before their first birthday. This impressive rate, however, fell in subsequent years to as low as twenty per cent, recovering somewhat only when a smallpox outbreak focussed minds on the seriousness of the disease.

17 TNA, MH 12/16249/332, Watkins to PLB, 5 April 1853; MH 12/16249/333, PLB to Watkins, 14 April 1853.
18 Paine, 1866 Report, p. 12.
Figure 4.3 Infant Vaccination Rates (1845-1853) and all Smallpox Deaths (1847-1858) within the Cardiff Union

As figure 4.3 also demonstrates, Cardiff’s worst smallpox outbreak in the two decades either side of the 1848 Public Health Act occurred in 1857. As Dr. Seaton, the Medical Officer of the Privy Council’s investigator for South Wales, was to remark later, ‘in some of the Welsh Unions, as at Cardiff and Merthyr Tydfil, there had been a mortality scarcely credible. Despite Seaton’s implied criticism, in his analysis of the 1857 outbreak, Paine attempted to show that the aetiology was more complex than simple failure to vaccinate in the areas of greatest destitution. Thus, in the Newtown area of Cardiff, known colloquially as ‘Little Ireland’, four adjoining streets were particularly hard hit by the epidemic. An astonishing 1722 people lived in

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this area’s 127 houses, an average of 13.6 per house. Despite the underlying poverty, as table 4.1 shows, the children’s vaccine uptake had been good and, with only three per cent of the vaccinated contracting smallpox, proved successful in preventing disease.

**Table 4.1 1857 Smallpox Outbreak Amongst Children in Four Streets in Newtown, Cardiff**

<table>
<thead>
<tr>
<th>Vaccination Status</th>
<th>Cases of Smallpox</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Vaccinated</td>
</tr>
<tr>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>608</td>
<td>86</td>
</tr>
</tbody>
</table>

Paine was rightly proud that there were only four smallpox fatalities in the four streets although it must be said that this means there were a further 157 deaths in the rest of Cardiff, a finding upon which he spent much less time in the rest of his report. As figure 4.4 shows, Paine’s reticence may have stemmed from a reluctance to highlight to his Local Board of Health, disparities in the vaccination coverage between the Cardiff Medical Districts. The data, also, demonstrate the advantage of a local history study for adding granular detail. For example, years in the mid-1840s when vaccination in West St. Nicholas and Llantrisant was almost non-existent, coincided with a changeover in the district medical officer. It is of interest that the Board of Guardians did not apparently see the hiatus as grounds to seek a locum vaccinator in the meantime.

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Figure 4.4 Vaccination Rates for Individual Cardiff Medical Districts, 1844-1853*22

*Since both adult and infant data are included, the actual rates of vaccination have been calculated per head of total population.

Waterborne Epidemic Disease

Having looked at epidemics in which microbes are transmitted through the air, the narrative now shifts to a disease in which the bacterium was ingested, namely cholera. Between 1847 and 1866 there were 1,402 deaths from smallpox, measles or scarlet fever in Cardiff and only 594 from cholera.23 Nevertheless, it seems to have been cholera that loomed largest in the public’s anxieties, with warnings as early as the Spring of an epidemic year that warm weather would see the return of the disease ‘like some destroying angel’.24

22 For source of data, see footnote (17)
Before analysing how Cardiff dealt with the visitations of the ‘destroying angel’, it will be necessary to examine the preventative options that were available to mid-nineteenth-century physicians. Although at this time John Snow was engaged in his ground-breaking work proving the waterborne transmission of cholera, the medical consensus remained that infections were passed through pathogenic emanations in the atmosphere, referred to as miasmas. At the time, these two theories of transmission were not the polar opposites they appear today. It was believed that, for epidemics to occur, there had to be both a pre-disposing cause and an excitant one. John Sutherland, for example, in his report to the General Board of Health on the 1854 cholera outbreak in London described how some commentators thought that water contained the specific poison of cholera, an excitant, whilst others believed that water containing rotting organic matter which was a powerful pre-disposing factor for the disease. This ill-defined concept of aetiology meant that a preventative strategy could ‘accommodate virtually any pattern of observed data’.

In common with the rest of the U.K., Cardiff suffered two cholera outbreaks between 1836 and 1858. The epidemic of 1866 will also be considered to see if lessons were learnt from these two earlier brushes with the disease. The mortality data is shown in figure 4.5.


The graph demonstrates clearly that in most years there was an almost complete absence of cholera deaths but when epidemics struck in 1849 and 1854, they contributed significantly to spikes in the overall death rate. It is noticeable, too, that the numbers of fatalities fell with each successive outbreak. Assuming this was not down to chance, either the cholera strain became less virulent as time went on or medical intervention became more effective.

Taking the former possibility first, the only direct attempt to estimate the cholera case-fatality rates in 1849, 1854 and 1866 seems to have been a small study of the first fifteen 1854 victims conducted by Paine. All fifteen were residents of overcrowded Irish lodging-houses and no less than nine (sixty per cent) of these sadly succumbed to the illness. Thus, even if the fatality rate had been one hundred per cent in 1849, this could not account for the

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almost fourfold number of deaths in the earlier outbreak. Furthermore, in the 1866 outbreak, while Cardiff was suffering 47 deaths, in nearby Neath, a Union district of almost identical population, a dreadful 476 people were losing their lives to the disease. It would appear, therefore, that any natural reduction in the potency of the causative vibrio cholerae bacterium can be discounted.

Cardiff’s apparent success in fighting the disease must, therefore, have been due to better treatment or better prevention or both. The one change in management between the 1849 and 1854 outbreaks was a move towards nursing the patient at home rather than in an isolation hospital. This difference in practice was made on the advice of John Sutherland who wrote a report on the national response to cholera and visited Cardiff in June, 1849 at the height of the cholera death-toll. Sutherland maintained that there was a 19.5 per cent improved survival chance for patients left in their own dwellings. Even if Sutherland’s suspiciously precise estimate was right, though, this small reduction in the case-fatality ratio cannot explain the significant improvement in the Cardiff death-rates over the course of the three cholera epidemics. One is, therefore, forced to conclude that, after the 1849 experience, more effective public health measures must have been taken to prevent the spread of the disease.

That Henry Paine, the Medical Officer of Health, was able to achieve this is interesting since he was a staunch disciple of now discredited miasma theory.

30 Paine, 1866 Report, p. 27.
A dozen years after Snow had had the handle removed from the Broad Street pump, Paine still blamed the death of a farmer on ‘a cesspool exposed to the sun and poisoning the atmosphere with foetid exhalations’. More than bad smells being a source of disease, however, Paine, like almost all his colleagues, would have agreed with Chadwick’s dictum that ‘filth causes fever’. During the 1854 outbreak, whilst endorsing Sutherland’s advice to leave a cholera sufferer in their own home, Paine added an extra element to his strategy by removing the other occupants of the dwelling to an isolation hospital. There, they were carefully observed for signs of illness and, more importantly, this allowed a thorough disinfection of their home to be carried out. Clean water was beneficial, not because it could be drunk but because it could be used as a cleansing agent. It wasn’t until thirty years later that Paine claimed credit for another intervention that probably also contributed greatly to containing the cholera. He prohibited the use of well-water in a part of the town that had suffered greatly in the 1849 outbreak, reducing the deaths from sixty-six to six. Even though he did not subscribe to the germ theory of cholera at the time, concern with pure water supply was entirely consistent with his sanitarian principles, a nice example of practical medicine getting the right result for the wrong reasons.

33 Hamlin, p. 110
34 Paine, 1854 Report, p. 19
Conclusion

This chapter has tried to analyse whether McKeown was correct in asserting that nineteenth-century doctors in general, and poor-law officers in particular, were impotent in the face of disease. In the absence of much in the way of treatment options, an investment in new public health strategies was the only way a realistic campaign against sickness could be waged but, in Cardiff at least, poor-law medical officers were at the forefront of such initiatives. Deaths from cholera, seem to have genuinely fallen as the years progressed and by restricting access to contaminated water supplies, Paine, as Officer of Health, can probably take credit for this. His accomplishments against airborne pathogens were less but this was not from want of trying. He warned persistently of the dangers of overcrowding in the poorer districts but was powerless to effect the changes needed. On the minus side, the data show that Cardiff displayed marked inter-district variation in the coverage of the smallpox vaccination programme and there is no evidence that the Board of Guardians took overarching responsibility for its success.

With this exception, though, Cardiff’s public health response seems to have been consistent with best practice at the time. If the doctors failed to prolong the life of its inhabitants to any great degree, it was not because they were far removed from an enlightened Metropolis but because they belonged to a profession which was still struggling to be effective on a national scale.
Relationships and Status

Thus far, this dissertation, by concentrating on the role of the poor-law and public health medical officers, has neglected to assess their position within the wider community. With the unique advantage that a local history brings of being able to follow individuals over the course of a career, this chapter seeks to address this omission. The relationship of the union doctor with his non-poor-law medical colleagues will be considered as will his status in wider civic society.

Who Were Cardiff’s Doctors?

To analyse these issues, a useful first step is to gauge how many of Cardiff’s medical fraternity were not participating in poor-law medical services. *Hunt’s Directory* of 1849 identified the town of Cardiff as having just ten men who were doctors, comprising two physicians and eight surgeons (see table 5.1). This list was only missing two doctors who were named in the U.K. and Ireland Medical Directory of the following year. One of these two, Richard Reece, was seventy-nine and had retired from active practice and the other, Alfred Andrews, was the house surgeon at the Glamorgan and Monmouthshire Infirmary.
Table 5.1  Cardiff Physicians and Surgeons in 1849

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Age</th>
<th>Union Doctor</th>
<th>Years Qualified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moore, John</td>
<td>Physician</td>
<td>69</td>
<td></td>
<td>Pre-1815</td>
</tr>
<tr>
<td>Vachell, C. Redwood</td>
<td>Physician</td>
<td>36</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>Edwards, William T.</td>
<td>Surgeon</td>
<td>28</td>
<td>√</td>
<td>5</td>
</tr>
<tr>
<td>Evans, Edward jnr.</td>
<td>Surgeon</td>
<td>36</td>
<td>√</td>
<td>15</td>
</tr>
<tr>
<td>Evans, Thomas</td>
<td>Surgeon</td>
<td>34</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Jenkins, George H.</td>
<td>Surgeon</td>
<td>32</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Lewis, James</td>
<td>Surgeon</td>
<td>58</td>
<td>√</td>
<td>Pre-1815</td>
</tr>
<tr>
<td>Paine, Henry J.</td>
<td>Surgeon</td>
<td>33</td>
<td>√</td>
<td>10</td>
</tr>
<tr>
<td>Reece, John R.</td>
<td>Surgeon</td>
<td>24</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Williams, Edward</td>
<td>Surgeon</td>
<td>52</td>
<td>√</td>
<td>18</td>
</tr>
</tbody>
</table>

Note that the towns of Pontypridd, Llantrisant, Cowbridge and Caerphilly (where other doctors in the Cardiff Union were resident) had separate entries in the Hunt’s Directory.

The observation that fifty per cent of the doctors in the table already were, or were going to be, union doctors in the decades either side of 1849 points to another area in which Cardiff was at odds with the dominant historical narrative. Thus, at a national level, only one in six doctors held a poor-law post. Furthermore, although the table suggests the medical practitioners could be neatly divided between union and non-union doctors, it would be a mistake to assume the latter group were insulated from the woes of the pauper community. John Moore, for example, was an almost omnipresent member of the Local Board of Health and Charles Redwood Vachell was the

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son of Charles Vachell, a ‘druggist’ who was Mayor of Cardiff and a prominent member of the Poor-Law Union Board of Guardians. Thomas Evans, whilst not officially a union doctor, became a public vaccinator when James Lewis forsook the role and also was responsible for one of the three districts into which Cardiff town was sub-divided during the cholera epidemic of 1849.³ John Reece, too, was recognised for his dedication to the poor during the outbreak by the presentation of a silver snuff-box.⁴

Being few in number and inevitably interacting when it came to public health matters, the Cardiff medical fraternity seem to have been a relatively close-knit community. This impression is heightened when one digs into the familial connections of the gentlemen in question. Edward Evans jnr. and Thomas Evans were brothers and the sons of Edward Evans, a Cardiff practitioner of longstanding. They also became Henry Paine’s brothers-in-law when he married their sister in 1845.⁵ W.T. Edwards was the son of Evan Edwards, poor-law medical officer for Caerphilly and the cousin of Daniel Ithiel Edwards who took over the Caerphilly post when his Uncle Evan died (see figure 2.1). W.T. Edwards married a Mary Paine whom one author has claimed was Henry Paine’s sister but, if she was related to Henry, the census suggests she was a more distant relative than that.⁶ As final proof that Cardiff, despite its rapid growth, still had the professional characteristics of a small town, John Reece was the nephew of Dr. Richard

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³ The National Archives, MH 13/44/87, Letter from R Lewis Reece, Coroner to the General Board of Health, 1 June 1849.
⁵ ‘Married’, The Cambrian, 30 August 1845, p. 3.
Reece (mentioned in an earlier paragraph) and a cousin of the (non-medically qualified) coroner, Lewis Reece.7

**Friendly Societies**

It can be seen that, for a not insignificant proportion of Cardiff doctors, family ties meant that a practice could be inherited and, thus, they never had to experience the difficulties of building up a remunerative private clientele. It should be noted, however, that, nationally, there was a tier of patients who were neither sufficiently wealthy as to be able to pay the fees charged for a private visit nor sufficiently poor that they had to apply to the relieving officer for medical assistance and thus accept the stigma of being labelled a pauper. This third tier were lower middle-class or working-class individuals in regular employment and they funded their medical care through an insurance-type system. Small weekly contributions to a friendly society paid for doctors to attend in times of sickness and covered funeral expenses should his efforts prove in vain. In practice, the records of these societies suggest the ailments treated were predominantly a cause of morbidity not mortality and were often work-related such as industrial accidents, back pain from manual labour and bronchitis.8

There appear to be no records in the archives to establish which doctors provided the medical cover for the friendly societies in the Cardiff area but newspaper reports do provide some information. Certainly, it seems probable

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7 *The Death of Mr. J.R. Reece*, *South Wales Daily News*, 12 May 1873, p. 3.
a number of doctors must have been involved since large employers such as the Melingriffith Tinplate Works and Bute Docks insisted on their employees subscribing to the works benefit societies. Moreover, there were other friendly societies for the wider community, some of local origin such as the Cardiff Benefit and Annuitant Society, for whom, amongst his numerous other commitments, James Lewis acted as surgeon. In 1849, this society had ninety-three subscribers and paid out £47 11s on behalf of its sick members although not all the money necessarily went to Lewis as some of this sum may also have been compensation for loss of wages. The nationwide Oddfellows Manchester Unity also had lodges in Cardiff. Their retained doctor was Thomas Evans who, in 1848, was presented with ‘a very handsome and complete set of medical and surgical works’ for ‘the kindness, humanity, and uniform attention in the discharge of his onerous duties as surgeon of these lodges’.

Hospitals

This discussion of the similarities and differences of poor-law and non-poor-law doctors has so far concentrated on the provision of what would now be recognised as general practice. There remains the question of how the two groups differed in their delivery of in-patient care. It was recognised early on that one of the tasks of a poor-law medical officer was to treat those paupers whose disease had actually necessitated their admission to the workhouse. These practitioners have largely been depicted by historians as

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10 ‘The Late James Lewis Esq.’, *Cardiff and Merthyr Guardian*, 31 March 1855, p. 3.
‘third-rate doctors who neglected the needs of sick paupers and did little to prevent guardians from denying inmates new forms of treatment.'\textsuperscript{13} Anne Digby, in her studies of rural Norfolk, agrees about the poor quality of care for pauper in-patients but attributes this not to medical incompetence but, rather, to the powerlessness of poor-law medical officers in the face of the ‘prejudice, parsimony and ignorance of boards of guardians’.'\textsuperscript{14} There is another story, however. Angela Negrine, whilst agreeing that doctors of the time viewed voluntary hospitals as a more prestigious environment than the workhouse infirmary, nevertheless concluded from her research on Leicester that ‘the medicine practised at the workhouse exceeded expectations and confounded the traditional image’.'\textsuperscript{15}

The evidence suggests that, Cardiff, too, between 1836 and 1858 confounded the traditional image. Like almost all workhouses of the time, when it was opened in 1839, the new Cardiff Workhouse did not have a separate infirmary but the demands imposed by the typhus outbreak of 1847 necessitated that the old workhouse was re-opened but this time serving the specific function of being a pauper fever hospital.'\textsuperscript{16} The only other institution in the town providing medical care, the voluntary hospital, was almost exactly contemporaneous with the erection of the new workhouse. In 1834, the committee that ran the dispensary (which itself was very much the brainchild


\textsuperscript{16} Glamorgan Archives, UC/2/4, Minutes of the Cardiff Poor-Law Union, 31 July 1847.
of Dr John Moore) undertook to establish the Glamorgan and Monmouthshire Infirmary. Thanks to a gift of £2,000 from Daniel Jones of Beaupré Castle in the Vale of Glamorgan, construction was able to start the next year and the hospital was fully functional by 1837.\(^7\) As early as the end of that year, at a charitable dinner to honour a local dignitary attended by George Clive, the Assistant Poor-Law Commissioner, no one seems to have baulked at the claim that the infirmary was the ‘pre-eminent charity in the county’. It says much of the ambivalent nature of philanthropy in South Wales at the time that the very next toast was to the ‘Medical Officers of the Union’.\(^8\)

This idea that altruism was not bounded by any artificial distinction between the publicly-funded workhouse and charitably-endowed Glamorgan and Monmouthshire Infirmary seems to have extended to the medical staffing of the two establishments. From 1837 to 1850, James Lewis, Poor-Law Medical Officer for Cardiff, was both provider of clinical services to the workhouse and surgeon-in-ordinary to the Infirmary. By 1855, when Lewis held the largely honorific post of Consulting Surgeon to the Infirmary, its two surgeons-in-ordinary were also current union doctors, Edward Evans jnr. and W.T. Edwards.\(^9\) Indeed, in these first eighteen years of the hospital’s existence, of its senior medical staff, only its two physicians, John Moore (1837-1852) and Charles Redwood Vachell (1852-1855), were not simultaneously employed by the Cardiff Poor-Law Union. That is not to say, however, that Negrine’s observation that a charitable hospital was seen as a

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\(^8\) ‘New Poor Law, Public Dinner to J.E.Bicheno Esq.’, *The Cambrian*, 18 November 1837, p. 3.

more prestigious employer than the workhouse did not apply in Cardiff.
When, in the 1850 competition for the vacant surgical post at the infirmary,
Henry Paine lost out to Charles Redwood Vachell by 89 votes to 54, Paine
could not help but express his bitterness at not landing the plum job. In one
respect he certainly had a point. As a subscriber, Vachell’s uncle voted for
him, as did his father, not once but twice – his second vote being cast in his
capacity as mayor.\(^{20}\)

The similarities between the Cardiff Workhouse and the Glamorgan and
Monmouthshire Infirmary extended well beyond the overlap in their
complement of staff. The ‘great and the good’ were often on both the
hospital’s board and the poor-law board of guardians and Walter Coffin M.P.
was chair of both bodies at the same time. Even the patients had more in
common than might be imagined. Around 700 medical cases per year were
treated in the workhouse and, somewhat paradoxically given that the patients
might easily have found themselves being treated by the same person, the
Poor-Law Union also paid a subscription of ten guineas a year to the
Glamorgan and Monmouthshire so that paupers could be transferred there
when required.\(^{21}\) On census day 1851, the workhouse had eleven male and
three female in-patients. Five of the men were labourers and three were
sailors; two of the women were servants and the other was a dressmaker. At
the same time there were twenty-six patients in the infirmary although, over
the course of a year, at just 110, the total number of in-patients there was

\(^{20}\) ‘Glamorganshire and Monmouthshire Infirmary’, *Cardiff and Merthyr Guardian*, 31 August 1850, p. 4.
\(^{21}\) GA, UC/2/5, CPLU Minutes, 22 December 1849; GA, UC/2/3, CPLU Minutes, 2 October 1845.
substantially less than in the workhouse. What strikes one most, though, is how similar the occupations of these patients were to those in the workhouse. Amongst the seventeen men, sailors and labourers predominated and five of the nine women were servants. This inability to distinguish between the social class of the two groups of patients even extended to out-patients, with the infirmary house-surgeon being reprimanded for attending paupers who should rightly have been treated by union doctors. Nor was there any evidence of the parsimony and prejudice of the guardians which Digby observed in Norfolk workhouses. True, there were complaints about the cost of the workhouse’s medical services but these came from rural guardians and were particularly focussed on the perceived unfairness that their ratepayers were charged the same as those from the town even though their parishes only accounted for just seven per cent of the in-patients.

‘A Lowly Sort?’

This chapter has suggested that, in mid nineteenth-century Cardiff, one would have struggled to distinguish the professional life of a poor-law medical officer from that of a non-poor-law colleague. It will be remembered, however, that Englander considered the poor-law medical officer to have been a ‘lowly sort of individual’ and it can’t be assumed that, merely because he was on an equal professional footing, a union doctor held the same social status as someone who practiced solely in the private sector. In trying to

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22 Wales Census, 1851, <Ancestry.com>; ‘Glamorganshire and Monmouthshire Infirmary’, *Cardiff and Merthyr Guardian*, 6 January 1849, p. 3.
23 GA, UC/2/7, CPLU Minutes, 28 February 1857.
test this assumption, one virtue of there being a relatively small cohort of poor-law medical officers employed by the Cardiff Union between 1836 and 1858 is that it is possible to read all their obituaries and gather some impression of their activities in wider civic society. The results are presented in Table 5.2.

### Table 5.2 Municipal Posts Held by Cardiff’s Poor-Law Medical Officers Whose Obituaries Appeared in the Local Press

<table>
<thead>
<tr>
<th>Doctor</th>
<th>Magistrate</th>
<th>Councillor</th>
<th>Alderman</th>
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<td>Davies, Daniel</td>
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<td>Edwards, D I</td>
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<td>Edwards, WT</td>
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<td>Evans, Edward</td>
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<td>Leigh, John</td>
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<td>Lewis, James</td>
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<td>Llewellyn, John</td>
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<td>Paine, Henry</td>
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<td>Sloper, Charles</td>
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<td>Sloper, Richard</td>
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The attachment to public service which the table demonstrates might cause one to question whether the union doctor’s perennial complaint of being overworked might have been exaggerated. James Lewis, in particular, was able to conduct his mayoral duties despite being at the same time a poor-law medical officer, surgeon to the infirmary and retained doctor for a benefit society. Henry Paine, however, seems to have been frequently available to
deputise for him, perhaps realising that, in the long run, this was a shrewd career move.

Whatever else might be gleaned from the table, this is not the picture of the medical man as second-class citizen. Indeed, some of them clearly moved in aristocratic circles. Two of them, James Lewis and Richard Reece, were among the select group who dined with the Marquis of Bute on the evening of his death. 25 There were career successes, too, which transcended the confines of what was still a fairly small Welsh town. W.T. Edwards became President of the British Medical Association and Henry Paine was an esteemed member of the Epidemiological Society. 26

Financial rewards could ultimately be significant too. When he died at the advanced age of ninety-four, Edwards left £80,955 in his will, equivalent to over £6 million at today’s values. He was the exception, though. No other Cardiff union doctors for whom probate records exist left estates valued at more than £1,500 and there is evidence that at least one, Edward Bates, suffered poverty in old age. 27 Paine made pleas to both the Cardiff and Bridgend Boards of Guardians that Bates, medical officer for West St. Nicholas for thirty years, should be granted a pension since illness meant he could no longer work and had left him in ‘in very poor circumstances’. 28 Paine’s campaign was successful in Cardiff but rejected by the rural

guardians in Bridgend who felt that it was ‘a farce’ that the ratepayers should be out of pocket to such a cause, even though the request was only for a meagre fifteen pounds a year.\textsuperscript{29} The fate of W.H. Wood, poor-law medical officer for Llantrisant was arguably even more grim. In 1850, he died of neurosyphilis in the Vernon Asylum in Briton Ferry near Neath where he had been a patient for six months.\textsuperscript{30} There was clearly a level of egalitarianism in mental health provision before the county pauper lunatic asylums were built since the Vernon Asylum was the very same institution to which Woods’ own pauper patients had been sent whilst he was still a practising doctor.

\textit{Conclusion}

Most historians would still maintain that there was a clear demarcation between union doctors and their colleagues in the private sector. If there was movement between the two groups, the argument goes, then that was merely because, in an overcrowded profession, poor-law practice was a necessary rite of passage before one could establish a lucrative private practice. As for the simply poor rather than the destitute, a superior medical response could be had by subscribing to a friendly society or entering a charitable hospital.

The experience of Cardiff between 1836 and 1858 would suggest that such distinctions were nothing like as clear-cut. In a tightly-knit world where most of the small community of doctors were related to at least one other member of the group, it was normal to have a foot in both camps. If you

\textsuperscript{29} ‘Proposed Superannuation to Dr Bates’, \textit{South Wales Daily News}, 13 January 1882, p. 4.
\textsuperscript{30} GA, Q/L/V/N/2, Vernon House Asylum Briton Ferry, Admission Register, 1849-1864.
were poor but in work and became one of the ‘poster-boys’ of the New Poor
Law by putting aside money to insure against sickness, you could easily have
discovered that your doctor was the very same person who was treating your
pauper neighbour. Even in wider society, far from being the downtrodden
figure of popular myth, many a Cardiff doctor was part of the local elite,
often elected to municipal office or dispensing justice as a magistrate. In
short, although there were examples of hardship for poor-law medical
officers, the post of union doctor could equally be compatible with the other
trappings of a successful career. Of course, there were some Cardiff doctors
who did start out working for the poor-law union only to become rich and
famous later but, even here, there is no evidence that they abandoned their
commitment to the poor just as soon as it was financially possible to do so.
Conclusion

The doctors who were employed under the provisions of the New Poor Law of 1834 have usually been portrayed as victims rather than beneficiaries of the legislation. This study set out to examine the accuracy of this dominant historical narrative by using the unique ability of local history to tell the story of medical provision in one poor-law union over a period of two decades. This novel approach not only enabled what is believed to be the first longitudinal study of a group of medical practitioners of the time but, in so doing, it also avoided the pitfalls inherent in previous ‘top-down’ national accounts with their inevitable tendency to focus on the failures not the successes of the system.

If there is one single lesson to be learnt from the study of the Cardiff Poor Law Union, it is that attempting a neat generalisation of the evidence is fraught with difficulty. Thus, when looking at the appointment of poor-law medical officers in chapter two, it was apparent that the doctors taken on were as likely to be veterans who had been practising for over twenty years as they were to conform to the stereotype of a union doctor as a very recent graduate thankful for any work in an overcrowded market. Nor was there any consistency in the selection procedure itself. Although a post did, on one
occasion, go to the candidate who was prepared to work for the least amount of money, factors such as being local and already known to the board of guardians were more influential. Chapter three further demonstrated how the victimhood of the poor-law medical officer may be an oversimplification. Thus, whilst the Cardiff doctors’ salaries per head of population for which they were responsible was far from generous, when broken down on the basis of pay per case, the financial rewards, particularly for the ones who practised in rural Llantrisant, were amongst the best in the country. Chapter three also revealed a split between urban and rural guardians in their appreciation for the professionalism of their union doctors. While the country authorities would seemingly, like Chadwick, have regarded practitioners as more akin to tradesmen, the powerful men of the town appear to have been more respectful, as manifest in their willingness to involve their medical men in decision making and their reluctance to scapegoat them in times of crisis.

These intra-union differences in attitude should also make us wary of suggesting, as others have done, that a study of Llantrisant might be ‘a useful foundation for making wider generalisations about the character and role of the New Poor Law in Wales’.¹ This point was particularly well highlighted in chapter four in which a strong case was made that, through their role in implementing public health measures, the poor-law medical officers of Cardiff town, itself, made a genuine contribution to saving lives. The same claim could not be made by their counterparts in the countryside, not

necessarily because of inferior skills and knowledge but simply because large outbreaks of infectious disease were confined to the overcrowded and insanitary slums of the rapidly growing seaport.

Nowhere, though, did the current historiography of New Poor Law medical services come under greater challenge than in chapter five. Far from being downtrodden individuals, many of Cardiff’s poor-law medical officers were already part of the town’s elite when they became union doctors. It was commonplace, too, for them to hold these posts at the same time as being on the staff of the Glamorgan and Monmouthshire Infirmary thus, making it hard to see how the medical attention received even in the workhouse could have been noticeably inferior to that in the town’s only other hospital. Already in possession of an income and social status, one is driven to conclude that, at least for some doctors, the motivation for applying for and then retaining poor-law posts was a sense of professional duty. To summarise, we might accept Englander’s portrayal of the union doctor as ‘overworked and underpaid’ but, in Cardiff at least, he could never be described as ‘a lowly sort’.
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