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The healthcare economy of Gloucester in the Age of Reform, c.1815 - c.1870

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For the past thirty years, the early-modern healthcare economy in Britain through to the mid-1800s has been described as a 'medical marketplace'; an unregulated commercial arena characterised by plurality, diversity, choice and competition. The demise of this medical marketplace is widely regarded as having been occasioned by the professionalisation of medicine and the regulatory reforms with which it is closely associated. In particular, the 1858 Medical Act has been seen as a watershed. This study challenges this chronology and makes the case for a new paradigm. Looking at Gloucester in the pivotal years between 1815, it comprises a detailed dissection of healthcare supply, drawing on familiar and previously neglected sources. First identifying gaps in the existing model through a wide-ranging literature review it then uses a combination of quantitative and qualitative analysis to map the supply of healthcare in the city in the years between 1815 and 1870; an era that can justifiably be termed the Age of Reform. Throughout, evidence of plurality, diversity, choice and competition is sought, beginning with an assessment of the role of institutional healthcare. This is followed by a quantitative analysis of commercial healthcare suppliers that raises questions around the degree and nature of competition. The discussion then moves to healthcare advertising; the most overtly commercialised sector of the healthcare economy, where through a sample survey of advertisements appearing in the local Gloucester press evidence of customer segmentation is revealed. Attention then turns to the dispensing activity of Gloucester's chemists and druggists with an analysis of surviving prescription books; a source so far lightly handled in the historiography of the medical marketplace. Finally, the experiences of the sick themselves are examined, revealing the extent of structural constraints on the individual agency of the 'healthcare consumer.' Overall, the study shows that long before 1858, the supply of healthcare in Gloucester was dominated by regular doctors and chemists and druggists. In this environment institutions imposed structural constraints on the free market and competition in the commercial arena was noticeably less than described in other studies elsewhere. It becomes clear that people of all social classes preferred regular medical advice when they perceived it was warranted and that proprietary medicines and irregular healthcare suppliers were not necessarily simply the resort of the gullible poor. Instead, they served those who had purchasing power but were, for a variety of reasons, least well-served by the regular medical offering. In addition, chemists and druggists, far from being fringe suppliers, were, through their role in dispensing medical prescriptions, a respected and trusted community resource. Cumulatively, the findings suggest that well before 1858, what existed in Gloucester was not a medical marketplace but a *stratified healthcare economy*.

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This study would not have been possible without the support and assistance of many people to whom I am most gratefully indebted. I wish to thank the Arts and Humanities Research Council and the Worshipful Society of Apothecaries, who jointly funded the Collaborative Doctoral Award of which this PhD forms part. I am especially indebted to my supervisors, Professor Steven King and Dr Elizabeth Hurren at the University of Leicester for their positivity, encouragement, and wise advice that kept me going at times when I thought this project was beyond me. I also wish to thank everyone at Gloucestershire Archives, the curator of the George Marshall Medical Museum, Louise Price, the staff of the British Newspaper Archive, the Royal Pharmaceutical Society Museum, and the Royal College of Physicians Library. My thanks also to my fellow PhD student Laura Robson-Mainwaring and all those whose encouragement in years past gave me the confidence to attempt this project; my school history teacher Peter Sillis, my MPhil supervisors at the University of Worcester, Professor Darren Oldridge and Dr Frank Crompton, and Dr Alan How also at the University of Worcester. Finally, I wish to thank my family; my mum, my wife Sarah, and my children Rob, Martha and Nick, who all sacrificed a lot for me to be able to do this.

I would like to dedicate this thesis to my dad, Peter James Helm (1926-1988).

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GA	Gloucestershire Archives
GMMM	George Marshall Medical Museum
F.R.C.P.	Fellow of the Royal College of Physicians, London
F.R.C.S.E.	Fellow of the Royal College of Surgeons, Edinburgh
L.D.S.	Licensed Dental Surgeon
L.R.C.S. Edin.	Licentiate of the Royal College of Surgeons, Edinburgh
L.S.A/L.A.C/L.A.S.	Licentiate of the Society of Apothecaries, London
M.D.	Medical Doctor
M.R.C.S./M.R.C.S.L.	Member of the Royal College of Surgeons, London
M.R.C.S.E.	Member of the Royal College of Surgeons, Edinburgh
M.R.C.V.S.L.	Member of the Royal College of Veterinary Surgeons, London.
R.C.S.E.	Royal College of Surgeons, Edinburgh

Chapter One - Introduction

The healthcare[1] economy of England from the sixteen-hundreds through to the mid nineteenth century has often been described as a medical marketplace,[2] or what Porter and Porter referred to as 'that free-range medical world.'[3] This way of thinking about medicine as a marketable commodity broke new ground when it emerged in the 1970s and 80s and necessarily moved historical debate beyond what Smith once described as 'the crudity of a historiography…enmeshed in celebratory 'great man' antiquarianism,'[4] and Huisman and Warner as 'Whiggish and triumphalist, unapologetically internalistic and naively positivist.'[5] The medical marketplace model was born out of a realisation that there was a need to 'obtain a better understanding of the impact of market capitalism. Not least, it was shaping attitudes to the body as a secular property, and health as a purchasable commodity.'[6] McKendrick has argued that by the late eighteenth century, 'a greater proportion of the population than in any previous society in human history was able to enjoy the pleasures of buying consumer goods'[7] and the medical marketplace represents a recognition of the 'consumer revolution in eighteenth-century England.'[8] The model was also a response to criticism by the likes of Woodward and Richards, who wrote in 1977 that 'the history of medicine has been 'doctor' orientated. It has been studied by doctors, and has been primarily about

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[1] Healthcare is defined here as "the maintenance or improvement of health via the diagnosis, treatment, and prevention of disease, illness, injury, and other physical and mental impairments in human beings." [www] http://encyclopedia.thefreedictionary.com/health+care [Date accessed: 27 July 2017].

[2] Important contributions include W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge, 1994); A. Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911* (Cambridge, 1994); A. Digby, *The Evolution of British General Practice 1850-1948* (Oxford, 1999); M.E. Fissell, *Patients, Power, and the Poor in Eighteenth-Century Bristol* (Cambridge, 1991); M.S.R. Jenner and P. Wallis (eds), *Medicine and the Market in England and its Colonies, c.1450-c.1850* (Basingstoke, 2007); I. Loudon, *Medical Care and the General Practitioner, 1750-1850* (Oxford, 1997); H. Marland, *Medicine and Society in Wakefield and Huddersfield 1780-1870* (Cambridge, 1987); M.J. Peterson, *The Medical Profession in Mid-Victorian London* (Berkeley, CA, 1992); D. Porter and R. Porter, *Patient's Progress: Doctors and Doctoring in Eighteenth-Century England* (Cambridge, 1989); I. Waddington, *The Medical Profession in the Industrial Revolution* (Dublin, 1984).

[3] Porter and Porter, p.209.

[4] F.B. Smith, *The People's Health 1830-1910* (London, 1990), p.9.

[5] F. Huisman and J.H. Warner, 'Medical Histories' in F. Huisman and J.H. Warner (eds), *Locating Medical History: The Stories and their Meanings* (Baltimore, MD, 2006), p.3.

[6] R. Porter, *Quacks, Fakers & Charlatans in English Medicine* (Stroud, 2000), p.208.

[7] N. McKendrick, 'Commercialization and the Economy' in McKendrick, Brewer and Plumb, *The Birth of a Consumer Society: The Commercialization of Eighteenth-Century England* (London, 1982), p.9.

[8] N. McKendrick, 'Introduction' in *Ibid,* p.1.

doctors'[9] and identified 'an important need for historical studies which view medicine, not merely from a medical or professional perspective, but from that of the typical contemporary man or women.'[10]

For Fissell, the medical marketplace was an 'an economic free-for-all'[11] and Porter and Porter similarly described how 'medicine was viewed as a commodity, and healthcare a service, freely traded in accordance with the laws of supply and demand'[12] and spoke of 'the Babel of the medical marketplace': a cacophony of competing providers trading in a commercial arena largely unburdened by regulation and control.[13] Here 'the sick, given the opportunity, would shop around' and 'those who could afford it frequently called in a whole range of regular physicians, seeking second, third, and fourth opinions [and] showed no hesitation about also sampling the therapies and the drugs of empirics.'[14] Marland similarly referred to the sick as 'shopping around for medical care'[15] where 'medicines and medical advice came to be seen as commodities, to be bought and bargained for.'[16] The assumption underpinning the paradigm is that the healthcare consumer shaped the complexion of healthcare supply through autonomous agency and, as Figure 1.1 shows, the defining characteristics of the medical marketplace model are plurality, diversity, choice and competition.[17] Within this rubric, the early nineteenth century has been described as 'perhaps the heyday of thinking about medicine as a market.'[18]

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[9] J. Woodward and D. Richards, 'Towards a Social History of Medicine' in J. Woodward and D. Richards (eds), *Health Care and Popular Medicine in Nineteenth Century England* (London, 1977), pp.16-17.
[10] J. Woodward and D. Richards, 'Introduction,' in *Ibid,* p.12.
[11] Fissell, p.10.
[12] Porter and Porter, p.96.
[13] Porter, *Quacks,* p.84.
[14] R. Porter, ''Before the Fringe: Quackery and the 18th-Century Medical Market' in R. Cooter (ed.), *Studies in the History of Alternative Medicine* (London, 1988), pp.3-4.
[15] H. Marland, ''The Doctor's Shop': The Rise of the Chemist and Druggist in Nineteenth-Century Manufacturing Districts' in L.H. Curth (ed.), *From Physick to Pharmacology: Five Hundred Years of British Drug Retailing* (Aldershot, 2006), p.92.
[16] *Ibid*, 102.
[17] Porter and Porter, p.96; Porter, *Quacks*, p.208.
[18] M.S.R. Jenner and P. Wallis, 'The Medical Marketplace' in Jenner and Wallis, *Medicine and the Market*, p.10.

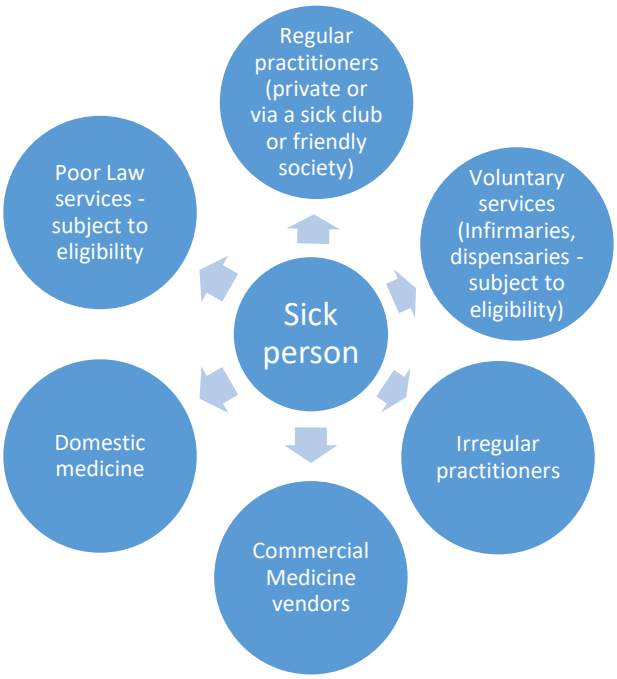

Figure 1.1 The medical marketplace

With so many potential choices available, King and Weaver have claimed that 'doctors were almost always the last port of call for most families confronting everyday illness, either because of cost, availability, or preference in the light of the limitations of medical diagnosis and treatment.'[19] According to Bynum:

> Competition could come in many forms; fellow practitioners, hospitals and dispensaries that treated patients who had the means to pay a private doctor; chemists and pharmacists who sold medicines directly to the public; advice books that encouraged every man to be his own doctor; itinerant "specialists", mountebanks and drug peddlers; shrewd mail-order merchants, homeopaths and other sectaries who challenged the very basis of medical orthodoxy. Small wonder many doctors felt themselves beleaguered on all sides.[20]

According to Porter, 'only when charlatans had thoroughly destroyed their health did the sick finally and sheepishly apply to the regular physician – but, all too often, too late.'[21] Qualified doctors thus struggled to make a living in the face of fierce competition from all manner of irregulars suppliers; a situation that sits in stark contrast to the highly-regulated modern healthcare economy dominated by the medical profession. The watershed is widely supposed to be the 1858 Medical Act, which supposedly brought the first truly effective regulation to the practice of medicine.

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[19] S. King and A. Weaver, 'Lives in Many Hands: The Medical Landscape in Lancashire, 1700-1820,' *Medical History*, Vol.44, No.2 (April 2000), p.173.
[20] Bynum, p.196.
[21] Porter and Porter, p.136.

Brown, for example, has observed how 'the conventional historical assumption is that the medical marketplace was an early modern phenomenon which ended around the middle decades of the nineteenth century. The factor generally held responsible for its demise is the 'professionalization of medicine'.'[22] However, both he and Tomkins have argued that well after this point 'market concerns persisted.'[23]

Despite the dominant place the medical marketplace paradigm has achieved in the social and economic history of medicine, there are some significant lacunae surrounding the model. Firstly, and perhaps most importantly, there has never been a definitive, generally accepted, definition of the term 'medical marketplace' and according to Jenner and Wallis, 'its meaning has become vague to the point of confusion.'[24] More than ten years ago, they remarked that 'two decades after the medical marketplace became a commonplace, historians still know very little about the scale, scope, boundaries or internal dynamics of the market for medicine.'[25] Biddle has similarly argued that 'despite research spanning three decades, very little was known about how the market worked; how it responded to changes in consumer demand; how consumers engaged with it (especially at a local level); and how providers both inside and outside of the market related to one another.'[26] Furthermore, King has found 'overarching studies offering the interlinkage of the different elements of the medical marketplace remain sadly lacking.'[27] Further criticism has come from Brown, who argued 'its greatest shortcoming in a tendency to conflate the general concept of medical plurality with a specific economic understanding of financial competition.[28]

There remains considerable scope for further research and as King also pointed out, 'we are desperately short of systematic regional studies of the medical

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[22] M. Brown, *Performing Medicine: Medical Culture and Identity in Provincial England, c.1760-c.1850* (Manchester, 2011), p.5.
[23] A. Tomkins, *Medical Misadventure in an Age of Professionalisation, 1780-1890* (Oxford, 2017), p.7.
[24] Jenner and Wallis, 'The Medical Marketplace,' p.2.
[25] *Ibid*, p.2.
[26] R. Biddle, 'Dissecting the Medical Marketplace: The Development of Healthcare Provision in Nineteenth-Century Portsmouth,' unpublished PhD thesis (Oxford Brookes University, 2009), p.236.
[27] S. King, 'Poverty, Medicine, and the Workhouse in the Eighteenth and Nineteenth Centuries: An Afterword' in J. Reinarz and L. Schwarz, (eds), *Medicine and the Workhouse*, (Rochester, N.Y., 2013), Kindle edition, ch.11.
[28] Brown, *Performing Medicine,* p.5.

marketplace.'[29] This is despite Chapman, for example, identifying that 'the most satisfactory way of approaching the subject of provision of medical services more than a hundred years ago is by examining local sources'[30] and Reinarz noting how 'research at the regional level has forced historians to reconsider many of the earliest paradigms and grand narratives to emerge in medical history.'[31] Brown has described local studies as 'emblematic of key developments'[32] but the relatively small number undertaken so far suggest 'the uniformity and universality of medical experiences are certainly questionable.'[33] More research is still needed to reach anything approaching a holistic understanding of nineteenth century healthcare.

In addition to confusion over what the medical marketplace was, there is a suspicion of anachronism surrounding the characterisation of the sick as primarily consumers, or healthcare shoppers. Although Ueyama has argued that 'medical commodities have always been produced within a commercial context, as have been medical services' and that 'for as long as medical doctors and hospitals have operated within a capitalistic system, they have had to face strong commercial pressures,'[34] Green, for example, pointed out 'many analysts…believe that consumer choice cannot operate at all in the sphere of health.'[35] Certainly, health is not like other commodities and we should not assume the sick had the same motivations, or behaved in the same ways, as other 'consumers.'[36] Despite its self-consciously 'patient-centred' approach, much of the literature remains primarily concerned with suppliers; in particular, the medical profession and quacks.[37] Popular histories continue to stereotype customers as

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[29] S.A. King 'Accessing Drugs in the Eighteenth-Century Regions' in Curth, *From Physick to Pharmacology,* p.51.
[30] S. Chapman *Jesse Boot of Boots the Chemists* (London, 1974), p.17.
[31] J. Reinarz, 'Medicine and Society in the Midlands, 1750-1950: Introduction' in J. Reinarz (ed.), *Medicine and Society in the Midlands, 1750 - 1950* (Birmingham, 2007), p.1.
[32] Brown, *Performing medicine,* pp.8-9.
[33] A. Withey, '"Persons That Live Remote From London": Apothecaries and the Medical Marketplace in Seventeenth- and Eighteenth-Century Wales,' *Bulletin of the History of Medicine,* (2011), p.223.
[34] T. Ueyama, *Health in the Marketplace: Professionalism, Therapeutic Desires, and Medical Commodification in Late-Victorian England* (Palo Alto, CA), p.8.
[35] D.G. Green, *Working-Class Patients and the Medical Establishment: Self-Help in Britain from the Mid-Nineteenth Century to 1948* (Aldershot, 1985), p.64.
[36] This study avoids wherever possible the use of this term to describe sick people, as it places undue emphasis on the role of the sick person as a *purchaser* of goods and services.
[37] The origins of the term 'quack' are obscure and it has often been interchangeable with 'charlatan' and 'mountebank.'

credulous, gullible and naïve.[38] Porter and Porter described 'the vulgar, demotic spirit of the age, encouraging the silly idea that everyman could be an expert when it came to his own health.'[39] The notion of the reckless and ignorant self-doser was however partly manufactured by the nineteenth century doctors, who 'wanted to end self-medication, especially among the working-class…[as] only by obtaining the sole right to prescribe certain drugs could their professional and qualified status being adequately established.'[40] Stereotypes gained widespread traction in a paternalistic society in which middle-class commentators believed the working-classes needed to be rescued from themselves. The enduring influence of these attitudes also demands scrutiny.

Another significant limitation of the model is that by emphasising the commercial sphere, it is unhelpful when it comes to care provided through informal kin and community networks and individual acts of charity. The historiography pays relatively little attention to this component of the healthcare economy, even though Waddington long ago identified that 'most care of the sick was not even part of the market economy, for it took place within the context of familial and neighbourhood relationships which were outside the realm of market exchange.'[41] Jenner and Wallis have argued 'if one conceptualizes the afflicted person as a consumer and presents every aspect of their search for relief or assistance as a kind of shopping, then including both commercial and non-commercial curers within it makes sense,' but to try to describe this activity in terms of market economics is problematic.[42] For one thing, there were many non-economic drivers involved in informal care, including cultural norms, social expectations of duty and familial responsibility, and religious belief. Of these, religion has been particularly neglected in the historiography, yet its promise of spiritual rewards to those who undertook acts of philanthropy exercised a powerful influence over the provision of healthcare. How religion impacted upon the dynamics of the marketplace remains unclear and the paradigm has similar difficulty accommodating the role of institutional care, which was provided either through not-

[38] See, for example, C. Rance, *The Quack Doctor: Historical Remedies for all your Ills* (Stroud, 2013) and K. Souter, *Medical Meddlers, Mediums and Magicians* (Stroud, 2012).
[39] Porter and Porter, p.137.
[40] V. Berridge, 'Victorian Opium Eating: Responses to Opiate Use in Nineteenth-Century England,' *Victorian Studies*, Vol.21, No.4 (Summer 1978), p.451.
[41] Waddington, p.181.
[42] Jenner and Wallis, 'The Medical Marketplace,' p.7.

for-profit charities or through local government; neither subject in any straightforward way to laws of supply and demand. Yet, 'by the mid-nineteenth century, the hospital had become a permanent feature of the medical landscape, a pillar of medical services and a crucial site of medical education'[43] and, importantly, it 'was the setting for the first contact on any scale between the doctors and the poor.'[44]

This study addresses these issues directly through an in-depth analysis of a single provincial city at a time of pivotal change between 1815 and 1870; a period that embraced the Apothecaries Act (1815) through to the Pharmacy Act (1868) and, within it the Anatomy Act (1832), Sale of Arsenic Regulation Act (1851), Pharmacy Act (1852) and Medical Act (1858). With this much legislation aimed at regulating the healthcare market, this epoch can, with justification, be termed the 'Age of Reform.' Quantitative and qualitative analysis will be employed in the search for evidence of plurality, diversity choice and competition. It will go beyond an incremental approach, not simply adding more data to the existing paradigm, but making the case for a more holistic view of healthcare provision that escapes the metaphorical straight-jacket of the 'medical marketplace.' It is geographically focussed on Gloucester, a cathedral city in the south-west Midlands of England that experienced rapid industrialisation and urban development during the nineteenth century. It was decided to concentrate on a single location to be able to undertake a detailed analysis of healthcare provision over time. Systematic dissection of Gloucester's healthcare economy using multiple perspectives provides a holistic and rounded study that will make a significant contribution to the historiography. Important source material will be introduced to the debate, including prescription books and coronial records, both of which have so far been lightly handled in the literature. The study will provide significant new insights, which challenge both the key tenets of the medical marketplace model and the timeframe associated with its decline. Covering a wide range of topics, it will highlight the importance of structure and customer segmentation in Gloucester's healthcare economy, something that represents a significant departure from thirty years of historiographical orthodoxy.

This study starts with a discussion of the context in which the medical marketplace model was conceived and has subsequently evolved. A thematic approach

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[43] Bynum, p.55.
[44] C. Lawrence, *Medicine in the Making of Modern Britain 1700–1920* (London, 1994), p.21.

is adopted, covering topics that include the changing relationship between doctors and their patients, competition, the rise of the chemist and druggist, advertising and the proprietary medicines[45] industry, and regulation of the market. This comprehensive review informs the subsequent chapters. Chapter three then begins with a contextual discussion of the salient features of Gloucester's development and history relevant to its healthcare economy, followed by a survey of institutional providers, discussing their role, purpose and significance, and their contribution to the process of medical professionalization in the county; something as discussed earlier that is attributed a key role in the demise of the medical marketplace in the second half of the nineteenth century. It considers not only the numbers of patients treated in institutional settings, but what sort of people used them, the ways in which demand was manipulated through rules and regulations, and their role in enabling Gloucester's medical men to further their professional and public ambitions. The second part of the chapter comprises a census of commercial suppliers, based on census data from 1841 through to 1871, local trade directories, and medical directories, supplemented by information taken from local newspapers. A similar methodology was employed by Brown for Bristol, where it yielded rich detail about commercial healthcare provision.[46] By deconstructing Gloucester's healthcare economy into its constituent parts and identifying temporal change, an understanding of the dynamics of competition becomes possible; one that challenges key methods and assumptions of the medical marketplace paradigm.

Chapter four looks at advertisers and comprises a sample survey of advertisements for healthcare-related products and services appearing in the Gloucester

[45] The terms 'proprietary,' 'secret,' 'quack' and 'patent' medicine have often been used interchangeably, although the definition of each is slightly different. This study uses the term 'proprietary' as the most encompassing. Jepson differentiated proprietary from patent medicines thus: *Proprietary Medicine*: 'a medicine for which the manufacturer claimed sole rights because of a secret formula'; *Quack or Secret medicine*: 'those medicines whose constituents were not disclosed on the label…usually advertised and promoted as proprietary medicines'; *Patent medicine*: '[a medicine protected by] the grant by government (or formerly the sovereign) of a sole right or exclusive privilege to make, use, or sell a new invention. A patent medicine would be a newly formulated medicine.'- M.H. Jepson, 'From Secret Remedies to Prescription Medicines: A Brief History of Medicine Quality' in S. Anderson (ed.), *Making Medicines: A Brief History of Pharmacy and Pharmaceuticals* (London, 2005), p.224.

[46] P.S. Brown, 'The Providers of Medical Treatment in Mid-Nineteenth Century Bristol,' *Medical History*, Vol.24, No.3, (1980), pp.297-314.

local press between 1814[47] and 1870.[48] Using quantitative and qualitative analysis, the chapter adopts a thematic approach with a view to understanding how the products and services advertised in local newspapers contributed to the healthcare economy. Topics discussed include language, advertising techniques, product differentiation, pricing, use of testimonials and warnings against counterfeits. Such an approach is surprisingly rare in the historiography, where despite widespread coverage, relatively little attention has been paid to what the content of advertisements can tell us about the types of people who were attracted by their claims, and the circumstances under which they may have been disposed to purchase the products or services being advertised.

Chapter five discusses the dispensing of medical prescriptions by Gloucester's chemists and druggists and comprises an analysis of surviving pre-1870 prescription books, one series of which unusually records the street-level address of the customer, allowing them to be cross-referenced with the 1851 census. Prescription books have rarely featured in the literature of the medical marketplace and interest in them has been largely confined to understanding developments in pharmaceutical practice and drug formulation.[49] This analysis will be primarily quantitative, looking at volumes of prescriptions dispensed, both overall and by prescribing doctor, dispensing levels on a daily, monthly and annual basis and the socio-economic distribution of customers. The evidence presented will aim to show that medical dispensing was the core of the chemist and druggist's trade and it was an area where customer service and trust were of crucial importance. It will be shown that Gloucester's chemists and druggists were mostly respectable tradesmen, whose business model was founded upon diligent dispensing of high-quality drugs, through which they were drawn into an ever-closer relationship with local doctors.

In chapter six attention is turned to customers, drawing upon a diverse range of sources including coronial records, letters, diaries, and newspapers. Focussing on the constraints placed upon individual agency and access to healthcare, the chapter looks

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[47] 1814 was chosen rather than 1815 to capture advertisements immediately prior to the Apothecary's Act, the first significant piece of legislation of the Age of Reform.

[48] This study defines an advertisement as 'a notice or announcement in a public medium promoting a product, service, or event or publicizing a job vacancy.' http://www.oxforddictionaries.com/definition/english/advertisement [Date accessed: 7th September 2016]

[49] See, for example, D.L. Cowen and D.F. Kent, 'Medical and Pharmaceutical Practice in 1854', *Pharmacy in History*, Vol.39, No.3 (January 1997), pp.91-100.

for evidence around decision-making with the aim of identifying the extent to which the plurality, diversity, choice and competition that supposedly defined the medical marketplace concurred with actual experience. The scarcity of suitable records necessitates a broadening of geographical parameters to include sources from the wider shire, something that presents both challenges and opportunities. As discussed earlier, finding the 'patient's voice' remains perhaps the most problematic part of any analysis of nineteenth-century healthcare, but this innovative blend of sources provides new insights into how customers from diverse socio-economic groups perceived, accessed, and navigated healthcare options in the Age of Reform.

Finally, overall conclusions are drawn reflecting upon what the evidence presented reveals about the healthcare economy of Gloucester in the Age of Reform and healthcare in England more widely. Specifically, it will discuss the value of the medical marketplace as a model for understanding healthcare in this period and the case for an alternative paradigm.

Chapter Two - Historiographical review

2.1 Introduction

The introduction described the key features of the medical marketplace paradigm, identifying significant lacunae surrounding aspects of the model and areas where it is unhelpful as a means of explaining developments in the healthcare economy of England during the Age of Reform. These included:

- The lack of any generally accepted definition of the term 'medical marketplace' and a sparsity of comparative studies, which has led to uncertainty as to the extent of plurality, diversity, choice and competition, the degree of local variation, and the chronology of the medical marketplace's demise.
- An unbalanced view that places excessive emphasis on the most commercialized areas of the healthcare economy and fails to convincingly accommodate the role of institutions.
- Despite a self-consciously 'patient-centred approach,' an historiography that still largely views healthcare from the perspective of medical practitioners.

To understand how these gaps arose and why they need to be addressed, this chapter will now explore the historiographical context in which the medical marketplace paradigm evolved. It will do this by looking at six key topics that have occupied much of the literature on the subject and contributed most to current understandings of nineteenth-century healthcare, comprising the structure of the medical profession; the doctor-patient relationship; competition in the medical marketplace; the rise of the chemists and druggists; advertising and the proprietary medicines industry; and regulation of the market. Most of this is well-trodden ground but in some areas the literature is more sparse and fragmented, for example on prescribing and dispensing practices, and the role of dispensaries. The medical marketplace paradigm intersects this voluminous historiography at multiple points and some of the topics discussed in this chapter relate to it more directly than others. However, these threads of debate each provide essential context to the case for a revised paradigm set out in the subsequent chapters. The literature review begins however with the topic of the organisation of medicine and the impact of the collapse of the old medical order; something that supposedly occurred contemporaneously with the rise of the medical marketplace.

2.2 The structure of the medical profession in the Age of Reform.

Until 1858, medicine was divided, theoretically at least, into three distinct estates; physicians, surgeons and apothecaries. Below them, and not recognised as part of the medical profession, sat chemists and druggists - a retail trade (Figure 2.1). Highest among the three estates in rank and status were the physicians, represented by the Royal College of Physicians, founded in 1518 by a Royal Charter from Henry VIII and the oldest medical college in England.[1] Physicians regarded themselves as learned gentlemen, a position conferred through a medical degree, commonly from Oxford or Cambridge University, where the curriculum centred upon a classical education and instruction in the manners and deportment that were the hallmark of gentility, rather than any practical therapeutic techniques.[2] Their studies did not require them to touch or examine patients, but rather they observed symptoms, listened to the patient's narrative, and referred to their knowledge of ancient medical texts to reach a diagnosis and prescribe remedies, which were then given to an apothecary to prepare and dispense. In practice, medical degrees could be bought for cash and even where some medical education was required it was unstructured and rudimentary.

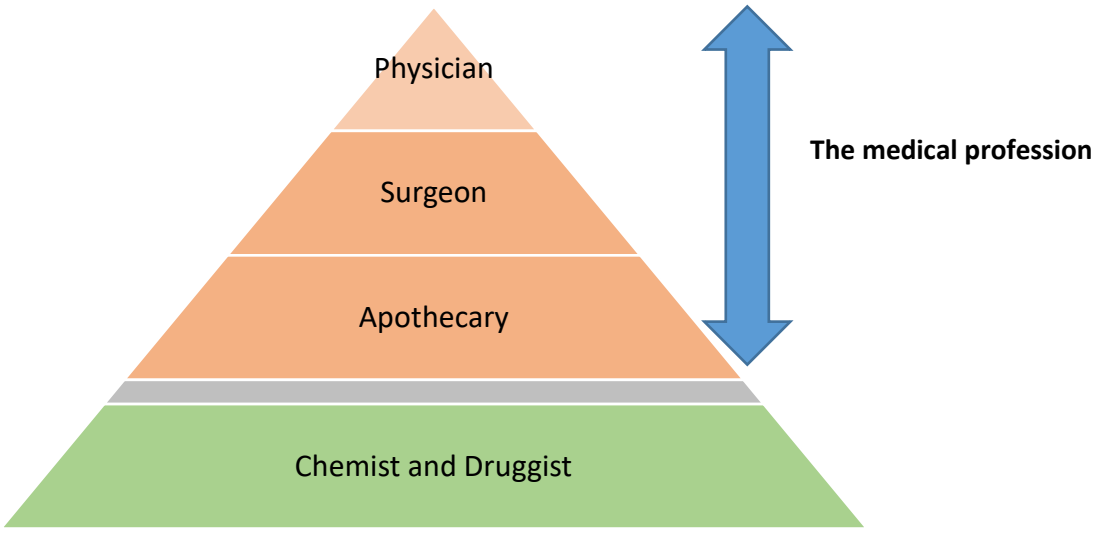

Figure 2.1 The early-modern medical hierarchy

In the middle ages, the church had oversight of medical practice; bishops could confer medical degrees and license doctors to practice. Theological unease over the

[1] Royal College of Physicians, 'Our History,' www.rcplondon.ac.uk/about-rcp/our-history [Date accessed: 26 April 2018].
[2] M.W. Carpenter, *Health, Medicine, and Society in Victorian England* (Santa Barbara, CA, 2010), p.15.

invasiveness of surgery resulted in the splitting of medicine and surgery into separate disciplines. Unlike physicians, surgeons were skilled craftsman who learned their art through apprenticeship. From 1540 until 1745 they were grouped with barbers in a guild; the Company of Barber-Surgeons. Barbers undertook minor surgery and blood-letting and the absence of anaesthetics and anti-septic techniques meant surgery was largely restricted to amputations, lithotomy, herniotomy and superficial excisions, so this association was not without logic.[3] By the late 1700s, no longer encumbered with the barbers, and with anatomy becoming increasingly important in research and teaching, the prestige of the surgeons increased and in 1800 the College (later Royal College) of Surgeons was founded. By the nineteenth century, they had largely achieved parity of status with physicians.

The lowest of the three estates were the apothecaries, who traditionally prepared and dispensed medicines prescribed by the physicians. They were tradesmen and were represented in London by the Society of Apothecaries, a city livery company. Originally combined with the Spicers and Grocers in the medieval period, in 1617 they were recognised as a separate guild by James I. The Society of Apothecaries was important to the evolution of pharmacy in Britain and was involved in the manufacture of drugs until the twentieth century. In 1703, the apothecaries had won an important court ruling over the physicians, allowing them to prescribe as well as dispense medicines without fear of prosecution, provided they charged only for medicines and not for advice. This ruling made possible the emergence of general practice[4] with Corfield finding 'the new composite noun (first used in 1714) ...rapidly coming into currency in the early nineteenth century, especially among the medical community itself.'[5]

Historians have long questioned the extent to which this tri-partite order was as rigid in practice as it was in theory; Pelling suggesting it 'existed more as a weapon in conflicts between practitioners than as an agreed framework.'[6] That the boundaries

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[3] J. Woodward, *To do the Sick no Harm: A Study of the British Voluntary Hospital System to 1875* (London, 1974), pp.75-96.
[4] I. Loudon, 'James Mackenzie Lecture: The Origin of the General Practitioner,' *Journal of the Royal College of General Practitioners*, No.33 (1983), pp.13-18.
[5] P.J. Corfield, *Power and the Professions in Britain 1700-1850* (London, 1995), p.149.
[6] M. Pelling, *The Common Lot: Sickness, Medical Occupations and the Urban Poor in Early Modern England* (London, 1997), p.32.

between the three medical estates were blurred was tacitly accepted by the state (as the 1703 ruling acknowledged) and beyond London, the demarcation between the three branches was never as clear-cut as Figure 2.1 suggests. In the provinces, physicians were rare and although 'by the end of the seventeenth century there can have been few market-towns without a resident physician… [they] were too expensive for the bottom half of the population, even though they often tailored their bills to fit the pockets of their clients.'[7] Consequently, the more numerous and cheaper surgeon-apothecaries (general practitioners) necessarily dealt with medical, surgical and midwifery cases, giving advice and dispensing medicines. According to Hill, 'by the 1830s [the general practitioner] …was the doctor of first resort, providing 90 per cent of the qualified medical care in England.'[8]

Although jealousy between the three branches was endemic, this situation was for the most part unproblematic until the Industrial Revolution expanded the middle-class and 'the growth of their incomes produced a massive increase in the market for medical care.'[9] At the same time, *laissez-faire* economics was becoming increasingly influential.[10] These twin developments Parry and Parry saw as being 'of enormous importance' to the fortunes of the medical profession. [11] The number of doctors increased rapidly to meet rising demand and at the same time chemists and druggists emerged as rivals in the provision of community health care. Doctors thus faced a period of unprecedented competition, while at the same time a wave of hospital construction created new medical roles and new opportunities. The consequence of all these changes was that 'the tripartite structure of the profession was increasingly breaking down and being replaced by a new structure, in which the two major groups were general practitioners and consultants.'[12] These developments were not experienced

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[7] K. Thomas, *Religion and the Decline of Magic* (London, 1978), p.12.
[8] J. Hill, 'The New Man of Medicine in Nineteenth-Century Britain,' *Perspectives in Biology and Medicine*, Vol.28, No.4 (1985), p.583.
[9] N. Parry and J. Parry, *The Rise of the Medical Profession: A Study of Collective Social Mobility* (London, 1976), p.104.
[10] *Ibid*.
[11] *Ibid.*
[12] I. Waddington, *The Medical Profession in the Industrial Revolution* (Dublin, 1984), p.42.

in the same ways everywhere; there was significant regional variation and differences in both the numbers of medical men per head of population and their incomes.[13]

Although physicians enjoyed greater prestige and status than the two other branches, no group possessed any greater therapeutic power than another. This equality of ability did not prevent the early nineteenth century being characterised by an increasingly acrimonious division between the small London-centric elite, who dominated the Royal Colleges, and rank-and-file of provincial general practitioners, whose qualifications they refused to recognise for admission as Fellows.[14] General practitioners 'defied the compartmentalized structure represented by the system of orders' and were increasingly dissatisfied with a *status quo* that treated them as second-class doctors.[15] The problem, as Loudon pin-pointed, was that although 'often no more than a hairs-breadth separated the physician and the general practitioner… professional respectability eluded the general practitioner as long as he sold bottles of medicine for sixpence or less, and dug in his back pocket for the change of a shilling like a grocer.'[16] Snobbery poisoned relations to the point whereby the early nineteenth century the rival branches of the profession 'were at loggerheads with each other.'[17] Typical of the complaints of the general practitioners was this contribution to *The Medico-Chirurgical Review* in 1826:

> Presuming on having practised the different branches of the profession, a physician of this cast is one time found dressing a sore leg, on attempting to reduce a fracture, and at another officiously interfering in a lying-in chamber; which perhaps he enters for the first time in his life. No set of men are more clamorous for practice, and none less delicate in their mode of obtaining it; and that they succeed beyond their merits, is a truth that must be acknowledged. They wish to inculcate an opinion that they have received from nature, a secret propensity to all that is good and virtuous; and indulge the extravagant vanity, that they are, by nature, superior to all others. They have the effrontery to expect that, when they are consulted, the inferior practitioner, as they indecently style the family attendant, is to surrender the case entirely into their hands; and express great surprise when they find any man with sufficient good sense and regard for the welfare of his patient, not tamely to submit to their wishes. Inflated with a vain conceit of their acquirements, with an intolerant temper, they aim at universal dominion over their better-

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[13] J.F. Kett, 'Provincial Medical Practice in England 1730–1815' *Journal of the History of Medicine and Allied Sciences*, Vol.19, No. 1 (1964), pp.17-29; I. Loudon, *Medical Care and the General Practitioner, 1750-1850* (Oxford, 1986).

[14] J. J. Rivlin, 'Getting a Medical Qualification in England in the Nineteenth Century,' *Medical Historian*, No.9 (1997), pp.56-63.

[15] Parry and Parry, p.104.

[16] I. Loudon, 'Medical Practitioners 1750-1850 and Medical Reform in Britain' in A. Wear (ed.), *Medicine in Society* (Cambridge, 1992), p.241.

[17] R. Porter, *Disease, Medicine and Society in England, 1550-1860*, second edition (Cambridge, 1993), pp.45-46.

> informed and more deserving brethren; and varnish over their mean designs with an affected liberality.[18]

The medical colleges were the embodiment of a class system that stifled the kind of meritocracy demanded by the aspiring middle-classes and the power struggle within the medical profession was in some ways a microcosm of wider divisions in British society. These tensions provided the impetus for reform and allegedly contributed to the end of the medical marketplace, although the extent to which the timescale of change corresponded to the chronology of medical reform is a question this study will need to explore.

In 1815, at the dawn of the Age of Reform, these developments were still in the future. In the narrative of medical marketplace, the immediate consequence of the erosion of the tri-partite order was the emergence of an anarchic free market in healthcare, one allegedly characterised by plurality, diversity, choice and competition. Bartrip, for example, has described how:

> At least until the passing of the Medical Act of 1858, the organisation of the medical profession and the provision of medical care in Britain were in chaos. Anyone could call himself a practitioner and attend the sick. The public had no guarantee of the proficiency or probity of those whom they consulted, for there existed no body to exercise effective control over education and licensing or to warrant professional competence.[19]

This era of 'free-range medicine' impacted too upon the doctor-patient relationship, with which medical authority was inexorably bound up.[20] Thus, this topic is critical to understanding how healthcare evolved in the way that it did. This subject has received a great deal of attention from both historians and sociologists over the past fifty years and it forms the topic of the next section.

2.3 The doctor/patient relationship

The relationship between doctors and their patients has never been fixed or uniform and as Davenport-Hines recognised, in the nineteenth century 'the ways in which medical authority was exercised were inseparable from the social position of the physician' who

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[18] *The Medico-Chirurgical Review*, new series, Vol. 5, No.9 (1 July 1826), pp.210-211.
[19] P. Bartrip, 'Quacks and Cash,' *History Today*, Vol.40, No.9 (September 1990), p.46.
[20] A. Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720–1911* (Cambridge, 1994), p.300.

held an 'ambiguous and precarious status.'[21] Digby too has argued that 'whether sufferers decided to become patients and place themselves under regular practitioners was influenced historically by an evolving state of medical authority.'[22] The changes in the organisation and structure of medicine described above thus had important implications for the doctor-patient relationship. Hogarth has described how:

> The early modern doctor-patient relationship was a more equal one for a variety of reasons. Doctors practised alongside a plethora of orthodox and non-orthodox practitioners, all competing for the business of the sick in a diverse medical marketplace relatively free of state regulation. Much primary care, moreover, was provided by friends and family in a society in which lay people both understood many of the basic aspects of medical theory, such as the humoral system, and supplemented this with different kinds of folk medicine.[23]

In the nineteenth century, the status of doctors changed markedly because of a confluence of factors, including scientific progress and the rise of hospital medicine, but also broader changes in society that saw greater public respect for medical authority and a decline in the influence of lay patronage on medical careers. Although Corfield rightly pointed out that 'provided that people had confidence in the medical profession, their role was assured'[24] it is also a truism that before the late nineteenth century, 'in his plight the common man could not turn to his physician with much hope of relief.'[25] The reality was that 'from the patient's point of view, there was little their regular medical attendant could do for them when they were ill in 1840 that his predecessor could not have done in 1780 and on the whole the public knew it.'[26] The innate conservatism of the medical profession meant this situation changed more slowly than it might have. Eliot looking back from the perspective of the 1870s thought this was a time when 'medical practice was still strutting or shambling along the old paths.'[27] Bynum found whereas 'science did matter to doctors collectively…it could be neglected by them

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[21] R. Davenport-Hines, *Sex, Death and Punishment: Attitudes to Sex and Sexuality in Britain since the Renaissance* (London, 1991), p.159.
[22] Digby, *Making a Medical Living,* p.300.
[23] S. Hogarth, 'Joseph Townend and the Manchester Infirmary: A Plebeian Patient in the Industrial Revolution' in A. Borsay and P. Shapely (eds), *Medicine, Charity and Mutual Aid: The Consumption of Health and Welfare in Britain, c.1550 – 1950* (Aldershot, 2007), p.92.
[24] Corfield, p.137.
[25] J. M. Young, 'Patent Medicines: An Early Example of Competitive Marketing,' *The Journal of Economic History*, Vol.20, No.4 (December 1960), p.652.
[26] Loudon, 'Medical Practitioners 1750-1850,' p.229.
[27] G. Eliot, *Middlemarch,* (London, 1994) [1871-2], p.146.

individually, and…much of ordinary medical practice was untouched by it.'[28] Digby meanwhile believed 'poverty of patient expectation did little to pressurize GPs into making improvements in their practices either in clinical or organization matters.'[29]

Well into the nineteenth century medicine remained as much an art as a science and according to Gisse 'the need to impress the clients often prompted 'heroic' measures of antiphlogistic practice, especially bleeding and purging, without proper follow up.'[30] Such behaviour led to the widespread suspicion that doctors regularly over-prescribed medicines for financial gain.[31] Heroic dosing, toxic ingredients and ignorance of the process of infection, also meant 'the fatal termination of many illnesses was attributable to the doctor rather than the disease.' Youngson concluded that 'doctors simply did not know enough about medicine' and with 'a wholly inadequate knowledge of pathology, and of drugs' 'it was indeed easier to prescribe than to think.'[32] Furthermore, the reality was that even 'against rising scientific developments in medicine, by 1825 few tangible improvements in reduction in morbidity had been accomplished'[33] and 'advances in pathological anatomy, in cell science, basic physiology and organic chemistry, and the systematic observation of the sick *en masse* in hospitals did not bear significant fruit for saving lives till the last third of the nineteenth century.'[34] Digby has identified how 'enduring weaknesses in much general practice were imprecise diagnosis (employing a limited range of instruments and with little stress on the examination of patients), a tendency to over-prescribe, under-cultivated prognostic ability and poorly developed obstetric skills.'[35] If medical advertising of the period is to be believed, the iatrogenic effects of orthodox treatment fuelled demand for proprietary medicines and probably also medical heresies like hydropathy, medical botany and homeopathy. Digby has suggested that 'where orthodox medicine was conspicuously unsuccessful in therapeutic terms, the patient

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[28] W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge, 1994), p.219.
[29] A. Digby, *The Evolution of British General Practice 1850-1948* (Oxford, 1999), p.8.
[30] G. Risse, 'Medicine in the Age of Enlightenment' in Wear, *Medicine in Society,* p.185.
[31] R.M.S. McConaghey, 'Proposals to Found a Royal College of General Practitioners in the Nineteenth Century,' *Journal of the Royal College of General Practitioners*, Vol.22, No.124 (November 1972), p.776.
[32] Youngson, p.19.
[33] C.J. Pfeiffer, *The Art and Practice of Western Medicine in the Early Nineteenth Century* (Jefferson, N.C., 1985), p.15.
[34] Porter, *Disease, Medicine and Society*, p.61.
[35] Digby, *The Evolution of British General Practice,* pp.16-17.

might see the quacks as at least no worse, whilst promising better'[36] and Chapman that herbalists 'were able to intrude into this crowded business because they could sometimes undercut the medical profession and the chemists and druggists, but also because of a profound distrust of the former's assumptions and methods.'[37] Many of these movements traded upon being 'natural' and 'gentle' alternatives to regular medical treatment. The Malvern water-cure doctor James Wilson warned his patients of the dangers of 'use and abuse of aperient medicines,' advertising his hydropathy treatment as a natural alternative to 'the abuse of drug taking… [resulting in] '*drug diseases*, or diseased states produced by drugs'[38] claiming that 'if the water-cure did nothing more than mitigate the injurious results of purgation as it is often practised in this country, it would be no small boon to society.'[39] He described how one of his patients had:

> …produced a huge packet of prescriptions, which he was anxious I should look over. Here I found the changes had been rung on every tonic and purgative, from calomel to croton oil, from gentian to quinine. Here was also creosote, with what intent I could not divine, and prussic acid, as well as a variety of narcotics. I should mention that his sleep was nearly gone, and when he did sleep, he said his dreams were so horrible that he dreaded going to bed. Here was a brain and bowels all but ruined by medicines and mismanagement.[40]

Therapeutic impotence is the 'elephant in the room' in any discussion of doctor-patient relationships in the first half of the nineteenth century, but we need to be cautious when making any assumptions about how it affected the choices made by different groups of consumers of healthcare products and services.

Although Petersen has claimed that 'the demonstrable efficacy of medical practice was not the source of the profession's prestige and authority, any more than the status of the Anglican clergy derived from the demonstrable effectiveness of prayer and ritual,' public attitudes toward the medical profession were at best ambivalent.[41] Corfield noted how 'knowledge was admired, especially when it had a practical application; but its possessors were ridiculed, if they seemed too vain in their learning

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[36] Digby, *Making a Medical Living,* p.64.
[37] S. Chapman, *Jesse Boot of Boots the Chemists* (London, 1974), p.19.
[38] J. Wilson, *The Principles and Practice of the Water Cure: And Household Medical Science*, 2nd edition (London, 1854), p.xxv.
[39] *Ibid,* p.689.
[40] *Ibid,* p.690.
[41] M. J. Petersen, *The Medical Profession in Mid-Victorian London* (Berkeley, CA, 1978), p.4.

or abstruse in their theories or odd in their personal behaviour.'[42] An environment where regular doctors were trusted, admired and lauded by some but distrusted, feared and lampooned by others was supposedly conducive to a flourishing medical marketplace and according to Porter the art of doctoring in this era was to understand that 'medicine's public presence was inextricably linked to recognition that it was a mode of theatre, be it a turn or a trick, cant, magic, or mumbo-jumbo.'[43] Flanders has even speculated that 'doctors saw patients' ignorance as an opportunity; the less patients knew of diagnosis, treatment and cure, the more reliant on their medical men they would have to be.'[44]

Unsurprisingly, all of this had implications for the relationship between doctor and patient. All too obviously lacking therapeutic powers, doctors relied instead upon social capital and when the fee-paying customer 'assessed the worth of his doctor in face-to-face interaction it was necessary for the physician to adopt the stereotyped manner and intellectual worldview of his upper-class clientele.'[45] This was a time when 'what counted for the rich in choosing a doctor was whether he was a gentleman.'[46] In this situation, 'the educated and affluent sick played an assertive and sometimes even dominant role in clinical consultations.'[47] Well into the nineteenth century 'professional status as a physician, surgeon or apothecary was determined less by the examining bodies, to which one might submit for certification, than by patronage'[48] and 'within the patronage system the aristocratic and wealthy client was the dominant figure in the doctor-patient relationship.'[49] Patients could be fickle and, as chapter six will show, routinely sought second or third opinions if they did not get the results they expected. Successful doctors were those who indulged the whims of their patients and whose 'ideal manner was the discrete sympathy of a wise family friend.'[50] Beside manner was

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[42] Corfield, p.46.
[43] R. Porter, *Bodies Politic: Disease, Death and Doctors in Britain, 1650-1900* (London, 2001), p.25.
[44] J. Flanders, *The Victorian House: Domestic Life from Childbirth to Deathbed* (London, 2003), p.305.
[45] N.D. Jewson, 'Medical Knowledge and the Patronage System in 18th Century England,' *Sociology,* Vol. 8, No.3 (September 1974), p.379.
[46] C. Lawrence, 'Incommunicable Knowledge: Science, Technology and the Clinical Art in Britain 1850-1914,' *Journal of Contemporary History*, Vol.20, No.4 (1985), p.506.
[47] R. Porter, 'Lay Medical Knowledge in the Eighteenth-Century: The Evidence of the Gentleman's Magazine,' *Medical History*, Vol.29, No.2 (1985), p.138.
[48] K.A. Morrison, ''Dr Locock and His Quack': Professionalizing Medicine, Textualizing Identity in the 1840s' in L. Penner (ed.), *Victorian Medicine and Popular Culture* (London, 2015), p.11.
[49] Waddington, *Medical Profession,* p.191.
[50] Corfield, p.143.

particularly important in terminal cases where only comfort and reassurance could be offered.[51] For Loudon, 'the essence of the family doctor was his combination of a clinical and a pastoral role'[52] and as Porter pointed out:

> in a society in which, for complex reasons, the Christian clergy were ceasing to meet the personal needs of many – a society in which other comfort-giving professionals, such as social workers and psychiatric personnel, had not yet emerged – the trusted family doctor had much to contribute, through the confidences of the sick-bed, as friend, advisor and guide.[53]

This was not of itself enough however; doctors also needed to maintain a certain lifestyle if they were to be favoured with the custom of the local elite. This was expensive and drove much of the profession's disquiet over competition that characterised the Age of Reform.

Patients at the other end of the social spectrum had good reason to distrust doctors. Attempts to suppress the illegal trade in cadavers and the practice of 'Burking' through the 1832 Anatomy Act (which made unclaimed pauper bodies from the workhouses available to the surgeons), were deeply resented by the poor and cast a long shadow over their relations with the medical profession.[54] Dissection was 'widely regarded as an insult to the body and to the person'[55] and doctors were suspected of being 'mercenary, often brutal, and prone to hide their ignorance behind grand-sounding diagnoses. They kept company with disease and death.'[56] It has been suggested that 'poor people… feared that doctors' strongest motive in admitting them to the hospital was to acquire their bodies after death, not to make those bodies well again.'[57] Certainly, nineteenth-century 'surgeons had extraordinary rights and powers over people's bodies'[58] and Holloway has described how 'among working people there was a strong current which rejected the elitism of those in authority and distrusted the services

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[51] D. Helm, '"The Beauty of a Sick Room": Family Care for the Dying in the English Upper and Middle-Class Home*, Family and Community History*, Vol.16, No.2 (October 2013), pp.100-112.
[52] Loudon, *Medical Care*, p.277.
[53] Porter, *Disease, Medicine and Society*, p.62.
[54] E.T. Hurren, *Dying for Victorian Medicine: English Anatomy and its Trade in the Dead Poor, C.1834–1929* (Basingstoke, 2012); R. Richardson, *Death, Dissection and the Destitute* (London, 1987).
[55] Jewson, 'Medical Knowledge and the Patronage System,' p.381.
[56] Corfield, p.43.
[57] Carpenter, p.17.
[58] M.E. Fissell, *Patients, Power, and the Poor in Eighteenth-Century Bristol* (Cambridge, 1991), p.167.

of professionals.'[59] Although Walvin has claimed that 'as the medical profession came under greater control the dislike or distrust of doctors, so common a feature of plebeian history in the 1820s and 1830s, gradually gave way to tolerance and acceptance,' resistance continued to be a feature of working-class relationships with doctors throughout the nineteenth century, manifesting itself, for example, in opposition to vaccination later in the century.[60] On this issue, Smith concluded that the attitudes of the poor comprised:

> a sober appraisal of their life chances and acceptance of the inescapability of death [where] small expectations were reinforced by apathetic ignorance shading into resentment and resistance to interference from superiors whose authority derived from knowledge, practices and status outside the relationships within their stratum and neighbourhood.[61]

The rise of hospital medicine allegedly played a critical role in the perpetuation of unequal relations between doctors and poor patients. According to Waddington, 'the significance of the development of hospitals…went far beyond the fact that they enabled doctors to see a far greater number of patients than was possible in private practice. Equally important… was the fact that it was within the hospital setting that a new type of doctor-patient relationship emerged.'[62] Hospital construction started in the mid-1700s and gathered pace in the 1800s, reflecting the increasingly complex, technical and scientific nature of medical research and treatment.[63] The first wave of new infirmaries to appear in provincial cities in the second half of the eighteenth century were conceived as charitable projects by local lay interests as a way of regularizing philanthropic giving and demonstrating their benevolence toward the poor. Corfield pointed out how these institutions played a 'defining role' in 'the growth of a corpus of medical knowledge'[64] and Fissell that although 'medical men did not create the hospital they medicalized it.'[65] The authoritarian regime of the hospital meant 'doctors could experiment and act on their prejudices in public practice.' [66] As Abel-

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[59] S.W.F. Holloway, *Royal Pharmaceutical Society of Great Britain 1841-1991: A Political and Social History* (London, 1991), p.73.
[60] J. Walvin, *Victorian Values* (London, 1987), p.30.
[61] F.B. Smith, *The People's Health 1830-1910* (London, 1990), p.158.
[62] I. Waddington, 'The Role of the Hospital in the Development of Modern Medicine: A Sociological Analysis,' *Sociology*, Vol.7, No.2 (May 1973), p.212.
[63] *Ibid;* see also I. Waddington, 'General Practitioners and Consultants in Early Nineteenth-Century England: The Sociology of an Intra-Professional Conflict,' in J. Woodward and D. Richards, (eds), *Health Care and Popular Medicine in Nineteenth-Century England* (London, 1977), pp.164-188.
[64] Corfield, p.137.
[65] Fissell, p.3.
[66] Smith, p.274.

Smith, one of the early pioneers of hospital history, observed, 'while the paying patient had a legitimate right to object to being observed and prodded by a group of students, a person in receipt of charity was hardly in a position to complain about such invasions of his privacy.'[67]

This situation reordered the relationship between doctor and patient; Bynum noted how 'as a kind of abstract concept. "the patient" seems to have acquired a more specific identity among doctors during the century, which is symptomatic, perhaps, of their increasing professional status and the new technologies distancing them from those they treated.'[68] Lewis similarly argued that 'in the course of the nineteenth century, the relationship between physician and patient changed – from the use of verbal exchanges to discover the patient's experience of illness, to direct contact with the patient's body using physical examination, to indirect contact with sickness in the body by the use of machines and technical expertise.'[69] For Fissell, 'diagnosis was undoubtedly the most important locus of the shift in authority from patient to practitioner.'[70]

Here the work of Foucault in the 1960s has been particularly influential.[71] Foucault identified the emergence of a new form of medical practice in late-eighteenth-century revolutionary France, which then spread across Europe. Whereas for previous generations 'medical consultations focussed upon the individual patient [and]… both practitioners and patients believed strongly that health and sickness were individual experiences,'[72] now the patient was regarded merely as the locus of disease, subject to what Foucault termed the 'clinical 'gaze.' He saw this process as intrinsic to medicine's transformation from an art to a science.[73] Foucault placed hospitals at the epicentre of this process. In this critically important area of healthcare, consumer agency was subject to constraint and whereas Jewson observed in the relationship between wealthy patients and their general practitioners 'one of the most important manifestations of the patient's power over the practitioner was his ability to dictate the very definition of illness itself,' in the confines of the hospital the poor patient was, according to this

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[67] B. Abel-Smith, *The Hospitals 1800-1948* (London, 1964), p.18.
[68] Bynum, p.211.
[69] M.J. Lewis, *Medicine and the Care of the Dying: A Modern History* (Oxford, 2007), p.44.
[70] Fissell, p.159.
[71] M. Foucault, *The Birth of the Clinic,* Trans. A.M. Sheridan, (London, 1973).
[72] S.J. Snow, *Blessed Days of Anaesthesia: How Anaesthetics Changed the World* (Oxford, 2008), p.6.
[73] Foucault.

interpretation, merely an object for study.[74] Illich has referred to 'the 'bedside' the clinic, the place where future doctors were trained to see and recognise diseases.'[75] Institutions quickly became the locus of medical power and exerted an influence disproportionate to the numbers of people they treated. Here traditional bedside medicine was replaced by the observation of clinical signs and a focus on the disease rather than the whole person. New techniques of clinical observation, systematic recording of symptoms, pathology, and anatomical dissection all lent themselves to an objectification of the patient, something compounded by doctors' use of arcane language that excluded the patient from the conversation about their care and treatment. In other words, 'the advent of the 'expert' meant that the 'patient' lost control.'[76] It also had the advantage of helping to close medical practice to the uninitiated.

Institutions do not sit well within the medical marketplace model with its emphasis on the power of individual agency, through the process of commercial exchange, as the arbiter of healthcare supply. Hospital patients instead entered a 'social world characterized by deference and obligation, a chain of individual connections between high and low…[where] doctors did not sell their wares to patients. Rather, medical men sold instruction to aspirant medical men,' and in this environment patients became teaching aids rather than consumers of medicine.[77] Waddington observed how 'by the mid-nineteenth century, the doctor-patient relationship was typically no longer one in which the practitioner faced a wealthy and influential patron, but one in which the status of the patient was comparable to or lower than that of the doctor.'[78] The clinical encounter became one in which 'the patient's interest in prognosis and therapy was eclipsed by the clinician's concern with diagnosis and pathology.'[79] Fissell, echoing Foucault, has described how 'a new relationship was forged between patient and practitioner'[80] in which 'the body, the disease, began to become the focus of the medical gaze rather than the patient's version of his or her illness.'[81] Later, 'the

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[74] Jewson 'Medical Knowledge and the Patronage System,' p.376.
[75] I. Illich, *Medical Nemesis: The Expropriation of Health* (London, 1975), p.114.
[76] Corfield, p.141.
[77] Fissell, p.170.
[78] Waddington, *Medical Profession*, p.199.
[79] N.D. Jewson, 'The Disappearance of the Sick-Man from Medical Cosmology, 1770-1870,' *International Journal of Epidemiology*, Vol.38, No.3 (June 2009), p. 628.
[80] Fissell, p.148.
[81] *Ibid,* p.149.

increasingly technologized medicine of the nineteenth and twentieth centuries buried the subjectivity of the patient deeper and deeper beneath a pile of objective evidence.'[82]

This narrative of disempowerment has not gone unchallenged and Foucault's contribution remains controversial. Corfield has argued that 'patients were not all the passive creatures of mythology'[83] and has cautioned that 'consumer reactions were crucially relevant. After all, the professions did not command their own battalions to enforce obedience. Instead, they relied upon public belief.'[84] If the hospital regime had been too tyrannical even the poor and the desperate would have rebelled against it and 'powers could wane if communal validation was withdrawn.'[85] Similarly, Hogarth has noted that 'we cannot simply think of the institution acting on the patient…these institutions [hospitals] were themselves transformed through the experience of being lived in and worked in by human beings who were never reduced to the status of cogs in a machine.'[86] Reinarz has further shown that rules designed to impose order and imprint middle-class values upon the poor were frequently not strictly enforced and were circumvented by patients who identified benefits for themselves in hospital care and knew how to play the system to their advantage.[87] Of course, learning how to navigate the system was not the same as exercising choice, but nevertheless, medical suzerainty was never complete and could be actively resisted by the patients.

In the wider context, a notable manifestation of working-class autonomy was that 'the nineteenth century witnessed a truly remarkable growth in self-help organizations of which the friendly societies were a formidable example.'[88] The suppression of outdoor relief by the state after 1834 encouraged working-class self-help, which also included sick clubs and medical institutes, and provided access to basic medical care via regular subscriptions. Tomkins has highlighted how 'friendly societies and sick clubs appealed viscerally to the working poor who could afford small

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[82] Lewis, pp.51-2.
[83] Corfield, p.141.
[84] *Ibid,* p.21.
[85] *Ibid*, p.245.
[86] S. Hogarth, 'Joseph Townend and the Manchester Infirmary: A Plebeian Patient in the Industrial Revolution' in A. Borsay and P. Shapely (eds), *Medicine, Charity and Mutual Aid: The Consumption of Health and Welfare in Britain, c.1550–1950* (Aldershot, 2007), p.109.
[87] J. Reinarz, 'Investigating the 'Deserving' Poor: Charity and the Voluntary Hospitals in Nineteenth-Century Birmingham' in *Ibid,* pp.111-133.
[88] Parry and Parry, p.147.

subscriptions, since they protected members from the need to treat with the Poor Law.'[89] Later in the century 'rising wages made professional help less financially crippling…working men were encouraged to pay small weekly sums into sickness clubs, to ensure treatment in time of need, from an officially appointed doctor.'[90] These organisations commonly offered medical attention for the employed breadwinner, thus helping to loosen the link between sickness and pauperization. Friendly societies had their own panels of doctors and chemists, who they employed on a fixed fee basis. Some also bought subscribers rights to local hospitals, enabling them to recommend members for treatment. For doctors, friendly society posts meant 'a galling lack of autonomy' with 'friendly society doctors…always liable to be hauled over the coals by the lay committee.'[91] Although 'doctors argued it was demeaning for middle-class professionals to be employed by working-class groups'[92] and complained about the poor remuneration associated with these posts, not all of them could afford the luxury of ignoring this work.[93] These forms of self-help challenge the notion of the working classes as simply passive recipients of healthcare. Instead of being the disempowered subjects of the clinical gaze, or the vulnerable and gullible prey of quacks and medicine vendors, it suggests patients who valued regular medical advice and set about getting it on their own terms. Which of these interpretations carries the more weight will be explored in chapter six.

What has emerged here is a nuanced picture of the doctor-patient relationship. Certainly, there is a case for the agency of some consumers being severely constrained by structural forces. A medical marketplace supposedly characterised by diversity, plurality, choice and competition was inevitably bound up with the shifting balance of power between doctors and patients. Trust varied widely between different individuals and different social groups. For some it was implicit; it was just a matter of which practitioner(s) to favour, for others, doctors *per se* were treated with suspicion and

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[89] A. Tomkins, ''The Excellent Example of the Working Class': Medical Welfare, Contributory Funding and the North Staffordshire Infirmary from 1815, *Social History of Medicine*, Vol. 21, No.1 (March 2008), p.14.
[90] U. Miley and J.V. Pickstone, 'Medical Botany Around 1850: American Medicine in Industrial Britain' in Cooter, R. (ed.), *Studies in the History of Alternative Medicine* (London, 1988), p.152.
[91] Porter, *Disease, Medicine and Society*, p.51.
[92] Bynum, pp.198-199.
[93] For two sides of this debate see D.G. Green, *Working-Class Patients and the Medical Establishment: Self-help in Britain from the Mid-Nineteenth Century to 1948* (Aldershot, 1985) and R.M.S. McConaghey, 'The History of Rural Medical Practice,' in F.N.L. Poynter (ed.) *The Evolution of Medical Practice in Britain* (London, 1961), pp.117-143.

alternatives to regular medical advice might have been more attractive. Importantly however, despite the large corpus of literature devoted to the doctor-patient relationship, the premise that unequal relations dissuaded working-class people from seeking medical advice is not proven and whether it was sick poor or other groups that were most attracted to other offerings is something this study will explore. All of these questions have implications for one of the cornerstones of the medical marketplace model – competition.

2.4 Competition in the 'medical marketplace'

In the Age of Reform, doctors faced competition from an overstocked medical profession and an array of unqualified 'irregular' suppliers, in the form of quacks, medicine vendors, chemists and druggists, and midwives. This section deals first with the literature relating to intra-professional competition within the medical profession and then with alleged competition from these 'irregular' providers. The two main external sources of competition to regular doctors, chemists and druggists and proprietary medicine manufacturers, are considered individually in subsequent sections.

Early nineteenth-century general practitioners complained vociferously about competition from unqualified rivals and bemoaned the stupidity of patients in using them. The failure of politicians to legislate to eradicate, or even significantly curtail, irregular practice in 1815 and again in 1858 was a bitter disappointment to the medical reform lobby, but as Waddington observed, 'the impoverished general practitioner had much greater cause for concern from the competition of his regular colleagues than he had from irregular practice.'[94] King has identified how 'from the early nineteenth century…competition amongst medical men became severe as the supply of fully and partially trained medical men overtook the growth rate of the general population.'[95] Overstocking became particularly acute in the immediate aftermath of the Napoleonic Wars, when large numbers of military surgeons were discharged into civilian practice. Hodgkinson referred to the presence of 'so many indigent doctors'[96] and Digby to 'an

[94] Waddington, *The Medical Profession,* p.214.
[95] S.A. King, *A Fylde Country Practice: Medicine and Society in Lancashire, circa 1760–1840* (Lancaster, 2001), p.67.
[96] R.G. Hodgkinson, *The Origins of the National Health Service: The Medical Services of the New Poor Law, 1834-1871'* (London, 1967), p.233.

abundance of practitioners.'[97] Loudon claimed that 'between 1820 and 1850 it was an article of faith that medicine was *the* overcrowded profession.'[98] Doctors had to somehow reconcile being seen to be fulfilling their duties as gentlemen, by treating the poor at reduced rates (and on the tacit understanding that payment may never be forthcoming), or for nothing, whilst maintaining the lifestyle demanded of that rank and status.[99] King found that 'whatever the notional and actual income of doctors, they were expected to have a certain standard of living, a civic and charitable role and a general visibility which could be costly to maintain.'[100] Demonstrating the necessary degree of largesse whilst staying financially solvent were not always reconcilable objectives, especially if the practice had few wealthy, full-fee-paying customers and Waddington found that 'poaching each other's patients, was common.'[101] According to Porter, general practitioners 'remained appallingly overworked… Most ended up, willy-nilly, treating scores of the sick poor who never paid at all'[102] and Tomkins has described how 'the strains of juggling private practice, public responsibility, domestic solvency and personal ambition could and did wreak havoc on individual men's physical and mental health.'[103]

In 1859, Dickens, writing in his weekly magazine *Household Words*, described how doctors were 'obliged not seldom to turn away the rich man who would pay him for his visit, to fulfil his duty to a poor man in more urgent need; and for all such labour he receives nominal payment, with few thanks from boards of guardians.'[104] King records how 'those who avoided bankruptcy might nonetheless experience considerable cash flow problems'.[105] In Eliot's retrospective, *Middlemarch,* Dr Lydgate famously loses his reputation by taking an ill-considered loan to pay off mounting debts, suggesting that when Eliot was writing forty years after the event, the notion of the

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[97] Digby, *Making a Medical Living*, p.299.
[98] Loudon, *Medical Care*, p.208.
[99] Having said this Hodgkinson cited 5.5 per cent of the population as receiving gratuitous medical relief in 1847 in both Gloucester and Cheltenham – much lower than in some northern industrial towns. Hodgkinson, *National Health Service*, p.256.
[100] King, *Fylde County Practice*, p.73.
[101] Waddington, *The Medical Profession*, p.168.
[102] Porter, *Disease, Medicine and Society*, p.51.
[103] A. Tomkins, 'Mad doctors? The Significance of Medical Practitioners Admitted as Patients to the First English County Asylums up to 1890,' *History of Psychiatry,* Vol.23, No.4 (December 2012), p.439.
[104] C. Dickens (ed.), 'Medical Practice Among the Poor,' *Household Words,* No.239 (21 October 1859), p.217.
[105] King, *Fylde County Practice,* p.69.

early nineteenth-century general practitioner as struggling to make a medical living had entered common parlance. Late or non-payment of fees was a perennial problem; in September 1842 the Berkeley surgeon Henry Jenner wrote to the executors of one Edward M. Pearce Esq, of Thornbury asking for reimbursement for 'consultations, professional advice and prescribing and occasional attendance for 19 [original underlining] years… to the sum of 50 Guineas![106] The early nineteenth-century general practitioner is presented as eking out a tenuous living, often only an illness, or riding accident, away from financial ruin. Porter described 'a highly vulnerable individual in a competitive, buyer's market.'[107] Financial insecurity appears endemic to general practice in the provinces and Loudon claimed 'one of the penalties of an overcrowded profession was the acceptance of very low salaries by inexperienced young outsiders over the heads of local, experienced, and known practitioners.'[108] When 'rivals were always snapping at their heels'[109] struggling general practitioners were forced to accept salaried posts in workhouses and gaols with low pay, long hours and heavy workloads.[110] Lane described how this could lead to poor patient care:

> the duties of a prison surgeon were performed part-time by a local practitioner who lived near the gaol and who would inspect prisoners and attend the sick in addition to his other patients. Gaol surgeons were appointed and paid by the county's magistrates at Quarter Sessions and, as the visits of the prison reformer, John Howard, revealed, levels of medical attention varied very considerably.[111]

An 1826 article in the *Medico-Chirurgical Review* claimed that 'it is true the profession is over-stocked – and men, the young as well as the old, will descend to many a shift, rather than starve.'[112] The more ambitious among them also indulged in various forms of self-promotion in order to attract attention especially if they were starting afresh rather than taking over an existing practice.[113] Granshaw found 'upwardly mobile entrepreneurs were as evident in the medical profession as in other

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[106] 'A letter from Henry Jenner, Surgeon, rendering account for professional services for 19 years,' 1842, Gloucestershire, GA, Berkeley, Chipping Sodbury, Dursley, Slimbridge, Westbury-on-Severn: deeds, MS D135/Z4.
[107] Porter, *Disease, Medicine and Society*, p.52.
[108] Loudon, *Medical Care*, p.240.
[109] Porter, *Disease, Medicine and Society*, p.51.
[110] Smith, p.363.
[111] J. Lane, *The Making of the English Patient: A Guide to Sources for the Social History of Medicine* (Stroud, 2000), p.144.
[112] *The Medico-Chirurgical Review*, new series, Vol. 5, No.9 (July 1826), p.209.
[113] R. Biddle, 'Dissecting the Medical Marketplace: The Development of Healthcare Provision in Nineteenth-Century Portsmouth,' unpublished PhD thesis (Oxford Brookes University, 2009).

social strands of nineteenth-century life.'[114] However, despite the body of evidence and opinion pointing toward an intensification of intra-professional competition in the early nineteenth century, the extent of local variation remains one of the key lacunae in the historiography.

In addition to competition from within their own ranks, exponents of the medical marketplace have placed much emphasis on the presence of unqualified suppliers, who proliferated in the *laissez-faire* commercialism of the Industrial Revolution.[115] Porter believed this to be symptomatic of the failure of orthodox medicine to provide what the public wanted.[116] Illich, on the other hand, argued that orthodox medicine needed quacks, as 'the existence of a few charlatans or racketeers has always served the credibility of the medical guild: by denouncing their misbehaviour, the typical practitioner could legitimize the abuses inherent in his ordinary practice.'[117] Marland saw their presence as inevitable when 'medicines and medical advice came to be seen as commodities, to be bought and bargained for.'[118] Although amateur healers had always existed in the form, for example, of wise women, conjurers and bonesetters – 'a job that would normally be carried out, in a country district, by a farrier or vet,' the literature describes how, in the eighteenth-century, quackery reached an industrial scale, targeting those too poor to afford regular medical advice, or gullible enough to believe in the false promises of the nostrum mongers.[119] According to Smith, because 'medical fees were high in relation to wages and salaries throughout the nineteenth century,' this fuelled demand for quack remedies.[120] It is a widely held belief that the principal

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[114] L. Granshaw, ''Fame and Fortune by Means of Bricks and Mortar': The Medical Profession and Specialist Hospitals in Britain, 1800-1948 in L. Granshaw and R. Porter (eds), *The Hospital in History* (London, 1990), p.202.

[115] M. Brown, *Performing Medicine: Medical Culture and Identity in Provincial England, c.1760-c.1850* (Manchester, 2011); W. F. Bynum and R. Porter, *Medical Fringe and Medical Orthodoxy, 1750-1850* (London, 1987), pp. 55–73; L. Barrow, 'Why were most medical heretics at their most confident around the 1840s? (The Other Side of Mid-Victorian Medicine),' in French and Wear, *British Medicine*, pp.165-185; H. Marland, 'The Medical Activities of Mid-Nineteenth-Century Chemists and Druggists, with Special Reference to Wakefield and Huddersfield,' *Medical History*, Vol.31, No.4 (1987), pp. 415–439; R. Moore, *Shropshire Doctors & Quacks* (Stroud, 2011); R. Porter, *Health for Sale: Quackery in England, 1660-1850* (Manchester, 1989); R. Porter, *Quacks, Fakers & Charlatans in English Medicine* (Stroud, 2000), p.208.

[116] See Porter, *Quacks.*

[117] Illich, *Medical Nemesis*, p.75.

[118] Marland, 'The Doctor's Shop,' p.102.

[119] G. Williams, *The Age of Agony: The Art of Healing c1700–1800* (London, 1975), p.181.

[120] Smith, p.28.

clientele of the quacks were the poor. Brown for example; has claimed that 'if the regular practitioners acted for the richer sections of the population, the poor could obtain medical relief under the New Poor Law but this had drawbacks and they often had recourse to various types of "irregular practitioners."'[121] Woodward and Richards similarly described how 'popular manuals and quackery satisfied rising demand, especially among the lower classes, who were not gaining access to the medical establishment.'[122]

Evidence in support of such conclusions has come not only from the complaints of nineteenth-century medical men but from a range of other contemporary commentators. In 1854 for example, an article in *Household Words* claimed 'innumerable are the quackeries and delusions to which the ignorant poor are exposed.'[123] Eliot suggested in *Middlemarch* that 'since professional practice chiefly consisted in giving a great many drugs, the public inferred it might be better off with more drugs still if they could only be got cheaply, and hence swallowed large cubic measures of physic prescribed by unscrupulous ignorance which had taken no degrees.'[124] Traditionally, quacks were conspicuous for showmanship and 'puffery.' They commonly offered 'secret remedies' for ailments such as venereal disease, hearing loss, or receding hair. Often itinerant, they moved from one town fair, street market, or hired room, to another. However, determining who was and was not a 'quack' was always a subjective exercise. Porter has described how:

> quacks, mountebanks, charlatans, and the like were the sweepings of the gutter, mere scum…They possessed no medical abilities. Their much-trumpeted arts and arcana, pills and potions, were at best worthless, and, all too often, positively deadly draughts. They laid claim to miraculous powers, encyclopaedic knowledge, wonder cures, stupendous successes, the patronage of popes, princes and people, and universal applause. But all this was utter bunkum. For they were nothing but liars, cheats, and impostors. Above all, quacks were other people. Everybody felt happy in execrating the quack, because, everybody could agree, the quack was someone else.[125]

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[121] P.S. Brown, 'The Providers of Medical Treatment in Mid-Nineteenth Century Bristol,' *Medical History*, Vol.24, No.3, (1980), p.297.
[122] J. Woodward and D. Richards. 'Introduction' in Woodward and Richards, p.11.
[123] Dickens, 'Medical Practice Among the Poor,' p.219.
[124] Eliot, *Middlemarch,* p.146.
[125] Porter, *Quacks*, p.15.

Before 1858, the boundary between regular and quack was blurred and, according to Corfield, 'became a matter of subjective judgement rather than systematic definition.'[126] Porter has suggested that 'where patients have some say, distinctions between so-called quacks and regulars will take on a reduced significance – for it is the professionals who, given the opportunity, magnify the distinctions.'[127] In the nineteenth century, "medical orthodoxy" and "medical fringe" 'were slowly but surely differentiated more rigidly and visibly.'[128] The Apothecaries Act of 1815 began a process of legal separation, differentiating the qualified and unqualified, but some 'irregulars,' such as the Malvern hydropathists, Drs Wilson and Gully were also qualified doctors. Prior to the mid-nineteenth century, any doctor who chose to specialise in any form of treatment, such as eye and ear doctors, dentists, and venereal disease specialists, incurred the suspicion of colleagues[129] and Weisz identified how in Britain 'specialization… took a unique form: it was cultivated to a considerable extent outside the medical elite, and it had a distinctly entrepreneurial cast.'[130]

One area where nineteenth-century quackery differed noticeably from earlier times was that 'the fringe… developed its own populist ideologies of plebeian radicalism.'[131] New health movements emerged that consciously rejected medical orthodoxy and Porter found 'considerable evidence that many Victorian patients repudiated regular medicine – became total abstainers, as it were – and abandoned themselves exclusively to some alternative system of their choice.'[132] The new medical heretics included galvanists, homeopaths, hydropathists, hygeists, medical botanists, mesmerists and phrenologists among others. These movements embodied the entrepreneurial, self-reliant *zeitgeist.*[133] While Branca observed how 'by applying some

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[126] Corfield, p.26.
[127] R. Porter, ''Quackery' and the 18th-Century Medical Market' in R. Cooter (ed.), *Studies in the History of Alternative Medicine* (London, 1988), p.8.
[128] D. Porter and R. Porter, *Patient's Progress: Doctors and Doctoring in Eighteenth-Century England* (Cambridge, 1989), p.114.
[129] L.F. Cody, '"No Cure, No Money," or the Invisible Hand of Quackery: The Language of Commerce, Credit, and Cash in Eighteenth-Century British Medical Advertisements,' *Studies in Eighteenth-Century Culture*, Vol.28, No.1 (1999), p.106.
[130] G. Weisz, 'The Emergence of Medical Specialization in the Nineteenth Century,' *Bulletin of the History of Medicine,* Vol.77, No.3 (2003), p.565.
[131] Porter and Porter, *Patient's Progress,* p.114.
[132] Porter, *Quacks*, p.118.
[133] L. Loeb, 'George Fulford and Victorian Patent Medicine Men: Quack Mercenaries or Smilesian Entrepreneurs,' *Canadian Bulletin of Medical History*, Vol.16, No.1 (1999), pp.125-145.

of the newest discoveries in scientific knowledge and an esoteric terminology, nineteenth-century quackery claimed for itself a very attractive aura of modernity and authenticity which appealed to the new mentality of the middle class,' some of these groups also drew upon a world view that rejected the values of urban-industrial society.[134] Porter identified how 'many nineteenth-century medical movements…declared their outright opposition to commercialism, fashion and the corruption of orthodox medicine, advocating instead a 'return to Nature.'[135] In this they had parallels with Victorian medievalism, the Arts and Crafts movement, and utopian socialism. Their emergence speaks of diversity and plurality, but it also suggests segmentation or stratification in the healthcare economy. All were vilified by the medical establishment, not because their treatments were necessarily dangerous, but because they threatened to undermine the epistemological pillars upon which the medical authority and prestige rested. The medical establishment devoted far more energy to suppressing them than it did questioning the suitability of booksellers, printers, grocers, and newspaper vendors to sell powerful medicines to the public.

The likes of James Morison, the founder of the hygeism, 'attempted – and with enormous success – to turn the selling of health into a cause and a crusade.'[136] Alternative theories resounded with a disillusioned public, who 'commonly believed they were being recklessly overdosed solely to inflate physicians' fees and apothecaries' profits.'[137] Griggs noted how 'the millions in the early nineteenth century who turned to homeopathy and Thomson, to Beach, to Coffin, to Botanic Medicine, were not so much attracted by a theory, or lured away by the idea of dosing themselves with herbs, as they were thoroughly dissatisfied with therapy that killed as often as it cured, and was painful as well.'[138] It was not just the working classes who were attracted by these movements; Brown found that mesmerists 'were patronised by the well-to-do whose

[134] P. Branca, *The Silent Sisterhood: Middle-Class Women in the Victorian Home* (London, 1975), p.67.
[135] Porter, *Quacks*, p.56.
[136] Porter, *Quacks,* p.201.
[137] Porter and Porter, *Patient's Progress*, p.61.
[138] B. Griggs, *Green Pharmacy: The History and Evolution of Western Herbal Medicine* (Rochester, VE, 1981), p.276.

interest they aroused and whose involvement they won by their lecture-demonstrations,' despite being regarded as 'grossly ignorant' by the medical profession.[139]

All these competitors were labelled as quacks by a medical establishment whose outward confidence in its own therapeutic powers concealed deep insecurity. What made heresies like medical botany and hygeism worse was that they were also predominantly working-class movements whose 'organization was advanced in head-on confrontation with the regular practitioners.'[140] Medical botany was based on the theories of the American Samuel Thompson (1769-1843) and was brought to Britain by the inauspiciously named Dr Coffin, who opened shops in working-class districts selling low-cost herbal medicines (Jesse Boot was an early disciple). The founding principle of the movement was a conscious and explicit rejection of conventional medical theory and practice. Homeopathy was equally loathed and potentially more dangerous to the medical establishment because it had influential supporters and, confounding all established medical and scientific principles, there was some evidence it worked. Youngson noted how 'homeopathy was often a great deal better than orthodox medicine; it at least gave an opportunity for spontaneous recovery.'[141] Typical of the medical profession's response was this contribution dating from 1852:

> HOMEOPATHY is the system of treating disease founded by Hahnemann, upon the principle that diseases presenting certain sets of symptoms are cured by medicinal agents, which have the power of exciting similar symptoms in the body of a healthy person to whom they may be administered. In conjunction with this principle, practical homeopathy enjoins the administration of the above medicinal agents in inconceivably minute doses. In a work like the present, it would be futile – in the limited space which could be allotted to the subject – for the author to attempt to lay before his readers, those reasons which, to his own mind, would render him loth to trust either his own life or the lives of his patients to homeopathic treatment.[142]

Despite such warnings, as Pfeiffer pointed out, homeopathy 'without doubt was less noxious and harmful to patients than the kinds and amounts of poisonous agents administered by orthodox physicians.'[143] Homeopathic treatment performed comparatively well in the cholera epidemics, perhaps less surprisingly when it is noted that calomel was the favoured medication of the Faculty. In response, the medical

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[139] P.S. Brown, 'Mesmerism, Galvanism and Quackery, *Bristol Medico-Chirurgical Journal*, Vol.98, No.2 (April 1983), p.62.
[140] Brown, 'The Providers of Medical Treatment,' p.417.
[141] Youngson, p.19.
[142] S. Thompson, *A Dictionary of Domestic Medicine and Household Surgery* (London, 1852), p.281.
[143] Pfeiffer, p.193.

establishment used its political influence to secure the systematic closure of official positions such as Poor Law medical officer, public vaccinator, coroner, medical officer of health, and prison surgeon to homeopaths and other irregulars. At the same time, the establishment undertook an epistemological cleansing of its own ranks through an increasingly prescriptive medical education and more rigorous examination, designed partly to suppress any deviant thinking; a process that arguably had little to do with public protection.

Such a response reflected the extent of medical unease and clearly these groups were an annoyance, perhaps even a threat, to medical practitioners, but the historiography remains weak when assessing their overall importance and uncertainty surrounds both their numbers and their impact. Superficially, their presence suggests the sort of diversity, plurality, choice and competition associated with a medical marketplace, but the picture is nuanced, and it is unclear whether these suppliers competed directly for customers with regular doctors. Indeed, it is not altogether clear who those customers were. The historiography, admittedly drawing upon contemporaneous sources, has assumed a large proportion comprised the gullible and the poor, but this is not yet proven and the extent of genuine competition, as opposed to a situation in which parallel and more complimentary markets existed, may be exaggerated. Almost certainly, the most serious threat to medical livelihoods in an overstocked market came from fellow doctors and beyond them, the chemists and druggists and the proprietary medicine manufacturers, who occupied a grey area between regular and irregular practice and are respectively the subject of the next two sections.

2.5 The rise of the chemists and druggists

The rise of the chemist and druggist in the late eighteenth and early nineteenth centuries partly reflected developments occurring in retailing[144] that involved what has been described as an 'ever increasing tide of commercial activity.'[145] According to Fissell,

[144] J. Stobart and I Van Damme, 'Introduction: Markets in Modernization: Transformations in Urban Market Space and Practice, c. 1800–c. 1970,' *Urban History* (October 2015), pp.1-14; N. Cox, *The Complete Tradesman: A Study of Retailing, 1550-1820* (Aldershot, 2000); J. B. Jeffreys, *Retailing in Britain* (London, 1954).

[145] N. McKendrick, 'George Packwood and the Commercialization of Shaving' in McKendrick, Brewer and Plumb, *The Birth of a Consumer Society,* p.188.

'medicine was consumption and like other forms of consumer goods and activities, became increasingly commercialized'[146] and Alexander has shown how a rapid increase in the number of chemists and druggists both in London and in provincial cities was one consequence of social and economic changes whereby:

> In England, personal, local and regional self-sufficiency began to break down in the late seventeenth century, accelerating in the late eighteenth and nineteenth centuries. Not only did the growing population require more distribution services, but as the society industrialised, as occupational specialism became more pronounced and population was distributed increasingly in urban settings, personal subsistence activities became increasingly less important and the *per capita* demand for distribution services rose.[147]

Originally, chemists and druggists had been wholesalers of raw ingredients or 'simples,' which they sold to the apothecaries who then compounded them; something they had been doing for centuries. In the eighteenth century, they became more prominent as retailers of drugs, servicing the demands of an expanding urban population. In the wake of the 1815 Apothecaries Act, their ranks were further swelled by a rump of apothecaries who chose to focus on their counter-trade.[148] Corfield spoke of chemists and druggists 'surging into the foothills of the [medical] profession,'[149] Loudon suggesting this 'occurred all over the country…to the detriment of the general practitioners.'[150] Their numerical increase, and the fact that they 'began to dispense and even prescribe on their own account,'[151] meant according to Marland that:

> By the mid-nineteenth century, chemists and druggists were the most numerous suppliers of medical aid. They were difficult to categorize and thus to target, neither fringe nor orthodox, but mere tradesmen. Their remit in principle, was to make up the prescriptions of qualified medical men, but in practice they offered a much wider range of medical services, including over-the-counter prescribing, preparation of family recipes, and the sale of a wide range of drugs and patent remedies. By the turn of the nineteenth century, chemists and druggists were being singled out as a particular threat to orthodox practitioners, as their numbers rose and they engaged increasingly in prescribing activities; dealing directly with the public, in many cases they cut the doctor out of medical transactions.[152]

Curth similarly concluded that 'chemists and druggists fulfilled a major role in the marketing of drugs in the nineteenth century, and by 1850 had become the most

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[146] Fissell, p.72.
[147] D. Alexander, *Retailing in England During the Industrial Revolution* (London, 1970), pp.5-6.
[148] In Gloucester, the chemist and druggist Thomas Washbourn was a trained apothecary.
[149] Corfield, p.156.
[150] I.S. Loudon, 'A Doctor's Cash Book: The Economy of General Practice in the 1830s,' *Medical History*, Vol.27, No.3 (July 1983), pp.266-267.
[151] McConaghey, 'The History of Rural Medical Practice,' p.135.
[152] Marland, 'The Doctor's Shop,' p.80.

numerous suppliers of medical aid, in significant part from the supply of patent medicines.'[153] Loudon referred to 'a sudden increase in the number of dispensing chemists who undercut the regular practitioners' and much of the literature attributes their success to their ability to out-compete doctors on price.[154] Marland, for example, claimed:

> …cost was a further factor that ensured the continuing popularity of the chemist and druggist, many of his products being available for as little as several shillings or pence, while advice was given gratis – provided, presumably, that it accompanied the sale of medicine. Meanwhile, by the mid-nineteenth century, the minimum fee generally charged for *one* visit by a general practitioner was approximately 5s.[155]

As well as successfully competing with general practitioners for the prescription medicines trade, chemists and druggists also fulfilled a need previously met through domestic medicine (something that will be discussed in the next section). According to Holloway:

> …self-diagnosis and self-treatment kept the doctor from the door. The idea of calling in an expert to discover whether and to what extent a person was ill and to have illness defined and categorised appealed more to the doctor than to the patient. Sick people preferred to visit the chemist's shop to have their own diagnosis confirmed, to gain information about the type and range of remedies available and to get some advice on dosages.[156]

This was nothing new: Leong identified how 'the sourcing of ingredients was one of the many areas where household practitioners had to engage with the medical economy'[157] and Holloway saw the rise of the chemists and druggists as 'an aspect of the adaptation of folk medicine to urban, industrial society.'[158] Chemists and druggists sold the ingredients for people to make up their own remedies at home, serving the needs of an urbanizing society where the kind of self-help medicine still possible in rural communities (using plants gathered from hedgerows and grown in gardens), was not always practicable. Long association with domestic medicine meant chemists and druggists were well-placed to take advantage of an increasing preference for the convenience offered by off-the-shelf remedies. Many acted as local agents for the big

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[153] L. H. Curth, 'Introduction: Perspectives on the Evolution of the Retailing of Pharmaceuticals' in Curth, *From Physic to Pharmacology*, p.8.
[154] Loudon, 'James Mackenzie Lecture: The Origin of the General Practitioner,' p.14.
[155] Marland, ''The Doctor's Shop,' p.104.
[156] Holloway, *Royal Pharmaceutical Society,* p.177.
[157] E. Leong, 'Making Medicines in the Early Modern Household,' *Bulletin of the History of Medicine*, Vol.82, No.1 (2008), p.161.
[158] Holloway, *Royal Pharmaceutical Society,* p.57.

London medicine manufacturers, as well as making up their own nostrums.[159] They were skilled entrepreneurs, who diversified so that by the nineteenth century 'a typical chemist's shop would, in addition to a wide range of pharmaceutical preparations, stock a selection of toilet articles, tobacco, snuff, tea, coffee, and other foodstuffs, oils, herbs, and dyes.'[160] What differentiated them from other medicine vendors however was the dispensing of medical prescriptions. This work gave chemists and druggists a much closer connection to the regular medical profession than most of its other competitors. As Holloway recognised, 'the chemist's and druggist's shop was the context in which patent medicines and orthodox medication were brought together. The boundary between the two was never clear cut.'[161]

General practitioners regarded chemists and druggists as 'ignorant interlopers.'[162] An 1825 article in the *Medico-Chirurgical Review*, discussing medical reform, warned that:

> The most respectable plan would be to separate the dispensing of medicine from professional advice or chirurgical aid; but in any but large towns, we fear this is impracticable; and would, at all events, diminish the present revenue of the general practitioner (which is quite little enough) and throw the difference into the pockets of the chymists and druggists, who have already more than their share of pharmaceutical profits.[163]

Criticism of chemists' and druggists' lack of formal education and training was widespread, ironically sometimes appearing in newspapers alongside a plethora of advertisements for the proprietary medicines they stocked. This article from an 1842 issue of the *Gloucester Journal* is typical of the criticism:

> The profession of chemist and druggist borders on the margin of the medical profession; but with this important difference, that it requires no previous examination; - a person of no education, of no understanding, of no skill; in fact, any person who chooses may open a shop, put "chemist and druggist" over the door, fill his window with pretty glass bottles

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[159] Traditionally the term 'nostrum' was used to refer to any medicine prepared by the person who recommended it, but the term came to be widely used to describe quack remedies and proprietary medicines. M.H. Jepson, 'From Secret Remedies to Prescription Medicines: A Brief History of Medicine Quality' in S. Anderson (ed.), *Making Medicines: A Brief History of Pharmacy and Pharmaceuticals* (London, 2005), p.238.

[160] H. Marland, *Medicine and Society in Wakefield and Huddersfield 1780-1870* (Cambridge, 1987), p.237.

[161] Holloway, *Royal Pharmaceutical Society*, p.56.

[162] R. Porter and D. Porter, 'The Rise of the English Drugs Industry: The Role of Thomas Corbyn,' *Medical History*, Vol.33, No.3 (1989), p.282.

[163] Anonymous, 'VIII. Quarterly periscope of practical medicine being the spirit of the medical journals, foreign and domestic; with commentaries,' *The Medico-Chirurgical Review*, new series, Vol.2, No.3 (January 1825), pp.246-248.

> filled with coloured liquids, and announce to the world that he is a chemist and druggist.[164]

Thompson referred to the danger of the 'prescribing druggist' in *A Dictionary of Domestic Medicine and Household Surgery* (1852).[165] Even the hydropathist, James Wilson, himself a medical heretic, complained how 'one day [I]…called at my druggist's, and he said he could prescribe for me *a warmer medicine*, and that the Seidlitz powders were too cold for the stomach.'[166] The stereotype was of a disreputable and unscrupulous incompetent handing out bogus advice and greedily exploiting gullible working-class customers. Picked up by middle-class social commentators, perhaps the most well-known now is Elizabeth Gaskell's description in *Mary Barton* (1848):

> He reached a druggist's shop and entered. The druggist (whose smooth manners seemed to have been salved over with his own spermaceti) listened attentively to Barton's description of Davenport's illness; concluded it was typhus fever, very prevalent in that neighbourhood; and proceeded to make up a bottle of medicine, sweet spirits of nitre, or some such innocent potion, very good for slight colds, but utterly powerless to stop, for an instant, the raging fever of the poor man it was intended to relieve...Barton left the shop with comfortable faith in the physic given him; for men of his class, if they believed in physic at all, believed that every description is equally efficacious.[167]

Although Holloway dismissed this novel as 'truly fictitious…based on neither experience nor empathy…it paints the working class exactly as bourgeois political economists imagined,' there was some truth in Gaskell's account.[168] As will be seen in chapter six, coronial records evidence how a combination of irresponsible dispensing and public ignorance could have fatal consequences. However, it was also clearly in the interests of general practitioners to exaggerate the scale of the problem and conflate competition with quackery. Most chemists and druggists were respectable tradesmen (and women), who learnt their business through apprenticeship rather than formal medical training, as the older generation of apothecaries had themselves done. Holloway believed 'the idea that chemists and druggists were ignorant and dangerous was a myth deliberately created by general practitioners who could not compete in open competition with them'[169] and took the view that 'the general practitioner wanted both

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[164] *Gloucester Journal*, 9 April 1842, p.4.
[165] Thompson, *A Dictionary of Domestic Medicine,* p.2.
[166] Wilson, *The Principles and Practice of the Water Cure*, p.689.
[167] E. Gaskell, *Mary Barton* (London, 1996 [1848]), pp.63-64.
[168] Holloway, *Royal Pharmaceutical Society*, p.70.
[169] *Ibid,* p.77.

to have his cake and eat it. He wanted to claim the status and income of a professional man but retain the right to supply medicines to his patients and even keep open shop for the sale of drugs.'[170] In giving advice, he suggested that chemists and druggists were simply responding to unmet demand and 'most counter-prescribing was initiated by the customer. It was an aspect of self-medication. All chemists and druggists engaged in it: refusal to do so would have met with a client's incomprehension and loss of confidence.'[171]

From the chemists' perspective, for the most part, they regarded themselves as tradesmen and had no aspirations to become a branch of the medical profession. The dispensing of medicines, which was becoming an increasingly important part of their business, was not as much a weapon with which to beat doctors but a source of prestige and an area where, through diligent customer service, they could lay claim to legitimacy and respectability. Many chemists and druggists ran well-established businesses; it was not in their commercial interest to sell rubbish or give false advice. Furthermore, 'the practice of resorting to the druggist's shop was not confined to the poor.'[172] As mentioned earlier, chemists and druggists sold a diverse range of products. By the mid-nineteenth century, they were a trusted and valued community resource not altogether dissimilar from modern community pharmacies. The failure of legislators to constrain their activities was partly a recognition of their utility, yet the historiography has, with important exceptions, done surprisingly little to challenge the negative stereotypes of them manufactured by the nineteenth-century medical establishment. Consequently, the positive contribution chemists and druggists made to healthcare in the Age of Reform has been undervalued. Their involvement in the proprietary medicines trade has weighed heavily against them, but here too they were responding to public demand. These remedies were stocked not just by chemists and druggists but by many other retail outlets and, arguably, represented a significant and useful component of the overall healthcare economy.

2.6 Advertising and the proprietary medicines industry

It was not a coincidence that the rise of the proprietary medicines industry occurred contemporaneously with the proliferation of chemists and druggists. Both were

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[170] *Ibid,* p.174.
[171] *Ibid.*
[172] Holloway, *Royal Pharmaceutical Society* p.72.

manifestations of the industrialisation, perhaps even the democratisation, of healthcare and are inseparable from the birth of a mass-market, urbanised, consumer society. Holloway believed 'the success of patent medicines was derived from two sources: the self-diagnosing, self-help health care tradition, and the newly constructed consumer desire for novelties and miracle-cures.'[173] Porter and Porter described how these 'mass-produced and mass-distributed medications, not surprisingly, often cost less per unit than pills laboriously rolled individually by the apothecary's apprentice – indeed, commercial nostrums could hardly have captured so much of the market had they not conspicuously undercut the one-off prescription.'[174] They furthermore claimed that 'the more sick people came into contact with doctors, the greater their own preoccupation with their health, their hunger for medical knowledge, and their consequent tendency to tamper with the powerful drugs increasingly advertised in newspapers and available in shops.'[175]

Successful medicine manufacturers, such as Thomas Holloway and Thomas Beecham, became household names and their products enjoyed remarkable longevity. Other firms, such as Barclay and Sons, Butler, Dicey and Co., E. Edwards, F. Newbery and Sons, and William Lambert, manufactured or distributed a wide range of medicines, selling both direct to the public and through local agents. Ueyama has described how 'these dealers in mass-produced patent medicines were able to expand their indigenous market in response to the rapidly growing public demand for various kinds of health commodities.'[176] Increasingly, large manufacturers and wholesalers like those cited above, dominated the market. Many of them were based around the St Paul's Church Yard area of London (just outside the city walls), which Mackintosh attributes to this being 'the most popular area in London for eighteenth-century booksellers, reflecting the links between distributing medicines and publishing books.'[177] These firms distributed their products nationwide using a network of chemists and druggists, hairdressers, perfumers, newspaper offices, booksellers, grocers and street vendors, as

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[173] *Ibid,* p.57.
[174] Porter and Porter, *Patient's Progress,* p.107.
[175] *Ibid,* p.51.
[176] T. Ueyama, *Health in the Marketplace: Professionalism, Therapeutic Desires, and Medical Commodification in Late-Victorian England* (Palo Alto, CA), p.3.
[177] A. Mackintosh, 'The Patent Medicines Industry in Late Georgian England: A Respectable Alternative to both Regular Medicine and Irregular Practice,' *Social History of Medicine*, Vol.30, No.1 (May 2016), p.41.

well as by mail order. It has been estimated that there were around 10,000 licensed retail outlets for medicines by 1865, but the true number can never be known.[178] An industry in advice literature actively encouraged self-doctoring. Established staples, such as Wesley's *Primitive Physic* (1743), Buchan's *Domestic Medicine* (1769) and Culpepper's *Complete Herbal* (1653), remained popular and were joined by hundreds of others, as well as magazines and newspaper articles and readers' letters.[179]

Mackintosh has explored how the medical profession 'saw patent medicines as an economic and professional threat' and condemned the people who bought them as ignorant and gullible.[180] The common assumption, reflected widely in popular histories of the topic, has been that these medicines targeted and were bought by the poor. [181] Porter however has cautioned that it is wrong 'to contend that the public was simply gullible when exposed to the hyperbole of charlatans. People were no more willing to take the pufferies of quacks on trust than to believe the faculty or any of that other Babel of politicians, preachers and publicists clamouring for the public ear.[182] Matthews has described how in the eighteenth century these products became 'a significant alternative to what were then unreliable medical practices,' occupying an ambiguous position between orthodox medicine and quackery.[183] Richards believed manufacturers did not set out to:

> simply to defraud their customers but to create a therapeutic system by and through which English consumers might construe their bodies as a field for advertising commodities. They knew they could not meet the medical profession on equal ground, so they took pains to rearrange the consumer's body and orient the commodity firmly within it. They took pains, in other words, to establish an alternative system of medicine.[184]

As chapter four will show, many were designed to appeal to specific groups of customers, who were neither poor nor gullible, or the same people attracted to other irregular offerings, in what was a highly segmented market. Some of these medicines were routinely prescribed by regular doctors and at least one contributor to *The Chemist*

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[178] Chapman, p.26.
[179] C. J. Golden, *Posting it: The Victorian Revolution in Letter Writing* (Gainesville, FL., 2009).
[180] Mackintosh, 'The Patent Medicines Industry, p.44.
[181] Brown, 'The Providers of Medical Treatment; P.S. Brown, 'Herbalists and Medical Botanists in Mid-Nineteenth-Century Britain with Special Reference to Bristol,' *Medical History*, Vol.26, No.4 (1982), pp. 405–420.
[182] Porter and Porter, *Patient's Progress,* p.101.
[183] R. Matthews, *The History of the Provincial Press in England* (London, 2017), p.48.
[184] T. Richards, *The Commodity Culture of Victorian Britain: Advertising and Spectacle 1851-1914* (Stanford, CA, 1990), p.183.

and Druggist bemoaned how 'the faculty …continually prescribes patent medicines unknown to the pharmacopoeia.'[185] Their role in the healthcare economy was therefore complicated and Mackintosh has argued persuasively that they represented 'a distinct form of health care, different both from regular medicine and from irregular practice.'[186]

Despite a large body of work on the subject, uncertainty remains as to who bought proprietary medicines and why. As mentioned already, their enduring popularity reflected both the self-reliant ethos of the age and their lineage to the domestic medicines of previous centuries, and they were attractive to citizens well-versed in making up their own remedies.[187] As chapter six will demonstrate, individuals from all sections of society expected to take personal responsibility for their own health and that of their family and were accustomed to self-diagnosing and self-prescribing. Advertisements for proprietary medicines appealed directly to these instincts, with memorable phrases such as 'certain means of self-cure *gratis'*; 'read this, and judge for yourselves'; 'cure yourself by the electric and magnetic self-adjusting curative'; and the ubiquitous 'every man his own doctor.'

The therapeutic gulf between proprietary medicines and those of the Faculty was never as great as that body liked to believe. Few had any clearly demonstrable health benefits but then again neither did the remedies prescribed by qualified doctors and although some were dangerous, particularly those containing heavy metals or opiates, so were many prescribed medicines. In fact, with a few notable exceptions, most proprietary medicines were relatively harmless, and certainly less unpleasant to take than some of the regular medical alternatives.[188] As with many complementary medicines today, the placebo effect probably played an important part in their popularity. Commonly, proprietary medicines acted (as did regular medicines), as laxatives or emetics and so some obvious effect could be perceived; which in this age was all that realistically might be expected. The absence of clinical trials, certification, or peer review process, meant the claims made for them could neither be verified nor disproven and this, combined with a lack of regulation, created the ideal conditions for

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[185] *The Chemist and Druggist*, Vol.1, No.15 (15 November 1860), p.368.
[186] Mackintosh, 'The Patent Medicines Industry,' p.23.
[187] R. Porter and D. Porter, *In Sickness and in Health: The British Experience 1650-1850* (London, 1988), p.269.
[188] R. Price, 'Hydropathy in England 1840-70,' *Medical History*, Vol.25, No.3 (1981), pp.269-280.

an industry that thrived on hyperbole. The rise of the popular press was thus crucial to the appearance of mass-market brands. Matthews has described how 'a key component of [provincial] newspapers from their earliest beginnings was… advertising'[189] and Brown described how 'the sale of proprietary medicines must have been important to justify the scale of newspaper advertising.'[190] In the nineteenth century, healthcare products dominated the advertising space of both provincial and national newspapers and provided a way for manufacturers and distributors to penetrate new markets distant from the factory or shop and 'for those without strong local ties of reputation such as most of those manufacturing medicines, advertisements appear to have offered an important route to securing sales.'[191]

The impact of advertising is hard to quantify; newspaper circulation figures, even where they exist are misleading and cannot account for how many times a paper was handed on, or read in reading rooms, gentleman's clubs, or libraries. In the eighteenth century, the size of the newspaper industry had been constrained by printing and distribution technology, and by the imposition of punitive taxes designed to suppress the radical press. Newspapers were printed and distributed locally, were restricted (by Stamp Duty) to four sides (a single sheet folded) and contained mainly national news with a few snippets of local interest and events. The constraints on space meant the smallest possible type and the maximum number of columns per page, with no room for illustrations or large headlines. However, between the 1830s and the 1860s Stamp Duty, Advertisement Duty and Paper Duty were first cut and then abolished. In addition, the advent of pressing, letter founding, and paper-making machinery made increases to the size of print runs possible. In 1801, *The Times* sold between 2,500 and 3,000 copies daily, by 1855 it was nearly 60,000[192] and 'within 15 years of the repeal of the press taxes, 78 new provincial dailies had been founded.'[193] Falling production costs and the transport and communication revolutions meant that the second half of the nineteenth century saw the rise of a mass circulation popular press,[194] with Bartrip

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[189] Matthews, *The History of the Provincial Press,* p.49.
[190] Brown, 'The Providers of Medical Treatment,' p.311.
[191] Barker, 'Medical Advertising,' p.383.
[192] T.R. Nevett, *Advertising in Britain: A History* (London, 1982), p.41.
[193] K. Williams, *Get Me A Murder A Day! A History of Mass Communication in Britain* (London, 1998), p.49.
[194] *Ibid*, p.48.

suggesting that the 'huge growth in newspaper titles after 1855 was largely financed by quack advertising revenue.'[195] The growth in working-class literacy fuelled demand and the content of papers changed as new titles such as the *News of the World* (1843) and the *Daily Telegraph* (1855) came onto the market, servicing a public appetite for sensation and titillation, so that 'politics and opinion started to be supplemented, if not replaced, with material of a 'human note,' crime, sexual violence and human oddities.'[196]

With the rise of this new media, Morrison observed how, in the Victorian period, 'the marketing of goods took on an identifiably modern appearance' and healthcare advertisers were pioneers of many modern advertising techniques.[197] Although the advertising agent belonged to the second half of the nineteenth century and American advertising methods did not reach Britain until the 1870s, proprietary medicine manufacturers early-on discovered the effectiveness of techniques such as simple repetition of the product name, combined with eye-catching headlines and the deployment of pseudo-scientific language.[198] Manufacturers also realised the advantages of giving their products a distinctive name, bottle, or packet, and from the 1840s the arrival of colour printing meant that decorative labels could be mass produced in a variety of sizes, allowing distinctive branding to develop.[199] Proprietary medicines were ideally suited for development into branded products:

> From the producer's point of view, it was desirable that each unit sold should be packaged separately so that it could carry a notice about the patent, and a warning regarding infringements and imitations. There was also a legal requirement, since duty was payable on patent medicines, and each bottle or box therefore had to carry the government stamp. A product available in its own separate and distinctive packaging was an obvious candidate for advertising, particularly since the medicine area was extremely competitive, with so many products, most of which offered to cure an incredibly wide range of complaints, as well as performing other socially useful tasks such as sharpening knives. Sordid though this form of enterprise unquestionably was the medicine vendors may well be regarded as the pioneers of modern marketing, branding their products, advertising them widely, and distributing them over large areas of the country…Where the quack doctors led, others were to follow.[200]

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[195] P. Bartrip, 'Quacks and Cash,' *History Today*, Vol.40, No.9 (September 1990), p.47.
[196] Williams, *Get Me A Murder A Day!* p.51.
[197] Morrison, ''Dr Locock and His Quack,' p.10.
[198] T. Richards, *The Commodity Culture of Victorian Britain: Advertising and Spectacle 1851-1914* (Stanford, CA, 1990), p.187.
[199] R. Opie, *The Art of the Label* (Royston, 2002), p.9; H. Barker, Medical Advertising and Trust in Late Georgian England,' *Urban History*, Vol.36, No.3 (December 2009), p.387.
[200] Nevett, p.24.

Some manufacturers spent huge sums, both in absolute terms and as a proportion of their revenue, on promotion.[201] Thomas Holloway (1800-1875), a man whose 'very surname became a synonym of self-puffery,' built his business on intensive advertising.[202] Holloway first began marketing his ointment and pills in 1837 [203] and in 1839 spent time in Whitecross debtor's prison after over-extending himself and being unable to settle a bill from *The Times*.[204] This did not dissuade him and in 1845 he spent £10,000 a year on advertising.[205] By 1865 the figure had risen to £40,000.[206] Benefitting from the introduction of plate glass window panes from the 1830s, a development which 'lent itself to the display of products such as patent medicines and began to be used… to promote impulse buying,'[207] Holloway turned his ointment pots into aesthetically pleasing objects (Figure 2.2).[208] Once established, his products generated their own momentum, as retailers preferred to stock brands customers demanded by name, something Holloway's advertisements encouraged them to do.

Figure 2.2 Holloway's Ointment pots

Source: Science Museum, London. Wellcome Images L0058537 [www] https://wellcomeimages.org/ [Date accessed: 8 October 2016].

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[201] *Ibid*, p.29.
[202] L.A. Loeb, *Consuming Angels: Advertising and Victorian Women (*Oxford, 1994), p.9.
[203] V. Holloway, *The Mighty Healer: Thomas Holloway's Victorian Patent Medicine Empire* (Barnsley, 2016), p.84.
[204] Royal Holloway, University of London, 'Thomas Holloway: A Victorian Entrepreneur,' www.royalholloway.ac.uk/aboutus/ourhistory/thomasholloway.aspx [Date accessed: 15 May 2017].
[205] *Ibid.*
[206] *Ibid.*
[207] W.A. Jackson, *The Victorian Chemist and Druggist* (Aylesbury, 2005), p.5.
[208] Displaying what appears to be a representation of Hygeia (a Greek muse) with a rod of Asklepios on one side and a child with a board displaying the words "Don't Despair" on the other.

According to Richards, 'patent medicine advertising laid the self completely open to commercial assault'[209] and lack of regulation meant advertisers could give full vent to their creative imagination. According to McKendrick:

> The dominant approach was still verbal rather than visual. The claims were unhindered by even the loosest code of advertising ethics – they were even less on oath than the authors of epitaphs, so superlatives abound and the most remarkable combinations of virtues co-exist in a single product. The knocking copy of rivals was more direct – usually straightforward warnings of deceit and commercial theft…There was the same insistent propaganda, the same constant repetition of brand names, the same exploitation of snobbery and social emulation, the same use of the famous and the authoritative to promote their products.[210]

Thus, 'advertisements provide the most obvious public evidence of how businessmen tried to manipulate consumer demand [and] provide the clearest public evidence of a businessman's persistence, inventiveness and commercial skill.'[211] Worth Estes has described how:

> In their net effect, the pseudo-scientific sites and modes of drug action presented in patent medicine advertising, and well understood by their purchasers, encouraged consumers to apply all-purpose panaceas selectively to each of their own special aches, pains, and illnesses. One need not postulate epidemic gullibility, and perhaps not even wilfully fraudulent advertising -although both certainly did exist - to explain the extraordinary sales of proprietary remedies.[212]

Although Nevett has cautioned that 'the widely held view of the nineteenth century as a time when advertisers could do virtually as they pleased is a long way from the truth. Controls of a kind existed from the early years and gradually increased in scope and severity as the century advanced,' these controls were minimal when compared to modern advertising standards legislation.[213] Given the obvious potential for exploitation and the potential risks to public health, it is a testament to both the popularity of these products and the depth of belief in free-market economic liberalism that regulation took so long to be brought to bear on this trade.

2.7 Regulating the market

Chapter one described how the raft of nineteenth-century legislation aimed at regulating the supply of healthcare has assumed a pivotal role in the narrative surrounding the end of the medical marketplace. Reform was largely driven by rank-and-file medical

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[209] Richards, p.196.
[210] McKendrick, 'George Packwood,' p.183.
[211] *Ibid,* p.148.
[212] J. Worth-Estes, 'The Pharmacology of Nineteenth-Century Patent Medicines,' *Pharmacy in History*, Vol.30, No.1 (January 1988), p.16.
[213] Nevett, p.126.

practitioners, who sought to improve their social and economic position by championing a cause that was ostensibly about public safety. Porter observed how:

> It was…during the early decades of the nineteenth century that the cry that quackery was destroying the very vitals of the nation rose to a crescendo. We should, however, be cautious before accepting such wails of public-spirited anguish at face value. For they emanated from the medical profession, and were blows in tactical professional infighting; they perhaps tell us more about the politicization of medicine than the fortunes of quackery itself.[214]

General practitioners saw the closure of their profession to irregulars as the way to safeguard their livelihoods and an existential threat, real or imagined, was also useful in focussing the minds of colleagues on the need for unity and solidarity in mobilizing public opinion and political support for reform. As Tomkins observed, 'medical professionalisation in this period went hand in hand with drives for reform.'[215] What the public thought about the need for change is more difficult to assess. Letters to magazines and newspapers suggest awareness and interest in medical reform amongst the middle-classes, but the extent to which the public shared the same objectives as reformers within the profession is uncertain. Loudon believed that 'by far the most striking feature of medical reform was the extent to which it was inward-looking. It was more like a family quarrel than a public debate.'[216] Legislation was focussed on restricting entry to the medical profession, rather than outlawing unqualified practice. Similarly, early nineteenth-century attempts to articulate a universal code of medical ethics were intended to regulate the conduct of doctors toward each other, rather than toward their patients.[217]

The Apothecaries' Act of 1815 heralded the beginning of the Age of Reform of medicine and pharmacy in Britain. According to Loudon, it came about because the increasingly numerous chemists and druggists 'posed a new and serious threat [to] rank-and-file practitioners.'[218] This Act has received much attention from historians, earlier generations of whom believed it to have been a landmark in the evolution of medical practice in England. Poynter described it as 'this enlightened Act…the most

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[214] Porter, *Quacks*, p.193.
[215] A. Tomkins, *Medical Misadventure in an Age of Professionalisation, 1780-1890* (Oxford, 2017), p.3.
[216] Loudon, *Medical Practitioners 1750 – 1850*, p.229.
[217] I. Waddington, 'The Development of Medical Ethics – A Sociological Analysis,' *Medical History*, Vol.19, No.1 (1975), pp.36-51.
[218] Loudon, *Medical Practitioners 1750-1850,'* p.230.

immediately successful and satisfactory of all the statutes up to recent times.'[219] Widely regarded as 'a remarkable achievement…which turned out to be a resounding success,'[220] for Newman, 'the passing of the Apothecaries' Act was the zenith of the apothecary in history.'[221] The Act established a system of licensing, training and examination, making it a legal requirement for anyone not already in practice when it came into force to obtain the License of the Society of Apothecaries (LSA) in order to practice as an apothecary. The new LSA qualification would be achieved through apprenticeship, attendance at lecturers, and passing an oral examination. Thus, the Act's most immediate impact was that 'it established a distinct legal boundary separating the qualified apothecary from lowlier medical tradesmen treading on their tails, such as retail druggists.'[222]

In the 1960s, Holloway offered a revisionist interpretation pointing out that contemporary reformers had regarded it as a frustrating disappointment. Its impetus had come from the grassroots, who saw their campaigning efforts emasculated by the conservative and self-serving London elite who controlled the medical colleges. Holloway laid the blame for the 'failure' of the Act firmly at the door of the Colleges of Physicians and Surgeons, who were 'more concerned with privilege than responsibility.'[223] Loudon agreed blame 'lay fairly and squarely on the Colleges of Physicians and Surgeons whose impenetrable opposition was based on naked self-interest.'[224]

Certainly, the Act fell far short of the expectations of general practitioners and singularly failed to deal with the threat of chemists and druggists.[225] The Act prohibited them from visiting customers to give advice (to do so would constitute illegally trading as an unlicensed apothecary), but it did nothing to restrict their retail activities. Trease's assessment was that the Act was 'almost a charter for the chemist and druggist to

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[219] F.N.L. Poynter, 'The Influence of Government Legislation on Medical Practice in Britain,' in Poynter, *The Evolution of Medical Practice*, p.11.
[220] Z. Cope, 'The Influence of the Free Dispensaries Upon Medical Education in Britain,' *Medical History,* Vol.13, No.10 (1969), p.32.
[221] C. Newman, *The Evolution of Medical Education in the Nineteenth Century* (London, 1957), p.77.
[222] Porter, *Disease, Medicine and Society,* p.46.
[223] Bynum, p.3.
[224] Loudon, *Medical Care,* p.188.
[225] S. Holloway, 'The Apothecaries Act, 1815: A Reinterpretation I. The Origins of the Act,' *Medical History*, Vol.10, No.2 (1966), pp. 107–129; S. Holloway, 'The Apothecaries Act, 1815: A Reinterpretation II. The Consequences of the Act,' *Medical History*, Vol.10, No.3 (1966), pp. 221–236.

practice pharmacy.'[226] The Royal College of Physicians saw that chemists and druggists could be used as a weapon to suppress the ambitions of general practitioners for parity of status by forcing them to compete for business. Loudon claimed a pecuniary motive for 'as long as the apothecary had the monopoly in pharmacy, he could, and often did, squeeze out the physician, even among the rich.'[227] The physicians contrived to ensure chemists and druggists were specifically excluded from the scope of the Act and whereas the Society of Apothecaries was given legal powers to inspect the premises of any apothecary practising in England or Wales and to destroy any sub-standard drugs they found, chemists and druggists were immune from its attentions.[228]

Another perceived failure of the Act lay in the fact that the Society of Apothecaries, as a London livery company, was not ideally suited to, and had little appetite for, the additional policing duties it acquired.[229] Thus prosecutions, especially in the provinces, were too rare for general practitioners' liking. One exception was the case of Charles Roberts of Winchcombe Street, Cheltenham, a chemist and druggist who appeared in court in 1842 charged with having 'attended patients in their illnesses, gave advice, provided drugs, and performed all those functions which in modern times belong to apothecaries.'[230] In this case, the charge was proven, but provided chemists and druggists kept to their shops and avoided house calls they were effectively safe from prosecution under the Act. Subsequent attempts to bring them under the control of the apothecaries through further legislation failed.

In Holloway's analysis, the Apothecaries Act, ostensibly a progressive reform, served only to maintain the *status quo.* It did not confer parity of status on general practitioners, who in Loudon's view, 'ended up with an Act designed by the medical colleges for their suppression, and administered by a Society not fit for purpose. It was a depressing outcome from all points of view.'[231] That oversight of general practitioners was given to the lowly Society of Apothecaries (a trade guild) was the final insult.

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[226] G.E. Trease, *Pharmacy in History* (London, 1964), p.181.
[227] Loudon, *Medical Care*, p.71.
[228] It was 1852 before this matter started to be addresses when under the Pharmacy Act those wishing to style themselves 'pharmaceutical chemist' were required to have passed the examination of the Royal Pharmaceutical Society. - J.A. Hunt, 'Pharmacy in the Modern World, 1841 to 1986 AD' in S. Anderson, *Making Medicines: A Brief History of Pharmacy and Pharmaceuticals* (London, 2005), p.78.
[229] Holloway, *Royal Pharmaceutical Society*.
[230] *Gloucester Journal,* 9 April 1842, p.4.
[231] Loudon, *Medical Care*, p.170.

Thomas Wakley, the radical founder of *The Lancet*, was rabid in his condemnation of the Act, as was an irate correspondent writing in the *Medico-Chirurgical Review* in 1824, who complained that 'it would almost appear that this act is principally calculated to annoy those for whose benefit it was designed' (he meant general practitioners, not the public).[232] In Gloucester, Hardwicke Shute, one of the city's leading medical men concluded that the medical colleges and the Act together 'had been altogether inoperative for good.'[233]

The reactionary attitude of the Colleges is understandable, as their privileges and status were dependent upon their ability to differentiate themselves from the rank-and-file. Democratisation of the profession was never going to suit their interests. The Apothecaries' Act's real success was in introducing, for the first time, a coherent and gradually more comprehensive programme of medical education to Britain. The very fact that it made it into law set a precedent and encouraged reformers to lobby for more ambitious measures. Nevertheless, over the next forty years, vested interests set about scuttling successive medical reform Bills that came before parliament.[234] The failure of these attempts reflected both the degree of disunity in the profession and the ideological aversion of nineteenth-century politicians to anything perceived as interfering in the free market, or likely to result in an (expensive) widening of the state's responsibilities. Medical legislation was generally drafted to facilitate consumer choice, not restrict it, and was based on the premise that bad practice could be driven out of the market by consumer power alone.

The next major step forward in medical reform did not therefore occur until 1858. The Medical Act of that year succeeded where so many others had failed because by this time even the Fellows of the Royal Colleges could see that reform was necessary to unify the profession and preserve its exclusivity and status. The 1858 Act has been described as 'the major landmark in the rise of the apothecary and of the surgeon from their lowly status of tradesmen and craftsmen and their assimilation into a unified profession… [and it] marked a legal closure of the profession against parvenu outsiders.'[235] Although it did not give general practitioners their own Royal College, it

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[232] 'Apothecaries Act,' *The Medico-Chirurgical Review*, Vol. 1, No.2 (1824), pp.505-6.
[233] *Gloucester Journal,* 5 October 1844, p.2.
[234] Loudon, *Medical Care;* Parry and Parry; Waddington, *The Medical Profession*.
[235] Parry and Parry, p.131.

did democratise the profession in recognising practitioners of all three branches of medicine equally as doctors, entered into a single medical register and overseen by the General Medical Council (GMC). Thus, it became much easier to tell who was, and was not, a qualified, registered medical practitioner.[236]

Once again, this Act stopped short of outlawing quackery. Digby has claimed that it 'disappointed the British medical profession in giving them no direct protection against alternative practitioners. In what was substantially still a laissez-faire society the freedom of sufferers to consult whomsoever they chose took precedent over sectional professional interests.'[237] Although the Medical Act was an important milestone that 'elevated medicine on to a more professional, more ethical plane, in part through erecting a tighter *cordon sanitaire* between it and what it abhorred as money-mongering quackery,'[238] it cannot be regarded as the sole causal factor behind the demise of the so-called medical marketplace.

The Medical Act occurred at a time when reform was also underway in the field of pharmacy; something that has received rather less attention in the literature of the medical marketplace. The regulation of pharmacy was partly a response to changes in the demand, supply and distribution of drugs in Britain. At the start of the Age of Reform, the British pharmaceutical industry comprised large numbers of small firms serving local markets. As local businesses, whose reputations and profits rested upon face-to-face customer service, they survived adequately with minimal legal protection. In the early nineteenth century, scientific advances in chemistry, mass production techniques, and improved distribution networks were reshaping pharmacy. Population growth also meant demand was increasing exponentially and the production of medicines moved to an industrial scale, with manufacturers remote from the point of sale needing to protect their brands from imitators and fraudsters. The rise of recognisably modern pharmaceutical practices made the need to protect both reputable pharmacists and the public more urgent. In 1850, lethal poisons such as mercury, arsenic, antimony and opium were readily available to anyone who wished to buy them

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[236] D. U. Bloor, 'The Rise of the General Practitioner in the Nineteenth Century,' *Journal of the Royal College of General Practitioners*, No.28 (1978), p.290; M.J.D. Roberts, 'The Politics of Professionalization: MPs, Medical Men and the 1858 Medical Act,' *Medical History*, Vol.53, No.1 (2009), pp.37-56.
[237] Digby, *The Evolution of British General Practice*, p.33.
[238] Porter, *Quacks* p.29.

for whatever purpose. According to Bartrip, 'some country druggists reckoned to sell more than one ton of the poison [arsenic] per year'[239] and 'arsenious acid and arsenite of potash were taken internally as tonics, as well as to treat fevers and recurring ailments such as migraine or neuralgia. Applied externally, arsenic was used as an escharotic in the treatment of cancer and skin diseases such as psoriasis.'[240] Poisonous chemicals were found in many everyday household products, including some proprietary medicines. Arsenic and strychnine were sold as rat poison and 'opiates were widely obtainable from chemists' shops, including the most respectable establishments and a variety of other retail outlets.'[241] Opium was the active ingredient in medicines for gastrointestinal complaints and teething, as well for as pain relief. Although Jalland argued that 'a more disciplined use of opium in treating terminal pain' prevailed in the nineteenth century,[242] there was significant public concern about dependency, and particularly about accidental, or intentional, overdosing and poisoning, fuelled by lurid newspaper accounts.[243] Overdosing was made more likely by the fact there was no requirement for medicines to carry warnings, storage, or dosage instructions. Although pharmacopoeia specified how to make up drugs and the proportions of raw ingredients to be used, dosages had always been problematic, not least because plant-based remedies contain varying concentrations of the active ingredient dependent upon growing, harvesting and storage conditions. As discussed earlier, the Society of Apothecaries' powers to inspect apothecaries' shops, confiscate substandard drugs and impose fines did not extend to chemists and druggists or any other medicine vendors. In addition, there was no requirement for producers of nostrums or 'secret remedies' to disclose the ingredients or for the products to contain what they claimed to contain. The Society, through its manufacturing laboratory, provided a gold standard but there were no legally enforceable quality controls applicable to chemists and druggists or proprietary medicine manufacturers.[244]

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[239] P. Bartrip, 'A "pennurth of arsenic for rat poison": The Arsenic Act, 1851 and the Prevention of Secret Poisoning,' *Medical History*, Vol.36, No.1 (1992), p.55.
[240] *Ibid.*
[241] Marland, ''The Doctor's Shop,' p.94.
[242] P. Jalland, *Death in the Victorian Family* (Oxford, 1996), p.87.
[243] V. Berridge, 'Victorian Opium Eating: Responses to Opiate Use in Nineteenth-Century England,' *Victorian Studies*, Vol.21, No.4 (1978), pp.437-461; Bartrip, 'A "pennurth of arsenic,' pp.53-69.
[244] A. Simmons, 'Medicines, Monopolies and Mortars: The Chemical Laboratory and Pharmaceutical Trade at the Society of Apothecaries in the Eighteenth Century,' *Ambix*, Vo.53, No.3 (2006), pp.221-236; A. Simmons, 'Stills, Status, Stocks and Science: The Laboratories at Apothecaries' Hall in the Nineteenth Century,' *Ambix*, Vol.61, No.2 (May 2014), pp.141-161.

This unsatisfactory situation could not be ignored forever, even in the age of *laissez-faire.* The case for reform to protect public safety was a compelling one, but the principal impetus for reform of pharmacy like that of the medical profession, came from within as the trade underwent a process of professionalization. With the founding of the Pharmaceutical Society of Great Britain in 1841 (originally to organise a defence against a medical bill that threatened to place chemists and druggists under the jurisdiction of the apothecaries) the more reputable element of the trade looked to differentiate themselves from the rest and began to lobby for regulation that would further this objective. The Society's members feared 'the medical reform movement was the attempt to eliminate the competition of the chemist and druggist and to create a monopoly for the licensed practitioner' and realised change was needed to professionalize the trade, retain its independence and improve its standing with the public.[245] However, 'the reluctance of the majority of chemists and druggists to join created the institutionalised rift between pharmaceutical chemists and chemists and druggists.'[246] Frustrated, the elite of the trade campaigned for reform. The start of the regulation of pharmacy came in 1851 with the Arsenic Act, a tentative piece of legislation, which did at least introduce some limited controls over the sale of that substance by requiring records to be kept of the purchaser and their purpose.[247] It was with the Pharmacy Acts of 1852 and 1868, however, that pharmacy began to emerge as a scientific profession.

The 1852 Act, while it did little to protect the public, was important for the evolution of the profession as it established the first register of chemists and druggists and gave legal protection to the titles 'pharmaceutical chemist' and the 'chemist and druggist,' thus recognising differences within the trade and between the trade and other medicine vendors.[248] Despite this, Holloway has argued that 'the consequences of the 1852 Pharmacy Act were far removed from the aims and intentions of Jacob Bell' (the founder of the Pharmaceutical Society).[249] Arguably, a more significant development occurred in 1858, when the Medical Act charged the newly-created GMC with creating

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[245] Holloway, *Royal Pharmaceutical Society,* p.86.
[246] *Ibid,* p.181.
[247] Legislators considered but ultimately decided against including opium in the Act.
[248] L.G. Matthews, *History of Pharmacy in Britain* (Edinburgh, 1962), p.132.
[249] Holloway, *Royal Pharmaceutical Society*, p.180.

the first British Pharmacopoeia. To do so, it recruited the assistance of the Pharmaceutical Society, thus officially recognising its professional status for the first time.[250] An Adulteration Act was passed in 1860, which although it only applied to food and drink,[251] did 'set in motion a movement to control the quality of what the typical family ingested.'[252] A second, more ambitious, Pharmacy Act followed in 1868 and created separate and mandatory registers of pharmaceutical chemists and chemists and druggists. The 1868 Act introduced Schedules of Poisons, with only pharmaceutical chemists and registered chemists and druggists permitted to supply poisons from the First Schedule.[253] This was a significant triumph for the Pharmaceutical Society and the elite of the trade it represented, who, as Berridge pointed out, 'wished to emphasise their metamorphosis from tradesmen and shopkeepers to professionals by demanding, and getting, control over the right to sell certain poisons, opium among them.'[254] It became mandatory to record the purchaser's particulars and purpose when selling opiates. In Lomax's view though, 'the best that can be said for the Act was that it made it more difficult for adults to take opiates, or give them to children.'[255] It was not until 1917 that morphine ceased to be available without a prescription.[256]

Regulation, even though it did little initially to directly protect the public had a pivotal role in the professionalisation of both medicine and pharmacy. Although the legislation passed in the Age of Reform fell short of its objectives it did, cumulatively, succeed in distancing regular medicine and later pharmacy from unqualified, irregular practice. The legal separation of qualified, state-sanctioned, practitioners from the rest made the closure of official posts to irregulars easier, if it did not begin this process. Nevertheless, as Porter has pointed out, 'the law, civil and criminal, proved next to

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[250] Trease, p.195. See also J.K. Crellin, 'Pharmaceutical History and its Sources in the Wellcome Collections I. The Growth of Professionalism in Nineteenth-Century British Pharmacy,' *Medical History*, Vol.11, No.3 (1967), p.221.
[251] R. D. Mann, 'From Mithridatium to Modern Medicine: The Management of Drug Safety,' *Journal of the Royal Society of Medicine*, Vol.81, No.12 (December 1988), pp.725-728.
[252] T.E. Jordan, 'The Keys of Paradise: Godfrey's Cordial and Children in Victorian Britain,' *Journal of the Royal Society of Health,* Vol.107, No.1 (February 1987), p.22.
[253] Jackson, p.3.
[254] Berridge, 'Victorian Opium Eating, p.451.
[255] E. Lomax, 'The Uses and Abuses of Opiates in Nineteenth Century England,' *Bulletin of the History of Medicine*, Vol.47, No.2 (March 1973), p.174.
[256] Mann, p.726.

useless for those campaigning against quack practice.'[257] Exactly how regulation of the market played out on in a provincial city like Gloucester is uncertain. We still know little about how reforms were perceived by the public, or if and how they affected the choices made by customers. The extent to which they can be said to have put an end to the medical marketplace is certainly questionable. Arguably, change was underway well before the passing of the 1858 Act, which has been widely regarded as the watershed reform. These issues will be explored through the forthcoming chapters.

2.8 Conclusion

This overview of the historiography shows how the literature relating to the medical marketplace overlaps earlier debates around medical professionalisation and reform, the changing doctor-patient relationship, and the 'birth of a consumer society.' This body of work is voluminous and to some extent fragmented and, as chapter one identified, in this lies one of the principal weaknesses of the medical marketplace paradigm is its inability to bring these strands together into a convincing overarching narrative – a situation exacerbated by the lack of a generally accepted definition of what constituted the 'medical marketplace.' Much of the historiography has focussed on the suppliers of healthcare, particularly the medical profession. The patient's perspective remains stubbornly elusive and despite frequent calls for the 'patient's voice' to be heard and some admirable, although not altogether successful, attempts to find it,[258] Porter and Porter's expressed wish 'to know more about the socio-dynamics of the sickbed' remains only partially fulfilled.[259] Over the decades the historiography has switched its attention from great doctors, scientific discoveries, and hospitals, to the medical fringe of quacks and medical heretics, but some areas have still only received cursory interest, for example, dispensaries and the dispensing activities of chemists and druggists. Porter felt that 'we still have nothing approaching a wide-ranging, well-researched economic history of medicine, in all its branches, as practised in the first industrial, the first consumer society. We equally lack proper studies of the cultural meanings of medicine – the place of the doctor, and the resonances of the healing arts, in society.'[260] Despite some excellent studies undertaken since, important questions remain unanswered

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[257] Porter, *Quacks* p.29.
[258] R. Porter, 'The Patient's View: Doing Medical History from Below,' *Theory and Society*, Vol.14, No.2 (March 1985), pp.175-198.
[259] Porter and Porter, *In Sickness and in Health*, p.196.
[260] Porter, *Quacks,* p.12.

particularly regarding what the public thought about healthcare, how they accessed different healthcare options, the choices they exercised and decisions they made, and the reasoning behind them. Furthermore, topics such as drug advertising and prescribing practices have been considered within narrow and discrete historical silos, with relatively little attention given to considering how developments in these areas impacted upon the wider healthcare economy. We are left with an incomplete and partial impression conceptualised through the prism of an ill-defined and arguably anachronistic paradigm. Expanding upon the gaps identified in chapter one, this chapter has shown that there is a compelling case for a new approach that can better bring together the threads of this wide-ranging historiography into a more holistic understanding of healthcare in the Age of Reform. This study addresses these gaps directly through a systematic and detailed analysis of supply and demand in Gloucester. The process begins in the next chapter by explaining why Gloucester was an outstanding candidate for this task and then by undertaking a deconstruction of healthcare supply in the city. It will show how many of the assumptions and claims surrounding the medical marketplace are not substantiated by the evidence, which instead points toward the existence of a *stratified healthcare economy*.

Chapter Three – Suppliers

3.1 Introduction

The previous chapters have identified important gaps in the historiography of the medical marketplace and significant deficiencies in the paradigm. It has been argued that there is a case for a new, more holistic, analysis of healthcare in the Age of Reform that better brings together the disparate body of literature surrounding the subject. This chapter will start this process by undertaking a forensic deconstruction of the supply of healthcare in Gloucester during this pivotal period of change. The chapter is necessarily long, as it encompasses institutional and commercial suppliers, which because of their interconnectedness need to be considered together as parts of a single healthcare system. The chapter will chart temporal change in the supply of healthcare looking at the number, type and distribution of suppliers and searching for those key features associated with the presence of a medical marketplace - plurality, diversity, choice and competition.

A discussion of sources and methods is followed by a contextual summary of the development of Gloucester up to the mid-nineteenth century, explaining why the city represented a suitable subject for this study and identifying salient features of the city's socio-economic complexion. This is followed by a substantive discussion of institutional healthcare provision, which covers the number and types of institution present in the city and the ways in which these institutions regulated access and manipulated demand. Their importance in Gloucester's wider healthcare economy will then be considered, with specific reference to their role in the professionalization of medicine, which, as discussed earlier, has been cited as a principal factor in the demise of the medical marketplace. There follows a quantitative analysis of commercial healthcare supply in Gloucester between 1820 and 1871, again focussed on evidence of diversity, plurality, choice and competition. This census-style approach, although not unique, has only infrequently been undertaken and detailed, local level data as to the numbers and types of healthcare suppliers operating in nineteenth-century cities thus remains surprisingly sparse and fragmented. Some excellent local studies suggest the presence of significant local variation, but more evidence is needed to reach definitive conclusions; something to which this chapter makes an important contribution.

3.2 Sources and methods

The census of healthcare suppliers in the second part of this chapter comprises quantitative analysis of data obtained from three main sources: census returns, medical and trade directories, where appropriate augmented with information from local newspapers. The selection of sources is thus similar to Brown's approach in Bristol, as the benefits of being able to compare Gloucester with its close neighbour were obvious.[1] Surprisingly, Biddle found trade directories are 'versatile, yet strangely under-utilised historical sources,'[2] despite Brown advising 'it would be wise to check the situation in other cities using precisely the same methods of collecting and classifying data.'[3] The methodology allows for this whilst also identify any temporal changes. The surviving trade directories used in this study are listed in Table 3.1 below.

Table 3.1 Extant trade directories covering Gloucester

Compiler	Year(s)	Medium / Location
Gell & Bradshaw	1820	Microfilm (GA)
Pigot	1830, 1842, 1844	Microfilm (GA)
Robson	1839	Microfilm (GA)
Bryant	1841	Microfilm (GA)
Hunt	1847, 1849	Hardcopy (GA)
Slater	1853, 1867	Online / Hardcopy (GA)
Kelly	1856, 1870	Online / Hardcopy (GA)
Harrison, Harrod	1859	Online
Morris	1865, 1867	Microfilm (GA)
Unknown	1867	Hardcopy (GA)
Slater	1868	Hardcopy (GA)
Bretherton	1869	Hardcopy (GA)

GA = Gloucestershire Archives

Sources: Gloucestershire County Council, 'Research Guide 37: Trade and Street directories' (June 2013) and University of Leicester Special Collections Online http://www2.le.ac.uk/library/find/specialcollections/specialcollections/historical-directories [Date accessed: 29 April 2017].

[1] P.S. Brown, 'The Providers of Medical Treatment in Mid-Nineteenth Century Bristol,' *Medical History*, Vol.24. No.3 (1980), pp.297-314.
[2] R. Biddle, 'Dissecting the Medical Marketplace: The Development of Healthcare Provision in Nineteenth-Century Portsmouth,' unpublished PhD thesis (Oxford Brookes University, 2009), p.69.
[3] Brown, 'The Providers of Medical Treatment,' p.313.

Unlike Brown, who excluded 'cuppers and appliers of leeches as well as those such as chiropodists, truss-makers, or opticians who might offer a very limited and specialized form of treatment' and 'full-time institutional officers,' where present in Gloucester these have been included.[4] This approach was adopted in accordance with the core aim of gaining a holistic insight into the supply of healthcare, including both institutions and the full range of irregular providers.[5] Having said this, the difficult decision was made to exclude nurses and midwives from the main analysis, for the same reasons as Brown: 'though probably an important group they presented problems of classification and location which require further study.'[6] The main problem lies in determining from the census returns what activities the various derivations of 'nurse' involved. Many of those listed as nurses were 'women, [who] may not have regarded themselves or have been classified as undertaking a healthcare role.'[7] Nurses and midwives both worked from home often informally and part-time and do not appear in trade directories, so establishing their numbers, particularly prior to 1841, is problematic. They will however feature in chapter six.

Cox and Anderson have recently highlighted the value of trade directories in tracking the growth and movement of businesses over time and have argued that 'they are of particular value during the nineteenth century when other sources of this information are much more limited.'[8] Trade directories proliferated in the 1800s and eventually dominant players such as Kelly and Pigot emerged. The scope and comprehensiveness of these directories increased greatly in the course of the century, although they were always more thorough in recording doctors, chemists and druggists and (resident) dentists, Biddle finding that they 'do not list every private provider that operated…Some, for example, would not have paid to be included… Due to their very nature, the data they yield is biased towards orthodox practitioners and chemists practising or trading from fixed premises.'[9] Marland also found ommissions, duplications, outdated and inaccurate entries. Evidence of this in Gloucester can be

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[4] *Ibid,* p.299.
[5] *Ibid,* pp.298-299.
[6] *Ibid.*
[7] H. Marland, *Medicine and Society in Wakefield and Huddersfield 1780-1870* (Cambridge, 1987), p.255.
[8] N. Cox and S. Anderson, 'The Emergence of Chemists' Shops in Wimbledon, South London, 1837-1901: Using Trade Directories and Registers to Track Local Pharmacies.' *Pharmaceutical Historian*, Vol.48, No.2 (June 2018), p.52.
[9] Biddle, p.69.

found, for example, by comparing the number of medical practitioners listed in *Robson's* directory of 1839 with the 1841 census, which recorded significantly higher numbers.[10] Of those omitted in 1839, Hardwicke Shute and Thomas Evans, for example, were certainly practising in Gloucester at that time. Similarly, looking at the chemists and druggists listed in the earliest extant trade directory, dating from 1820, it lists four – Robert Fouracre, William Fream, John Lovett, and Messrs Washbourn, Morgan and Rose. However, a sample of medical advertisements from that year mentions another, Watkins. Such inconsistencies highlight the value of cross-referencing to other sources wherever possible.

The second source available to us is the census, which from 1841 onwards recorded occupations and thus provides a decennial snapshot of employment. Each census thus, in theory at least, should have captured all those individuals whose primary occupation was related to the supply of healthcare. However, as just mentioned in relation to nurses and midwives, gaps occur here too and amateur and part-time healthcare-related work, especially if undertaken in addition to a primary source of employment, was often not captured. Anyone away from the city on census day would also be omitted. In addition, those actively practising, or trading are not always easily differentiated from those who had retired, were not currently in work, or were working for someone else. The decennial frequency obviously means that those whose tenure in the city did not overlap a census year are invisible to posterity. Some of these issues can be mitigated by cross-referencing to trade directories and medical directories but as discussed already certain types of supplier are under-represented in these sources.

The third main source for this chapter was medical directories, which in theory listed each practising, qualified doctor in the city. They were initially published infrequently but more systematically as the nineteenth century progressed and annually by the mid-1840s. Editions of *Churchill's London and Provincial Medical Directory* from 1845 onwards were transcribed at five-yearly intervals. Medical directories probably provide the most accurate data for practising doctors, but they too had limitations, as inclusion in the main list was dependent upon the doctor returning their details to the compilers. As it was in their commercial interest to be included in the

[10] Robson & Co., *Robson's Commercial Directory of London, Bedfordshire, Buckinghamshire, Cambridge, Gloucester, Hunts, Norfolk, Oxon, Suffolk & Wiltshire* (London, 1839). 15 compared to 25 surgeons and 11 compared to 17 chemists and druggists.

directory most did so, but there were inevitably omissions. Lane analysed a very early example in Simmons' 1783 medical register and found it incomplete and this was still to some extent a problem in the 1840s.[11] Nevertheless, Marland successfully used them in her study of Wakefield and Huddersfield and there is scope for comparison with her findings. Although a comprehensive catalogue of every healthcare supplier is not achievable, by combining these sources we can get the best possible picture to inform subsequent discussions. Before proceeding further however, it is first necessary to look at the development of Gloucester up to the mid-nineteenth century to demonstrate why the city represented an outstanding candidate for a study of this kind.

3.3 Gloucester in the early nineteenth century

The choice of Gloucester was informed partly by the existing historiography, with as has been discussed both nearby Bristol and Bath being the subjects of previous studies, allowing scope for comparative analysis. In addition, Gloucester fortuitously possesses a significant corpus of primary source material covering relevant topic areas. Most importantly though the city underwent all the socio-economic upheavals occasioned by the Industrial Revolution that fuelled demand for healthcare and were supposedly conducive to the kind of medical marketplace the literature describes. Gloucester's similarity to other provincial cities like Worcester, Shrewsbury and York, also offers the possibility of further comparative studies, which chapter one identified as urgently needed.

Gloucester is located on the banks of the River Severn in a wide glacial valley between the Cotswold escarpment to the east and the Forest of Dean to the west, some thirty-five miles upstream from the deep-sea port of Bristol. Historically, as the 'gateway to Wales,' Gloucester's importance lay in its geographical location:

> Gloucester's position at the intersection of the principal long distance routes through the county at the lowest bridging point on the River Severn gave the town economic and strategic importance for many centuries. The London to South Wales road crossed the river by way of the Westgate and Over bridges on the western edge of the town, and it was intersected at the Cross, in the centre of town, by the road from Bristol and the South West to Worcester and the Midlands. In the early nineteenth century these routes were as important as ever for the town's prosperity.[12]

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[11] J. Lane, 'The Medical Practitioners of Provincial England in 1783,' *Medical History*, Vol.28, No.4 (1984), p.354.

[12] E. A. Christmas, 'The Growth of Gloucester 1820-1851: Tradition and Innovation in a County Town, unpublished PhD thesis, University of Leicester, 1989, p.8.

Although by the nineteenth century its strategic importance had diminished, as a cathedral city, Gloucester remained a significant administrative and cultural hub and it had a long industrial and trading pedigree. Ironworking and cloth making industries developed in the middle ages and the city was important to the corn trade, taking supplies from the Vale of Gloucester and further up river for export, or shipment down river to Bristol.[13] The granting of port status by Elizabeth I in 1580 made Gloucester officially Britain's most inland port and allowed direct access to overseas trade. This significantly boosted economic development and led to some expansion of the quayside area, although the city's viability as a seaport was inhibited by the precocious tides and shallows along the Severn and consequently it was perpetually overshadowed in this respect by Bristol.

In the early-modern period, Gloucester became an important centre of pin-making, which was deliberately introduced to the city in 1626 by John Tilsley of Bristol to make work for the poor. Pin-making 'became the one industry of the town supplying distant markets and [Gloucester was] the main centre of pin making in the eighteenth century.'[14] By 1800, nine pin making factories were employing 1,600 people. However, thereafter a collapse in the export market occasioned by the Napoleonic Wars and then increasing competition from Bristol, Bath, and Birmingham forced the industry into long-term decline.[15]

Despite these early steps toward industrialization, as Figure 3.1 shows, at the end of the eighteenth century, much of the old medieval city and its boundary wall was still discernible, earlier suburbs having been largely pulled down during the Civil War siege. In 1779, Samuel Rudder gave a favourable account of Gloucester's aesthetic appearance:

> The prospect of the city, on the west side of it is delightful, being adorned with many beautiful towers and spires, but more especially with the lofty and most elegant tower of the cathedral church, which, to use Leland's expression, stands as a Pharos to all parts around for a considerable distance.

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[13] N. M. Herbert (ed.), *A History of the County of Gloucester: Volume 4, The City of Gloucester* (London, 1988), p.41.
[14] Christmas, p.19.
[15] The last hand-made pin manufacturer in Gloucester, Hall and English, succumbed to machine made competition in 1845.

> From the middle of the city, where the four principal streets meet, there is a descent every way, which makes it not only clean, and healthy, but adds great beauty to the place.
>
> The buildings are chiefly of brick, whereas formerly they were of wood. The streets are well paved, and enlightened with lamps by authority of parliament…'[16]

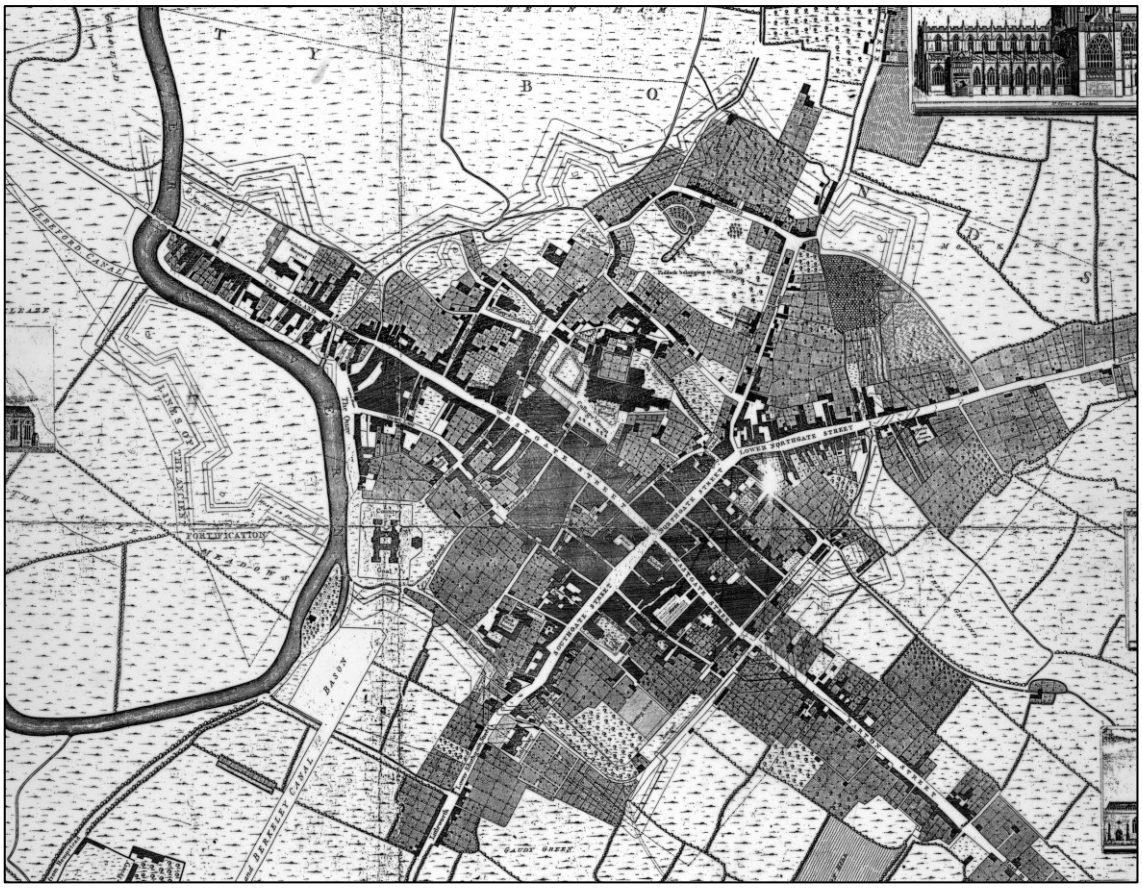

Figure 3.1 Hall and Pinnell's plan of Gloucester, 1796

Source: Gloucestershire Archives, GM&P15b – Hall and Pinnell, acknowledgement and © Gloucestershire Archives, http://www.glosarch.org.uk/glosmapsprospectspdffiles.html#PDFFILES [Date accessed: 7 August 2016].

Although the docks offered the potential for further industrialization, in the early years of the nineteenth century it seemed possible Gloucester might follow a different path. The accidental discovery of springs near to the south-east edge of the city, following the sinking of a well in 1814, led to a brief period of popularity as a brine spa. At one point it appeared Gloucester might even develop in a manner akin to Bath, with advertisements of the time boasting of the 'valuable impregnations' in the water (Figure 3.2). In 1819, Fosbrooke remarked in his history of the city that:

[16] S. Rudder, *A New History of Gloucestershire* (Stroud, 2006), p.81 [originally published 1779].

> …the impregnations on which the virtues of saline chalybeate waters depend are more abundant in the Gloucester Spa water than in any other hitherto observed in this country… the advantage of these springs to those who reside in Gloucester must be very great, when we consider the beauty and convenience of the situation, the salubrity of the air, and the extensive and picturesque views with which it abounds, together with the pleasant habitations…'[17]

Similarly, in 1828 an advertisement for the Spa announced that 'everyone who visits this delightful spot, either for health or pleasure, speaks in the highest terms of the medicinal virtues of the waters, and the beauty and peace and quiet of its promenades.'[18]

However, local entrepreneurs failed to fully capitalise on the potential of the waters to attract upper-class visitors and Gloucester would soon be eclipsed as a health spa by its near neighbour Cheltenham, a development that was to have significant implications for the city's healthcare economy. Even in its halcyon days, it had not generated sufficient custom to bring about the critical mass needed to turn the city into a health resort. Gloucester's doctors too seemingly did not feel the need to 'diversify in order to make a medical living,' as was to happen in nearby Malvern in the 1840s and 50s.[19] Ultimately, industrial development and the arrival of the railway proved incompatible with 'the salubrity of the air' so essential to the ambience of a spa town. Nevertheless, set in attractive pleasure gardens, the Spa remained an oasis of gentility that endured long after the waters had fallen from fashion and it was taken into public ownership as a park in the 1860s.

While the Spa went into gradual decline, the building of the Gloucester and Berkeley ship canal paved the way for rapid industrialization. Construction began in 1793 and was completed in 1827. Although financial difficulties scaled back the size of the project, the Gloucester and Sharpness canal as it became known, ran for sixteen miles and when it opened, it was the longest, deepest and broadest ship canal in Britain. The canal bypassed the notorious bends and shoals in the stream of the Severn below Gloucester and its dangerous tides, allowing larger vessels to reach the city. Its opening

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[17] T.D. Fosbrooke, *An Original History of the City of Gloucester, almost wholly compiled from new materials; supplying the numerous deficiencies, and correcting the errors, of preceding accounts; including also the original papers of the late Ralph Bigland, Esq.* (London, 1819) facsimile edition (Gloucester, 1986), p.220.

[18] *Gloucester Mercury*, 24 September 1828.

[19] J. Bradley and M. Dupree, 'Opportunity on the Edge of Orthodoxy: Medically Qualified Hydropathists in the Era of Reform, 1840-60,' *Social History of Medicine*, Vol.14, No.3 (2001), p.422.

led to major development of the dock area and to some degree freed Gloucester from its dependence upon Bristol. Expansion continued and 'in the later 1840s and the early 1850s, as waterborne traffic grew, the docks area was enlarged and more warehousing was provided.'[20]

GLOUCESTER

Saline Chalybeate Spa.

THAT the PUBLIC may form a proper judgment of the qualities of this Water, the following TABLE, exhibiting a View of its component Parts, together with those of *Cheltenham* and *Leamington*, is subjoined. The Analysis of the two first is furnished by Mr. ACCUM; of the last, by Dr. MIDDLETON.

	Gloucester.		Cheltenham.*		Leamington.	
	PINT. Grs.	GALLON Grs.	PINT. Grs.	GALLON Grs.	PINT. Grs.	GALLON Grs.
Sulphate of Soda..	18.25	146.00	10.00125	80.01	20.00000	160.00
Ditto of Magnesia	13.75	110.00	12.28125	98.25		
Muriate of Soda..	38.50	308.00	27.46875	219.75	53.75000	430.00
Ditto of Magnesia	4.75	38.00	5.00000	40.00	6.25000	50.00
Ditto of Lime....	3.50	28.00	4.50000	36.00		
Sulphate of Lime	16.00	128.00	10.62500	85.01	16.87500	135.00
Carbonate of Iron	2.00	16.00	0.89375	7.15	0.09375	0.75
	96.75	774.00	70.77025	566.17		
Gaseous Contents IN CUBIC INCHES.	PINT.	GALLON	PINT	GALLON		
Carbonic acid Gas	16.00	128.00	1.50375	12.07	0.75000	
Atmospheric Air	9.00	72.00	0.15125	1.21		
Oxygene Gas.....			0.53375	4.03		

*This Analysis was made from the Chalybeate Saline Water, No. 1, Montpelier Wells.

It thus appears, that the *Gloucester Water* contains in the greatest degree those valuable Impregnations, on which the virtues of Springs of this Class depend.

TERMS FOR DRINKING THE WATER.

A Family,.....£1 1 0 | An Individual,...£0 10 6

TERMS FOR THE USE OF THE BATHS.

Hot and Cold Saline, 3*s.* 6*d.* each; Cold, with common Water, 1*s.* 6*d.*; and 6*d.* each Bath to the Attendant.

TERMS AND REGULATIONS FOR THE WALKS.

[The *Walks* are free to those who subscribe for the *Waters*; but as the Proprietor has incurred considerable Expence in providing them for the Accommodation of the Public, he is under the necessity of exacting from others the following Rates:]

A Family,.....10*s.* 6*d.* | An Individual,.....5*s.* 0*d.*

☞ Subscribers who have the Water carried home, are particularly requested to name to the pumper, the person they send for it, as none can be delivered without authority.

N. B.—The *Water* will be carefully sealed up in Bottles, and sent to any part of the Kingdom, at 10*s.* per dozen.

*** *Salts* obtained by the evaporation of the *Water*, warranted genuine, may be had at the Pump Room, at per lb.

☞ All Orders addressed to Mr. CLARK, at the Pump Room, post-paid, will be immediately attended to.

††† *It is expected that all Subscriptions will be paid at the time of subscribing.*

April 22, 1815.

Figure 3.2 Advertisement for the Gloucester Saline Chalybeate Spa, 1815

Source: *Gloucester Journal,* 1 May 1815, p.3, www.britishnewspaperarchive.co.uk [Date accessed: 31 March 2017] Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

[20] Herbert, *The City of Gloucester,* p.255.

The repeal of the Corn Laws in 1846 meant the docks benefited from the ensuing imports of cheap grain from the Ukraine and elsewhere, resulting in the construction of several large warehouses. Along with corn, timber was the primary import with yards and sawmills coming to occupy much of the east bank of the canal, while the principal exports were coal from the Forest of Dean, for which Llanthony Quay was constructed in the early 1850s, and salt from Droitwich and Stoke Prior. Established industries such as pin-making, various other metalworking trades, shoemaking, leather and cloth making were still present, but they were now joined by a boat building yard, breweries, brickworks, flour mills, soda water manufactories, a gasworks, a vinegar factory and other large factories producing enamelled slate and cabinets. An 1859 trade directory stated that:

> …the import trade of Gloucester consists chiefly of corn and timber, wines and spirits, with an export of salt, iron, bricks, &c., which is most extensively carried on. The manufactories are pin manufactories (introduced here in 1625), soaperies, steam flour-mills, a brewery, a parchment manufactory, and several steam saw-mills, which, with ship, boat, and barge building, hemp and flax dressing, rope, sack, sail, and brush making, combined with a considerable trade in corn, coal, and timber, together with the large quantities of coal and culm shipped coastwise, furnish employment for a vast number of persons.[21]

In 1867, Moreland's match factory opened on the Bristol Road and by the end of the nineteenth century was employing 450 workers.[22]

By the 1840s the Gloucester quays were operating at full capacity and in 1849 a second basin opened for the export of salt to Ireland and Europe.[23] The 1840s also signalled the arrival of the railway and by 1849 a trade directory described how:

> Gloucester has lately become the connecting link of important railway communications, a line on the broad gauge is connected to Bristol, where it joins the Great Western, thus affording facilities for visiting the counties of Somerset, Devon, Dorset and Cornwall; a line on the narrow gauge is open to Cheltenham, Worcester and Birmingham; thus communicating with the whole of the north of England and Scotland. Another extensive and very important line of railway is in the process of formation, namely, the South Wales Railway. This line is intended to open a direct communication between England, South Wales, and Ireland, having its starting point at Gloucester, where by means of the Gloucester and Forest of Dean railway, it will form a junction with the Great Western railway.[24]

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[21] *Harrison, Harrod, & Co.'s Bristol Post Office Directory & Gazetteer with the Counties of Gloucestershire and Somersetshire…* (London, 1859), pp.375-376.
[22] 'Grace's Guide to British Industrial History: S.J. Moreland & Sons'. http://www.gracesguide.co.uk/S._J._Moreland_and_Sons [Date accessed: 8 October 2016].
[23] D. Kirby, *The Story of Gloucester* (Stroud, 2007), p.117.
[24] E. Hunt & Co., *Hunt & Co.'s Commercial Directory; for the Cities of Gloucester, Hereford, and Worcester, etc.* (London, 1849), p.8.

The railway brought freight traffic from the ironworks and coal fields of South Wales and the factories of the Black Country and the Potteries. It came to occupy a large swathe of land to the east and north of the city, with accompanying streets of workers' housing and a huge wagon works on the Bristol Road, which by 1860 was employing 360 workers.[25] In the mid-1850s, the Crimean War disrupted trade and brought a recession in which the city experienced 'a prevalence of pauperism and attendant social problems which persisted in some districts in 1859' but the 1860s were perhaps the docks' heyday.[26] Traffic declined again in the 1870s with the opening of a new facilities at Sharpness capable of handling vessels too large to pass through the canal and rail freight also impacted the coastal trade, but the docks remained important to the city's economy until the 1960s.

Throughout the nineteenth century, Gloucester was fully embroiled in the industrial revolution with all the economic and social upheaval that entailed. Rapid population growth and geographical expansion meant much of the old city was swept away and replaced by slum housing and factories. Table 3.2 shows that in 1801 the population of Gloucester Registration District was 13,814; by 1871 it was 41,641. Between 1831 and 1901 the number living within the boundaries of the old city (approximately 680 acres) rose from c.12,000 to c. 48,000.[27] By 1901 the population was over six times what it had been a century earlier.[28] Such rapid growth forced the expansion of the city boundaries and whereas 'in 1801 nearly eight lived within the old city boundary to one outside it… by 1851 the ration was two to one.'[29] The first boundary extension in 1835 took in the Spa and part of Barton Street. By the mid-1800s Barton, Kingsholm, South Hamlet, North Hamlet, Littleworth, Longford, Tredworth and Wotton had practically, if not administratively, been subsumed into the city. The geographical expansion of Gloucester can be seen by contrasting a map of the city in 1870 (Figure 3.3) with the earlier map (Figure 3.1) from 1796.

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[25] Herbert, *The City of Gloucester*, p.178.
[26] *Ibid,* p.177.
[27] Herbert, *The City of Gloucester*, p.4
[28] J. Jurica, *Gloucester: A Pictorial History* (Chichester, 1994), p.8.
[29] Christmas, pp.72-74.

Table 3.2 Population increase in the Gloucester Registration District 1801-1851

Year	Current Total Population
1801	13,814
1811	15,281
1821	17,986
1831	22,312
1841	26,815
1851	32,045
1861	34,950
1871	41,641

Source: GB Historical GIS / University of Portsmouth, Gloucester RegD/PLU through time | Population Statistics | Total Population, *A Vision of Britain through Time*. URL: http://www.visionofbritain.org.uk/unit/10029739/cube/TOT_POP [Date accessed: 14 December 2015]

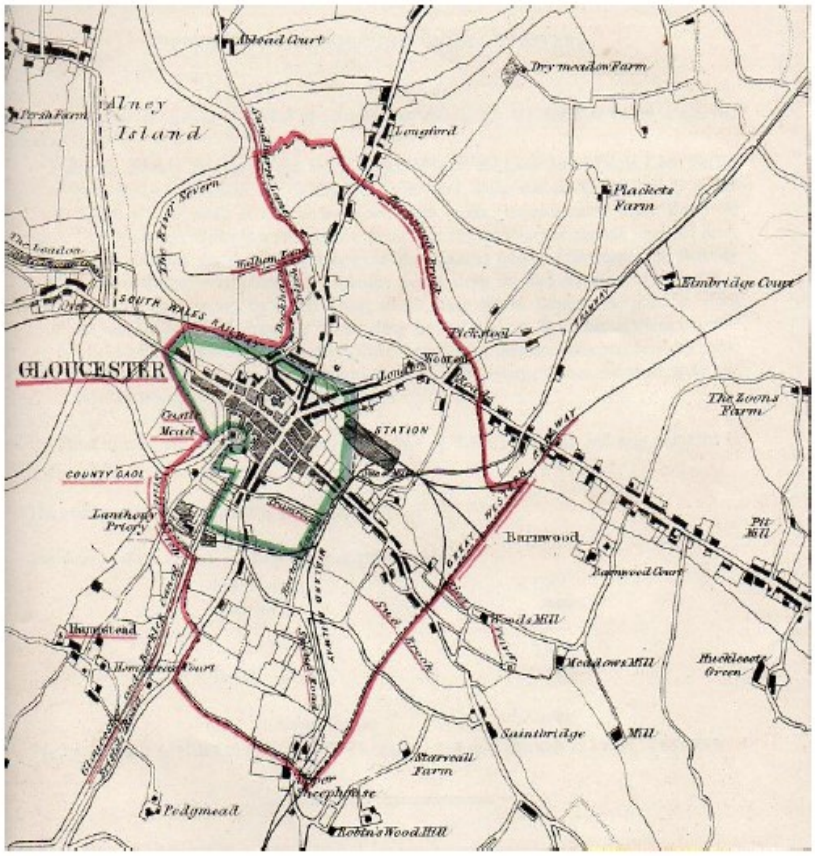

Figure 3.3 Gloucester about 1870 showing 1832 and proposed 1868 boundaries

Source: GM&P21 Gloucester in 1870. Henry James, Royal Engineers, http://www.glosarch.org.uk/glosmapsprospectspdffiles.html#PDFFILES [Date accessed 7 August 2016]

The increase in density of the existing housing, together with land being appropriated for industrial development, meant that the major population increase occurred in

suburban areas where the infrastructure was not yet in place to absorb rapid development. This, combined with bad governance, meant parts of Gloucester suffered from overcrowding, damp, inadequate sanitation, and insufficient access to clean, fresh water. Carpenter and others have observed how 'people who lived in cities were much less healthy than those who lived in the country'[30] and Gloucester's low-lying position beside the Severn and proximity to marshy ground to the north compounded the problems endemic to the nineteenth-century urban environment.

Unsurprisingly, the city was visited by the first Asiatic cholera epidemic in 1832 and the second in 1849.[31] Squalid living conditions and contaminated water supplies in the Island and Archdeacon Street areas ensured the mortality rate was much higher here than elsewhere. The use of the Sud Brook and Twyer (streams emptying into the Severn) and the river itself as open sewers created an ideal breeding ground for the disease. The problem was compounded by the refusal of outlying parishes to contribute to rectifying these problems. In 1858, the surgeon James Peat Heane, then an alderman, complained of 'such a nuisance as this ditch is to the Spa…showering its filth down, and polluting the stream in its course…When visitors came to this city they generally visited the Spa, and if at a dry season, and the water low in the ditch, the stench arising from the filth carried down from hundreds of houses, at once gave them a bad impression of the city.'[32] At the same meeting it was suggested that this nuisance was 'but trifling compared with the skin yard, in Worcester-street.'[33] In Clare Street, one privy serviced around 13 houses[34] and domestic water supplies came from wells contaminated by overflowing cess-pits, street run-off and the effluent from shambles and domestic pig keeping; [35] 'conditions were particularly insanitary in the older western districts near the river where once fashionable houses were converted as lodgings and their back yards were filled with cottages and where flooding was an occasional hazard when the Severn overflowed its banks.'[36] Furthermore, by 1848 most

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[30] M.W. Carpenter, *Health, Medicine, and Society in Victorian England* (Santa Barbara, CA, 2010), p.24.
[31] Herbert, *The City of Gloucester*, p.151. The first epidemic infected 366 people between July and September 1832, killing 123 of them. It returned in 1849, killing nearly 100 people mainly in the Island and Archdeacon Street areas and then again in 1854 when it was limited to the county gaol.
[32] *Gloucester Mercury,* 19 June 1858.
[33] *Gloucester Mercury,* 19 June 1858.
[34] Herbert, *The City of Gloucester*, p.194
[35] *Ibid.*
[36] Jurica, p.10.

of the city's burial grounds were overflowing and the reappearance of the dead after heavy rains had also become a public nuisance.

The introduction to Gloucester's 1858 Sanitary Report remarked that 'the suburban hamlet of Kingsholm St. Mary was stated by Mr. Rumsey to have been the most fatal locality in 1847, the cause of which he attributed to the Sweetbriar ditch, at that time an open sewer, poisoning the neighbourhood with its exhalations.'[37] The infamous ditch was culverted in 1852, but despite this and other improvements, in 1858 the death rate in the Urban Division of the Gloucester District was 19.19 per thousand; above the 17 per thousand then considered acceptable[38] and remained at 19.83 per thousand in 1862.[39] In the period 1861-1863, Gloucester Registration District had one of the lowest life expectancies in England and Wales. Life expectancy at birth was 25.0 to 39.9 years and at age 20, between 33.0 to 39.9 years.[40] Between 1861 and 1870, the infant mortality rate was amongst the highest, being in the range of 150 to 249.9 per thousand live births.[41] Neither was high mortality the preserve of the poor - the surgeon, Charles Clutterbuck, lost his eldest daughter Mary Ann Elizabeth aged three and a half in 1834[42], his son Conrad, aged six in 1843[43], and his infant daughter Helen in 1846. His own death followed in 1854 at the age of 48.

Recurrent public health crises were compounded by political incompetence and corruption, for which Gloucester was notorious, even by nineteenth-century standards. The arrival of cholera in 1832, prompted widespread criticism of the lethargy and self-interest of city corporations, such as this example from *The Gloucester and Cheltenham Standard*:

> We have something in reserve for those "bodies without souls" – Corporations. It is monstrously absurd, that self-elect and irresponsible men should have a control over the public money. Corporations are an anomaly in the British Constitution, exercising, as they do, a power *over* the people, not derived *from* the people – a power not belonging to the House of Commons itself! Birmingham and other rich marts of wealth, owe the origin of their enterprize [sic] and opulence, in a great degree, to the absence of corporate monopoly or self-elect rulers. Many wealthy persons repaired to Birmingham, and other

[37] B. Washbourn, *Report on the Sanitary Condition of the City of Gloucester, during the Year 1858* (Gloucester, 1858), p.3. GA B241/44908GS* NQ12.51GS
[38] *Ibid,* p.5.
[39] *Ibid,* p.3.
[40] R. Woods and N. Shelton, *An Atlas of Victorian Mortality* (Liverpool, 1997), pp.29-30.
[41] *Ibid,* p.49.
[42] *Gloucester Journal,* 1 November 1834.
[43] *Gloucester Journal,* 11 February 1843, p.3.

> similarly *governed* places, as "refugees" from the petty tyranny and rapacious cupidity of certain little aristocrats, constituting, in each of their respective bodies, an *imperium in imperio*. We hope to excite such a feeling in Gloucester as will ensure the downfall of a self-elected Corporation. The day of "nice little pickings," feasting and parades, at the public expense, is virtually over. A reformed House of Commons, echoing the wishes of a reform*ing* people, will chaunt [sic] the funeral service over the self-elect of Gloucester, Bristol, Bath, and other Corporate retreats.[44]

Gloucester was not unique in suffering under the curse of corruption and vested interest but the problem was particularly acute and despite the parlous state of the urban environment, 'the city's medical practitioners were unable to convince the Corporation of the need to act.'[45] Until 1835, the city corporation was a closed body, controlled by what was essentially an oligarchy, comprising a small number of influential families:

> That alderman which was last mayor is generally the coroner, and the president of the hospitals. The commissioners for municipal reform on their visit to Gloucester in 1833, received many complaints about the functioning of the corporation: among matters raised were the use of its influence at parliamentary elections, the lack of energy in some aspects of administration, and the animosities and jealousies caused by the exclusion of some prominent citizens from the governing body…[46]

Even after the corporation was replaced by an elected body under the 1835 Municipal Corporations Act, many officials from the previous regime remained in post.[47] As late as the 1880s, a Royal Commission was to find that 'Gloucester was among the most corrupt of the seven towns investigated.'[48] The same issue of the *Gloucester and Cheltenham Standard* referred to above, also gave vent to its dissatisfaction with the Board of Health, set up to combat the cholera epidemic:

> That snug, secret, and aristocratic body – the Board of Health, have given some awkward proofs of their desire to cooperate with other authorities of a less pompous character, in arresting the progress of Cholera. It appears that the worthy members of that mysterious conclave applied for the "sinews of war" – that wonder-working agent, money – to the parishioners of St. Michael's, who promised compliance on the reasonable condition that their minister, churchwardens, and a few respectable parishioners should be admitted as members of the Board. This reasonable proposal was rejected by the self-elected conclave. We understand that the parishioners' purpose memorializing the Privy Council on the subject. We cannot forbear censuring the arrogance of the haughty aristocrats, who are like Danae, unapproachable unless through the magic influence of gold. We commend the parishioners for the spirit which they have manifested, in demanding admission, for some of their body, to the Board – 'tis due to the public, that public money should be publicly expended. An irresponsible agency is at all times mischievous. Alas!

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[44] *The Gloucester and Cheltenham Standard*, 1 September 1832.
[45] Christmas, p.208.
[46] Herbert, *The City of Gloucester,* p.146.
[47] Jurica, pp.8-9.
[48] 'Gloucester, 1835-1985: Parliamentary Representation,' in Herbert, *The City of Gloucester*, pp,205-209.

> how often are people of thought slighted for not falling down and worshipping golden calves![49]

It took the return of cholera in 1849 to force the establishment of a permanent local Board of Health. Thereafter, the Corporation did instigate the laying of a new sewerage system between 1853 and 1855 and took control of the city's water supply in 1854, with water being supplied via a conduit in Southgate Street. Even this proved a contentious issue, as did the extension of the city's responsibilities to its burgeoning suburbs outside of the municipal boundary.[50] Despite some improvements, much poor-quality accommodation remained, and the city continued to be plagued by inadequate sanitation, poor housing, and industrial pollution throughout the nineteenth century. Consequent morbidity of course resulted in demand for healthcare and as the next sections will show, this contributed in the first half of the century to a dramatic increase in both institutional and commercial supply.

Unusually, Gloucester was surrounded by affluent health resorts; Bath to the south, later Malvern to the north, but most importantly its near-neighbour Cheltenham, with its large cohort of wealthy patients and a density of medical practitioners and chemists and druggists akin to that of London. Jane Adams has noted that before Cheltenham's emergence as a major health spa, in 1801 there were far fewer doctors per head of population in Gloucestershire than in the surrounding counties and concluded 'it is likely that the ratio noted for Gloucestershire was influenced by the proximity of Bath and Bristol, with more practitioners choosing to base themselves in those centres rather than in more rural areas.'[51] If these places had lured away both doctors and wealthy customers, the impact of Cheltenham proved even greater. These features made Gloucester both typical and exceptional. This, and the opportunity for comparison with its nearest neighbour, made it an outstanding candidate for study. This process will now begin by looking at institutional healthcare; something we have identified as peculiarly problematic to the medical marketplace paradigm.

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[49] *The Gloucester and Cheltenham Standard*, 1 September 1832.
[50] The surgeon, James Peat Heane, also opposed this during his tenure as Mayor.
[51] J.M. Adams, 'The Mixed Economy for Medical Services in Herefordshire c.1770-c.1850, unpublished PhD thesis (University of Warwick, 2003), p.7; See also, A. Digby, *The Evolution of British General Practice 1850-1948* (Oxford, 1999), p.27.

3.4 Hospitals and other healthcare institutions

This section examines the role of institutions in Gloucester's healthcare economy and their contribution to the professionalisation of medicine; something that has been cited as instrumental to the demise of the medical marketplace. A discussion of the role of hospitals generally is followed by a chronological examination of each of Gloucester's healthcare institutions, looking at why they were formed, who they treated, and their place in the healthcare landscape of the city, followed by a sub-section devoted to their role in the professionalisation of medicine.

It has been said that hospital medicine has enjoyed a 'clear hegemony…over the last two centuries'[52] and in the nineteenth century 'hospitals…became the landmark institutions – the secular cathedrals – of the emergent medical science.'[53] Eighteenth-century infirmaries had a dual purpose; 'the hospital was there to heal the sick; but it was intended to function as a social balm as well,' 'an act of conspicuous, self-congratulatory, stage-managed *noblesse oblige*' that, according to Porter, 'threw a cloak of charity over the bones of poverty and naked repression.'[54] The new infirmaries reflected 'the attempt to tie paternal relations to a set of clearly defined, permanent institutions [which] was a new feature of paternalism'[55] and were designed both to bolster the social order and act as a source of civic pride.[56] Importantly, as Carpenter pointed out, 'one important difference between middle- or upper-class patients and poor or working-class patients was that only the poorer classes were hospitalized.'[57] Hospitals also 'catered for individuals only after they were taken ill, were usually only available for the acute phase of the illness and in any case were often limited to persons with certain diagnosis.'[58] King has concluded that 'what is surprising is not how much

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[52] D. Armstrong, 'The Rise of Surveillance Medicine,' *Sociology of Health & illness*, Vol.17. No.3 (1995), p.395.
[53] P.J. Corfield, *Power and the Professions in Britain 1700-1850* (London, 1995), p.161.
[54] R. Porter, 'The Gift Relation: Philanthropy and Provincial Hospitals in Eighteenth-Century England' in L. Granshaw and R. Porter (eds), *The Hospital in History* (London, 1990), p.152.
[55] J. Gerrard, 'Lady Bountiful: Women of the Landed Classes and Rural Philanthropy,' *Victorian Studies*, Vol.30, No.2 (Winter 1987), p.196.
[56] See A. Borsay, *Medicine and Charity in Georgian Bath* (Aldershot, 1999) and P. Elliott, 'The Origins of the 'Creative Class': Provincial Urban Society, Scientific Culture and Socio-Political Marginality in Britain in the Eighteenth and Nineteenth Centuries,' *Social History,* Vol.28, No.3 (October 2003), pp.361-387.
[57] Carpenter, p.25.
[58] W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge, 1994), p.55.

institutional care there was, but how little.'[59] Far from catering for the healthcare needs of the general population, the hospital's primary function was to treat those productive members of the workforce who could not afford private treatment, but who could be cured through medical intervention, and 'restore them to labour as speedily as possible.'[60]

In Gloucester, as elsewhere, healthcare institutions comprised a mixture of charitable and public bodies and access to treatment was determined by not only clinical but moral and economic criteria. Policy was generally to restrict eligibility, partly to avoid being swamped with demand and partly to impose the moral, religious and social convictions of the founders and benefactors upon patients and to exclude certain 'undeserving' groups. Digby has cautioned that 'it is important to appreciate that hospital care was conceived almost as much as a moral or spiritual opportunity as a clinical one.'[61] Unsurprisingly, there were gaps in coverage, so that many of the sick poor found themselves trapped between being too well-off for parochial relief and being ineligible for one reason or another for admission to charitable institutions.

Chapter two discussed the importance of hospitals in re-defining the doctor-patient relationship, yet as the introduction highlighted, these and other healthcare institutions do not sit comfortably within the medical marketplace model, which emphasises the importance of individual agency in determining the nature of supply. Hospitals operated on a not-for-profit basis and not in any straightforward accordance with the laws of supply and demand. The hospital patient was in some ways the antithesis of the 'healthcare shopper' described by some of the literature. Hospital patients were regarded not as consumers of services, but as objects of charity by founders, benefactors, governors and doctors, who wielded autocratic power over them. It has been argued that increasingly in the nineteenth century, 'medical men were able to take control of the process of illness interpretation within the hospital because the authority of the Infirmary's benefactors devolved upon them.'[62] The class divide

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[59] S. King, 'Poverty, Medicine, and the Workhouse in the Eighteenth and Nineteenth Centuries: An Afterword' in J. Reinarz and L. Schwarz, (eds), *Medicine and the Workhouse*, (Rochester, N.Y., 2013), Kindle edition, ch.11.
[60] Porter, 'The Gift Relation,' p.163.
[61] A. Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine 1720–1911* (Cambridge, 1994), p.235.
[62] M.E. Fissell, *Patients, Power, and the Poor in Eighteenth-Century Bristol* (Cambridge, 1991), p.10.

between doctors and patients created an imbalance of power, compounded by the patient's dependency on treatment and the doctor's 'expert' knowledge.

Between the mid-eighteenth and mid-nineteenth centuries the number of hospitals and other healthcare institutions in Gloucester increased dramatically and they came to play a central role in the city's healthcare economy. Although there was some overlap in the patients they admitted, each made a unique contribution to overall healthcare provision. The public undoubtedly recognised the value of the care they provided, but attitudes towards these institutions were ambivalent and most likely differed significantly between their middle and upper-class supporters and staff, and their working-class patients. Early on, workhouse medicine in particular acquired a bad reputation amongst the people it was supposed to help. Summers has claimed that 'the poor did everything in their power to avoid entering the Workhouse infirmary or sick ward,'[63] but it is not only workhouse care that has attracted criticism and 'even the best hospitals, remained dark and overcrowded, ill-run and insanitary.'[64] Although 'doctors and benefactors of the hospital firmly believed in the usefulness of medical treatment' their faith was not necessarily shared by their patients for whom applying for admittance sometimes amounted to a triumph of desperation over fear.[65] As late as 1877, Thompson and Smith held that:

> Far from being in a position to record the extinction of the race of " herbalists" and "doctors for the million" who practise upon the poor, my investigations prove they are still about as numerous as their trade is lucrative... I found in the course of my inquiries that the poor, many of them, prefer either resorting to quack remedies or employing their own paid surgeon, to placing themselves in the hands of the parish doctor, or under hospital treatment.[66]

It is widely assumed 'hospitals were not places to which one went through choice' and they were shunned by the middle and upper classes, who firmly believed treatment at home was more efficacious both socially and medically.[67] As discussed in chapter two, surgery, whether undertaken in a hospital or at home, was, before

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[63] A. Summers, 'The Costs and Benefits of Caring: Nursing Charities, c.1830–c.1860' in J. Barry and C. Jones (eds), *Medicine and Charity Before the Welfare State* (London, 1991), p.134.
[64] A.J. Youngson, *The Scientific Revolution in Victorian Medicine* (London, 1979), p.24.
[65] E. E. Cockayne and N. J. Snow (eds), *Stutter's Casebook: A Junior Hospital Doctor, 1839-1841* (Woodbridge, 2005), p.xxx.
[66] J. Thomson and A. Smith, *Street Life in London* (London, 1877) http://www.victorianlondon.org/ [Date accessed: 26th August 2010].
[67] I. Waddington, 'The Role of the Hospital in the Development of Modern Medicine: A Sociological Analysis,' *Sociology*, Vol.7, No.2 (May 1973), p.216.

anaesthetics, blood transfusions and antiseptics, both agonising and risky. It 'was always a last resort and only done in matters of life and death,'[68] some claiming that 'operating theatres were gateways to death.'[69] Crude treatments and the unsanitary state of many wards, mean 'it is not easy to imagine what these mid-Victorian hospitals were like. They were dreadful places, even with chloroform…The smell alone was appalling.'[70] Even when hygiene and anaesthetics had become widely established, the trepidation patients still felt on entering hospital was eloquently articulated by Gloucester born poet William Ernest Henley (1849-1903):

> THE morning mists still haunt the stony street;
> The northern summer air is shrill and cold;
> And lo, the Hospital, grey, quiet, old,
> Where Life and Death like friendly chafferers meet.
> Thro' the loud spaciousness and draughty gloom
> A small, strange child — o aged yet so young! —
> Her little arm besplinted and beslung,
> Precedes me gravely to the waiting-room.
> I limp behind, my confidence all gone.
> The grey-haired soldier-porter waves me on,
> And on I crawl, and still my spirits fail:
> tragic meanness seems so to environ
> These corridors and stairs of stone and iron,
> Cold, naked, clean — half-workhouse and half jail.[71]

Yet, despite their many deficiencies and the abuses of power that Foucault and others have attributed to the hospital regime (discussed in chapter two), it is a salient fact that 'the public was not deterred from attending hospitals in increasing numbers.'[72] In fact, hospitals expended much more effort trying to restrict eligibility and deny access to the "underserving" than in attracting patients and, as Porter pointed out, 'if they had really been 'gateways to death,' it is hard to see why community and doctors alike continued to patronise them.'[73] Hospital mortality rates were, surprisingly, low, although partly this was because they commonly excluded cases that were unlikely to survive, or discharged them before death. It has been said that 'hospitals did achieve

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[68] L. Fitzharris, *The Butchering Art: Joseph Lister's Quest to Transform the Grisly World of Victorian Medicine* (London, 2017), p.5.
[69] *Ibid,* pp.5-6.
[70] Youngson, p.186.
[71] W.E. Henley, "In Hospital." *Poems*. 2nd edition (London, 1889). http://www.victorianweb.org/authors/henley/inhospital/henley1.html. [Date accessed: 22 February 2017].
[72] Corfield, p.161.
[73] R. Porter, *Disease, Medicine and Society in England, 1550-1860*, second edition (Cambridge, 1993), p.61.

what appears to be a remarkable degree of success in treating their patients…mortality…generally being under 10 per cent of the patients admitted.'[74] Thomas pointed out that unsanitary as many hospitals were, 'conditions in respect of fresh air and cleanliness might have been an improvement on a pauper's home.'[75] However tempting the conclusion may be with benefit of hindsight, it is nonetheless almost certainly a myth that early-Victorian hospitals killed more patients than they cured, a charge that Woodward claimed is 'completely erroneous.'[76] Nevertheless, the authoritarian regime and torturous treatments available meant self-discharging against medical advice was commonplace and it is easy to see why Thompson and Smith believed the poor would turn to irregulars rather than submitting themselves for admission. To form a view on these points and the role of institutions in Gloucester's healthcare economy more broadly, it is helpful to discuss each of them in the chronological sequence in which they appeared.

Oldest and pre-eminent among Gloucester's healthcare institutions was the General Infirmary, located at the bottom of Southgate Street. Founded in 1755 to serve the sick poor from across the whole county, it opened in 1761 and was one of a wave of provincial hospitals constructed in the mid-eighteenth century. Modelled on Northampton, the Infirmary was the creation of a group of wealthy and influential philanthropists, who 'contributed to this noble charity in a measure adequate to their great generosity, and public spirit'[77] at a time when 'philanthropy was assuredly in fashion.'[78] In 1826, J. K. Walker in his *Observations on English Hospitals* wrote of the Infirmary that 'at the period of its erection, [it] was considered as commodious and complete a structure of the kind, as any in the kingdom.'[79] In 1818, Thomas Fosbrooke remarked that 'it is needless to say that the institution is so admirably conducted as to be a pattern for imitation.'[80] Typical of the period, Gloucester's was styled an 'infirmary,' rather than 'hospital' as a way of emphasising its medical nature and thus to distinguish it from earlier generations of hospitals, which were effectively almshouses. As a major

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[74] J. Woodward, *To do the Sick no Harm: A Study of the British Voluntary Hospital System to 1875* (London, 1974), p.142.
[75] E.G. Thomas, 'The Old Poor Law and Medicine,' *Medical History*, Vol.24, No.1 (1980), p.5.
[76] Woodward, p.126.
[77] Rudder, p. 59.
[78] R. Porter, 'The Gift Relation,' p.149.
[79] J. K. Walker, 'Observations on English Hospitals,' *The Midland Medical and Surgical Reporter, and Topographical and Statistical Journal*, Vol 1, No.3 (February 1829), p.317.
[80] Fosbrooke, p.219.

part of its purpose was to reduce the loss of productivity due to sickness and injury in the county's workforce, the Infirmary dealt primarily with injuries requiring surgery and curable acute medical conditions. From the outset, its admissions policy was also designed to attract subscribers by enabling them to demonstrate their largesse by recommending patients:

> Every subscriber hath a right to recommend one in-patient, and one out-patient, every year, for each guinea *per ann.* subscribed and paid, provided the in-patients do not exceed five. A benefactor of 50/. Hath the privilege of a subscriber of five guineas; of 20/. that of two guineas *per annum*. But no subscriber can have more than one in-patient at a time; nor can a benefactor of less than 20/. at one time, recommend a patient. Only such as are recommended by a subscriber, or benefactor, and appear to the weekly board and receiving physician and surgeon to be curable, and real objects of charity, to be admitted, and that on Thursdays only; except in such cases as will admit of no delay.[81]

Admission policy was designed to exclude both the incurable and those likely to 'infect' others, either physically or metaphorically. The 1851 Infirmary rulebook specified those inadmissible for treatment:

> …no female in a state of pregnancy, no child under five years of age, except in the cases after-mentioned [being cases of 'severe accident or peculiar emergency'] emergency, no person insane – or having small-pox, scarlet fever, scarletina, measles, or itch – nor any person who, in the opinion of the examining Physician or Surgeon, might receive equal benefit as an Out-Patient – nor any person infested with vermin – shall be admitted as an In-Patient. [82]

Fever patients, who risked contaminating other patients and staff, were thus not admitted.[83] In addition, patients were automatically discharged after a maximum stay of twelve weeks and those deemed incurable would not be readmitted again with the same complaint. Apprentices and domestic servants, whose master or employer could, in theory at least, afford to pay for their treatment privately, were also excluded. It was not until 1846 that the rules were amended to state that patients could be admitted without recommendation in 'cases of severe recent accident or of urgent emergency.'[84] Gloucester Infirmary was unusual however in admitting children aged five and over,

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[81] Rudder, pp.59-60.

[82] Gloucester Infirmary, *Rules for the Government of the General Infirmary at Gloucester 1851* (Gloucester, 1851), p.54.

[83] Isolation hospitals did not appear until late in the nineteenth century, although a temporary facility operated from a house off Barton Street during the 1832 cholera epidemic and the Dispensary treated cholera patients during the 1849 outbreak – see 'Gloucester: Hospitals,' in Herbert, *The City of Gloucester*, pp. 269-275. *The Eighteenth Annual Report of the Gloucester Dispensary & Vaccine Institution* (Gloucester, 1849).

[84] G. Whitcombe, *The General Infirmary at Gloucester and the Gloucestershire Eye Institution: Its Past and Present* (Gloucester, 1903), p.76.

contrary to the prevailing wisdom that 'children should not be admitted to hospital at all.'[85]

Despite this restrictive admissions policy, which also incidentally stipulated that patients had to bring with them 'three shirts (or shifts), and three pairs of stockings, unless his washing be provided for outside of the House' (another measure designed to control costs and deter dependency), overcrowding was a periodic problem.[86] Governors and subscribers suspected that undeserving cases were abusing the admissions system and the uncoordinated nature of institutional healthcare supply fuelled a situation whereby 'each medical relief institution constantly sought to rid itself of a portion of its liabilities by throwing them on others, and the poor were the victims in the struggle.'[87] In 1790, it was reported that 'there were many instances of two patients having to share the same single bed.'[88] In December 1825, the Infirmary was forced to announce a temporary ban on admissions except in cases of 'extreme necessity,' a situation that finally forced the extension of the premises and an increase in the number of beds.[89] A south wing was added in 1827, bringing the in-patient accommodation up to some 170 beds, with a north wing being commissioned four years later.[90] Attempts were also made to limit the number of recommendations subscribers and donors could make, based upon the amount they contributed.

Although periodic episodes of overcrowding occurred, the number of patients treated in the Infirmary was still relatively small. Nationally, it has been estimated that as late as 1861, only one in five hospital patients were treated by voluntary hospitals.[91] At the start of the Age of Reform, in 1815, figure 3.4 shows the maximum capacity of Gloucester Infirmary was only 117 beds and even then, it was not operating at full capacity. During that year the average bed occupancy rate was 0.72 for males and 0.73 for females.[92] Overcrowding was cyclical and even in the 1850s there were periods when the wards were far from full. In July 1850 for example, there were 61 male

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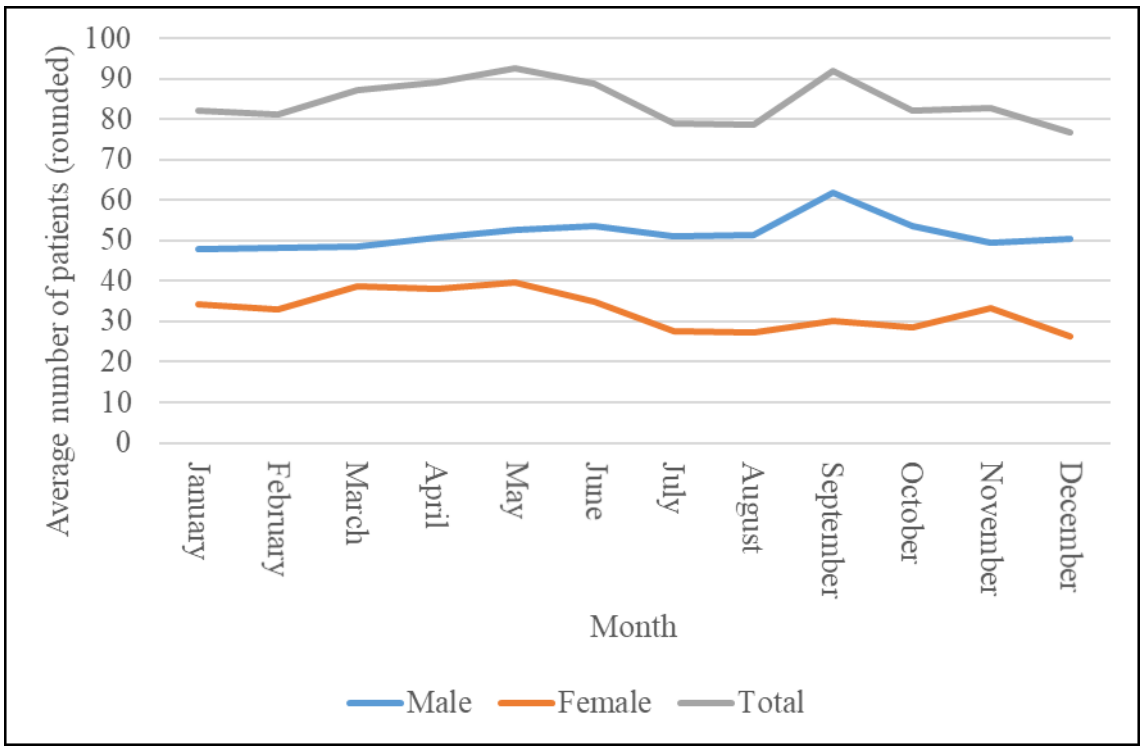
[85] B. Abel-Smith, *The Hospitals 1800-1948* (London, 1964), p.14.
[86] Whitcombe, p.53.
[87] R.G. Hodgkinson, *The Origins of the National Health Service: The Medical Services of the New Poor Law, 1834-1871* (London, 1967), p.612.
[88] B. Frith, *The Story of Gloucester's Infirmary* (Gloucester, 1961), p.13.
[89] *The Glocester Herald,* 3 December 1825.
[90] Frith, p.16.
[91] S. Cherry, *Medical Services and the Hospitals in Britain, 1860-1939* (Cambridge, 1996), p.61.
[92] The number of patients divided by the number of beds.

patients and 106 male beds, 40 female patients and 55 beds;[93] in February 1870 this had fallen to 72 male patients and 89 male beds, and 41 female patients and 51 female beds.[94] More male than female beds were provided partly reflecting the greater value placed upon them as economic units and partly reflecting the greater likelihood of them suffering workplace injuries. Later in the period, males were more likely to be covered for hospital treatment through membership of a friendly society, or through their employment, a benefit that did not usually extend to their dependents.

Figure 3.4 Gloucester Infirmary: average monthly number of in-patients, 1815



Source: *The Glocester Herald* N.B. No figures were published in the 2 June 1815 edition.

For those unable to gain access to the Infirmary, the healthcare service of last resort was the Workhouse and 'it was the Poor Law service which accommodated the bulk of the sick children, the mental cases, the skin conditions, those with epilepsy, tuberculosis and venereal diseases and the unexplored mass of the chronic sick.' [95] Most of those who could no longer support themselves or rely on family, friends or neighbours ended up as Poor Law patients. Tomkins has noted that 'before the demands of an urban-industrial society overwhelmed the system, paupers seem

[93] *Gloucestershire Chronicle*, 4 July 1850.
[94] *Gloucester Journal,* 12 February 1870, p.5.
[95] Abel-Smith, *The Hospitals,* p.49.

potentially to have had access to some of the same treatments and medical personnel that were available to Infirmary patients because parishes paid for them'[96] and 'agency among the parish poor has formed a discernible refrain in recent scholarship on the Old Poor Law'[97] However, after 1834 outdoor relief was actively discouraged and the Workhouses took on the mantle of caring for the sick poor, treating far greater numbers than the voluntary hospitals. Under the New Poor Law, there was a lack of incentive to provide high-quality care and 'complaints of poor treatment and insufficient supply of medicine were frequent.'[98] The principle of 'less eligibility' was designed to discourage indolence amongst the work-shy, but as sickness was one of the primary causes of pauperism, punished the infirm and disabled in equal measure. Tomkins suggested 'the sick poor were (at least initially) subjected to harsh treatment akin to that applied to the able-bodied poor, so access to medicine under the new law was degraded as the number of practitioners was cut, along with spending. Consequently, the poor came to regard medical relief at best as undesirable and at worst as repellent.'[99] Conditions were unsanitary, food plain and lacking nutrition, and workhouse nurses were commonly fellow inmates, who might be variously aged, alcoholic, even insane. Smith claimed that 'workhouse nursing remained a harrowing compound of neglect and mindless cruelty'[100] and Hallett that 'England's Poor Law medical wards and infirmaries were in a desperate state.'[101] The consequence, as Tomkins points out, was that 'the agenda of the Poor Law Commission of 1834… did not succeed in deterring all entrants, but it was wildly successful in terms of stigmatizing the institution.'[102]

Under the New Poor Law, both patients and doctors could exercise little control within a prescriptive, cumbersome and sometimes obstructive bureaucratic structure. Although the way in which the New Poor Law system was implemented varied from one union to another, generally it is fair to say that the system was underfunded and

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[96] A. Tomkins, 'Paupers and the Infirmary in Mid-Eighteenth Century Shrewsbury' *Medical History*, Vol.43, No.2 (April 1999), p.226.
[97] A. Tomkins, 'Workhouse Medical Care from Working-Class Autobiographies, 1750–1834' in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse*, (Rochester, N.Y., 2013), Kindle edition, ch.4.
[98] Hodgkinson, p.233.
[99] A. Tomkins, ''The Excellent Example of the Working Class': Medical Welfare, Contributory Funding and the North Staffordshire Infirmary from 1815, *Social History of Medicine*, Vol. 21, No.1 (March 2008), p.14.
[100] F.B. Smith, *The People's Health 1830-1910* (London, 1990), p.388.
[101] C.E. Hallett, 'Nursing 1830-1920: Forging a Profession' in A. Borsay and B. Hunter (eds), *Nursing and Midwifery in Britain since 1700* (Basingstoke, 2012), p.54.
[102] Tomkins, 'Workhouse Medical Care.'

contained obvious disincentives to good patient care.[103] Until recently 'workhouse medical officers [have been] generally characterized in the historiography as apathetic, ineffectual, self-interested, and, accordingly guilty of medical neglect by complying with the system.'[104] Inevitably, as chapter six will show, there were examples of bad practice and negligence and the risks to patients was compounded because 'parishes sometimes selected a practitioner according to how much he charged.'[105] Poor Law medical posts were not well remunerated and were regarded as either stepping stones for young doctors on their way up the career ladder, or as the resort of failed general practitioners. The post was demanding, demoralizing, and carried the stigma of low-paid, salaried employment, which according to Tomkins meant 'there was a strong temptation to give less regard to pauper patients.'[106] When the cost of medicines came from the medical officer's overall remuneration, the incentive to under-prescribe was obvious, leading some to claim 'patients got only the cheapest stuff, when they received anything at all.'[107] However, the stereotype of medical officers as self-serving and disinterested does not bear close scrutiny and it would be a mistake to assume all Poor Law medical care was substandard. King has flagged that 'significant gaps in our knowledge on the nature and role of medical care offered in the Workhouse remain'[108] and 'an understanding of the exact medical role of the Workhouse remains elusive.'[109]

Poor Law medical officers deserve some sympathy, for as Englander has pointed out, 'hired on a short-term contract, he had to supply all drugs and medical appliances from his own salary. He was subservient to the guardians and often under the thumb of economically-minded masters who frequently ignored or countermanded his recommendations on patient care'[110] In addition, they often travelled vast distances attempting to cover several parishes and for which they were not reimbursed; as Carpenter noted, rural medical districts 'might be impossibly large for a single medical

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[103] S. King, 'Poverty, Medicine, and the Workhouse'.
[104] A. Negrine, 'Practitioners and Paupers: Medicine at the Leicester Union Workhouse, 1867-1905' in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse*, (Rochester, N.Y., 2013), Kindle edition, ch.9.
[105] Carpenter, p.27.
[106] A. Tomkins, *Medical Misadventure in an Age of Professionalisation, 1780-1890* (Oxford, 2017), p.5.
[107] Smith, p.357.
[108] King, 'Poverty, Medicine, and the Workhouse.'
[109] *Ibid.*
[110] D. Englander, *Poverty and Poor Law Reform in 19th Century Britain: From Chadwick to Booth, 1834-1914* (London, 1998), p.36.

officer to manage.'[111] Gloucester surgeon Henry Rumsey stated that 'the Gloucester union consists of 40 parishes and hamlets and about 28,000 inhabitants, about one third of whom reside in the suburbs and rural districts from one to five miles from the city. The sick poor of this union are consigned to the care of *two* surgeons… no amount of possible labour from two gentlemen so circumstanced can fulfil the requirements of the case.'[112]

Certainly, 'the lack of medical autonomy experienced by workhouse medical officers, along with their acceptance of lowly paid posts and their willingness to treat the poorest patients, undermined their status among the medical profession.'[113] In 1818, the salary of a Gloucester Poor Law surgeon was a mere £30 per annum.[114] Medical officers inevitably struggled to establish themselves professionally and stand up for themselves against criticism. Englander found that 'the 'parish doctor,' who combined workhouse service with private practice, was generally regarded as no better than a struggling tradesman. Poor Law medical officers 'frequently complained about their working conditions and the principles of the poor law system through the medical journals.'[115] However, Rose has also noted that 'the poor law medical officer often played a vital role in collecting information and arousing consciences on the subject of treatment of the poor.'[116] One such was the Gloucester surgeon Charles Clutterbuck, who publicly voiced his opposition to a proposal to reduce patients to four feet each of sleeping room (to increase capacity), which he likened to 'the Black Hole of Calcutta, or the packing of negroes between decks in slave ships!,' declaring that 'my office is to cure, not to kill my patients, and therefore I must wash my hands altogether of this packing system.'[117]

Conditions in Gloucester were not as bad as some places elsewhere. Following the 1834 Act, a new workhouse was constructed between 1837 and 1839 with a dedicated infirmary attached. This building was short-lived: in 1850 it was demolished to make way for the South Wales railway and in 1852 a new infirmary opened to the

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[111] Carpenter, p.27.
[112] Evidence submitted by H.W. Rumsey to the Select Committee on Poor Law Medical Relief, 1844, cited in Hodgkinson, p.262.
[113] Negrine, 'Practitioners and Paupers'
[114] *The Glocester Herald*, 12 December 1818.
[115] Negrine, 'Practitioners and Paupers'
[116] M.E. Rose, *The Relief of Poverty 1834-1914*, (London, 1972), pp.24-25.
[117] *Gloucester Journal,* 12 October 1850, p.3.

west of the Workhouse.[118] As was common practice, from 1851 through to 1871 the Workhouse matron was the wife of the master and as such likely 'knew little of nursing work and essentially played the role of housekeeper.'[119] Unusually however, from the outset a salaried nurse was employed. This did not guarantee high-quality care, as the nurses appointed were untrained and possessed no medical education, but it did at least remove the task from fellow inmates. Conditions in the Workhouse infirmary were basic, but its medical officers, despite the meagre pay and demanding hours, appear to have been professional, diligent and sympathetic. Gloucester seems to have been one Union that supports Higgs' view that 'with little investment in improving sanitation, furnishings or staffing levels, overworked medical officers and nurses struggled on to provide the best care they could.'[120] Nevertheless, provision was still inadequate. In 1858, the Workhouse infirmary admitted 286 patients, who as Table 3.3 illustrates, suffered from a wide range of conditions including venereal, maternity and geriatric cases, as well as some lunatics – surely only a fraction of those in need.

Table 3.3 Gloucester Workhouse hospital patients by condition, 1858

Disease	**Zymotic diseases sub-divided**	**Number of admissions**
Zymotic diseases	Measles (29) Small Pox (12) Influenza (3) Fever (11) Diarrhoea (10) Erysipelas (1)	66
Dropsy		3
Abscess		4
Ulcers		12
Mortification		1
Cancer		1
Gout and Rheumatism		5
Strumous Affections		5
Diseases of Brain, &c.		14
Diseases of the Heart		3
Diseases of Respiratory Organs		16

[118] 'Gloucester, Gloucestershire: after 1834,' http://www.workhouses.org.uk/Gloucester/ [Date accessed: 2 May 2017].
[119] Hallett, 'Nursing 1830-1920,' pp.54-55.
[120] M. Higgs, *Life in the Victorian Hospital* (Stroud, 2009), p.28.

Disease	Zymotic diseases sub-divided	Number of admissions
Diseases of Digestive Organs		22
Diseases of Urinary Organs		7
Uterine Diseases		2
Skin Diseases		44
Chilblains		18
Gonorrhoea and Syphilis		17
Diseases of the Eye		11
Debility		6
Lunatic		4
Febricula		2
Inanition		2
Scald		1
Fractures		2
Disease of Spine		1
Old Age		1
Tumour		1
Childbirth		15
TOTAL		**286**
	Male	**Female**
Deaths	20	11

Source: B. Washbourn, *Report on the Sanitary Condition of the City of Gloucester, during the year 1858* (Gloucester, 1858), p.10. GA B241/44908GS* NQ12.51GS

In 1857, Rumsey remarked that 'the three sources from which the poor of Gloucester currently derive their medical relief…are, the poor-law union, the Dispensary, and the benefit clubs…the medical relief so derived is of necessity insufficient to meet the wants of the poor.'[121] Earlier, in 1844, he had estimated that 12.34 patients in every hundred (3,310 patients) in Gloucester were pauper or medical charity cases, representing 5.6 per cent of the population.[122] Furthermore, 'he found that one-third of the deaths returned by the Registrar had no medical certificates attached to them, and as no Medical Officer ever refused to furnish one… this great proportion of cases died

[121] *Gloucester Journal,* 31 July 1847, p.4.

[122] Evidence submitted by H.W. Rumsey to the Select Committee on Poor Law Medical Relief, 1844, cited in Hodgkinson, *Origins of the National Health Service*, p.262. Henry Wyldbore Rumsey (1809-1876), a Gloucester surgeon and medical reformer, became President of the Public Medicine Section of the British Medical Association, authored numerous publications relating to sanitary reform and state medicine, and was described by Hodgkinson as 'one of the greatest reformers of the Poor Law medical service' (Hodgkinson, *Origins of the National Health Service*, p.684).

without medical attention.'[123] Rumsey thus lends some support to King's conclusion that 'only the smallest proportion of paupers and the minutest proportion of all sickness episodes by those paupers are likely to have been encompassed by treatment in…institutions.'[124]

From 1831, the poor did have another option available to them; the Gloucester Dispensary and Vaccine Institution, which provided outpatient care from premises initially from a building in the shell of Greyfriars church. The Dispensary's opening hours were 10 a.m. to 2 p.m. and from 5 p.m. till 7 p.m. except for Sundays (when it was from 9 a.m. till 10 a.m. and 5 p.m. till 6 p.m.).[125] By 1855 this had changed to 11 a.m. till 1 p.m. six days a week and from 3 p.m. till 5 p.m. on Sunday. [126] The surgeons were tasked to attend 'at the Dispensary every morning, from ten o'clock till two, for the purpose of vaccinating all poor persons who shall be there in waiting'[127] and to 'administer medical and surgical advice and medicines, *gratis*, to all such poor persons as shall be properly recommended,' either at the Dispensary or 'to visit such patients at their own habitations as reside within the first mile-stone round the city, and may be unable to attend at the Dispensary.'[128] Like that of the Poor Law medical officer, the work was arduous, compounded by the fact the Dispensary was sometimes understaffed. An article celebrating its centenary quoted from the 1851 Annual Report that:

> The Medical Officers of this institution have been, by various circumstances, reduced in number greatly below the staff originally contemplated when the Charity was first established. At the opening of the present year (Midsummer, 1850) the Attendant Officers were only three, and in December last, two of them withdrew, leaving only one attendant Medical Officer, Fortescue Morgan, who undertook the burden of prescribing for all patients of the Charity. The number treated in that particular year was 673.[129]

Rumsey, one of its early medical officers, was later critical of the care dispensaries provided, claiming he 'did not believe that dispensary patients were as conscientiously treated as patients of the Union Medical Officer. The larger number of cases requiring

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[123] *Ibid,* p.323-324.
[124] King, 'Poverty, Medicine, and the Workhouse.'
[125] Gloucester Dispensary and Vaccine Institution, *Report of Meeting held on 30 August 1831 for Inaugurating the Dispensary, with Rules, and List of Subscriptions* (Gloucester, 1831).
[126] Gloucester Dispensary and Vaccine Institution Recommendation Form for Patients, 1855, Gloucestershire, GA, Needham & Sons, printers of Gloucester, MS, D11223/4/12.
[127] Gloucester Dispensary and Vaccine Institution, *Report of Meeting held on 30 August 1831,* p.13.
[128] [Unknown], *Gloucester Directory* (unknown, 1867), p.27.
[129] *Gloucester Journal*, 17 October 1931, p.15.

attendance every day only allowed a hurried and imperfect examination.'[130] Dispensary posts were seen as being of lower status than those at the Infirmary and salaried positions were not well remunerated; in 1840, the apothecary to the Gloucester Dispensary (Mr Williams) received only £60 per annum, a sum that had not increased since its foundation in 1831.[131] Despite this, the Dispensary attracted some high-calibre doctors and many of Gloucester's most successful and esteemed medical men held Dispensary appointments during their careers, including amongst others, Messrs Meyler, Williams, J.W. Wilton, W. Wilton, J.F. Cooke, Heane, Clutterbuck, Buchanan, Hicks, Carden and Wood.[132] These were competent doctors; Clutterbuck, for example, who was a medical officer from the opening of the Dispensary through to 1847 was no second-rate sawbones.[133] He demonstrated his surgical prowess when in 1840 he successfully removed a twenty-pound tumour of four and a half feet in diameter from a man from Elmore.[134] In February 1847, he became the first surgeon in the city to undertake an operation using ether as an anaesthetic – only weeks after Liston first used it as a general anaesthetic in England on 21 December 1846. A few months later, in December, he used chloroform for the first time, again only a month after its anaesthetic properties were announced by Simpson.[135]

The success of the Dispensary and its importance to Gloucester's healthcare economy is underlined by the fact that from the outset it struggled to meet demand. Governors and administrators frequently claimed its services were being abused by 'undeserving' cases. These comprised those who could otherwise afford to pay, those suspected of rightly belonging to the Workhouse, and those medically ineligible for treatment. Typical was the view expressed by the Dispensary committee members at the Annual General Meeting of the Governors in 1851:

> Your committee urge upon the consideration of the promoters of this charity that as the proper objects of it are the industrious poor *not receiving parochial relief,* care should be taken to recommend such persons only as patients of the Dispensary who are, by this rule, entitled to its aid. Your committee would also draw attention to a complaint that a great

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[130] Hodgkinson, *Origins of the National Health Service*, p.212.
[131] *Gloucestershire Chronicle,* 4 July 1840, p.2.
[132] Gloucester Dispensary and Vaccine Institute, *The Second Annual Report of the Gloucester Dispensary and Vaccine Institution* (Gloucester, 1833), p.1.
[133] *Gloucester Journal*, 15 November 1851, p.2.
[134] *Gloucester Journal*, 28 November 1840, p.3.
[135] *Gloucester Journal*, 27 February 1847, p.3. See also Frith, p.16 and G. Williams, *The Age of Miracles: Medicine and Surgery in the Nineteenth Century* (London, 1981), pp.49-50.

> proportion of cases admitted to the Dispensary are chronic cases; the effect of such admissions is, that the two months are insufficient, and the renewal of the admission for other two months, and sometimes for four months, takes place, thus burthening the institution with a heavy expense in cases incurable.[136]

The Governors had to frequently remind subscribers both of the parameters within which recommendations should be made and that patients should express their gratitude for the treatment they received:

> N.B. Subscribers are requested to make enquiries into the circumstances of those whom they recommend as patients, in order to prevent ineligible persons receiving benefit of the Institution – more especially to ascertain that they are not receiving parochial relief.
>
> The Patients, when cured or discharged, are to return their recommendations to the Dispensary and to give thanks to the recommender.[137]

The Dispensary experienced frequent funding crises. In 1847, it was declared that 'the Medical Committee again regret that the Funds of the Institution have not been sufficient to carry out its benefits to the increasing Poor of this City.'[138] Financial pressures resulted in the Committee reaching the point where:

> …continuing to dispense our own Medicines would, under existing circumstances, be decidedly objectionable; and therefore, upon consultation with the Medical Officers, we came to the determination that the best and most economical way which seemed to be within our reach, was to contract with some Druggist for the supply of Drugs, for keeping the Books, and for providing Rooms for the use of the Committee and the Medical Officers; whereby the expense of an Establishment would be avoided, and the expenses of the Institution reduced nearly to a certainty.[139]

The tender of Mr Hampton, a chemist with a shop at 9 Eastgate Street, was duly accepted in June 1850 and the Dispensary accounts for 1851 refer to payments totalling £91 16s being made to 'the Dispensing Chemist for Medicines to the Patients for one year.'[140] On Hampton's death in 1852 Messrs Vick and Smith in Southgate Street took over the contract.[141] Ultimately however, financing through subscriptions and donations proved untenable and in 1870 reported that 'the subscriptions paid in the last year are less, even than those in the preceding year; and now, as then, the payments have exceeded the receipts, so that the treasurer has been obliged to call in the sum placed out

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[136] *Gloucester Journal,* 28 June 1851, p.3.
[137] Gloucester Dispensary and Vaccine Institution, Recommendation Form for Patients, 1855.
[138] The Gloucester Dispensary and Vaccine Institute, *The Sixteenth Annual Report of the Gloucester Dispensary and Vaccine Institution* (Gloucester, 1847), p.1.
[139] *The Nineteenth Annual Report of the Gloucester Dispensary and Vaccine Institution* (Gloucester, 1850), p.1.
[140] *Gloucester Journal*, 28 June 1851, p.2.
[141] *Gloucester Journal*, 17 October 1931, p.15.

at interest as a deposit receipt, to meet the deficiency.'[142] In 1872 the Dispensary became a provident society funded by members' subscriptions and voluntary contributions.

Risse has described how 'more economical to operate [than hospitals] and providing as part of their mission home visits to sick patients among the 'deserving poor,' dispensaries played a significant role in the process of medicalization.'[143] From the outset, the Dispensary was a major provider of healthcare to the poor, treating 906 patients in 1832-3[144] and by mid-1871 a total of 32,777.[145] In 1875, it was reported that in the three years since the Dispensary had become a provident institution, 26,236 attendances had been made by its medical officers and 1,384 new members had joined.[146]

In addition to the Dispensary, the General Infirmary and the Workhouse Infirmary, from the late 1700s onwards specialist institutions began to appear in Gloucester. According to Loudon these 'were both symbols of charitable care and centres for teaching.'[147] Weisz described how:

> In the nineteenth century, the establishment of such hospitals accelerated, giving rise to a new form of entrepreneurship: rather than making direct appeals to the public through handbills or a publication that vaunted their treatment, specialists now targeted philanthropists who might support a small specialized dispensary or hospital; this could make a practitioner's reputation as a specialist and bring him wealthy private patients.[148]

There is, however, no evidence of the 'vigorous hostility' to these specialist institutions Weisz has described elsewhere.[149] Earliest of them in Gloucester was the Lying-in Hospital, founded in 1793 by the surgeon Charles Brandon Tyre (1757-1811) (a former

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[142] *Gloucester Journal,* 2 July 1870, p.3.
[143] G. Risse, 'Medicine in the Age of Enlightenment' in A. Wear (ed.), *Medicine in Society* (Cambridge, 1992), p.180.
[144] *The Second Annual Report of the Gloucester Dispensary and Vaccine Institution* (Gloucester, 1833), p.2.
[145] *The Fortieth Annual Report of the Gloucester Dispensary* (Gloucester, 1871), p.1.
[146] *Gloucester Journal,* 24 July 1875, p.6.
[147] I. Loudon, 'Childbirth' in I. Loudon (ed.), *Western Medicine: An Illustrated History* (Oxford, 1997), p.212.
[148] G. Weisz, 'The Emergence of Medical Specialization in the Nineteenth Century,' *Bulletin of the History of Medicine,* Vol.77, No.3 (2003), pp.565-566.
[149] *Ibid,* p.568.

apothecary to the Infirmary) and Reverend Thomas Stock. Lying-In hospitals were vehicles for doctors interested in obstetrics to hone their skills on the poor before attending paying customers, who were becoming an increasingly important source of revenue. Thus, according to Abel-Smith, they differed from earlier hospitals in that 'while in the eighteenth century hospitals had been founded by laymen to meet the needs of the sick poor, in the first half of the nineteenth century many hospitals were founded to serve the needs of medical students and their teachers.'[150] In terms of numbers of patients they saw, Loudon claimed 'these lying-in institutions – which catered only for the poor and never for the middle classes – accounted for a very small proportion of total births.'[151]

Next to appear was the Lunatic Asylum, the planning of which also began originally in 1793, but which finally opened in Horton Road, Wotton in 1823. Contrary to popular stereotypes of these institutions, under the supervision of the first superintendent, Samuel Hitch (1800-1881) 'the asylum developed an excellent reputation and was reported to have the highest recovery rate in the country.'[152] Among Hitch's innovations was 'the introduction of a "self governing" group of patients. These 14 patients worked in the gardens and lived in a separate cottage of their own. The building was outside the asylum walls.'[153] Uniquely, initially the Asylum admitted mixture of pauper and fee-paying patients. Like the Infirmary it too struggled to meet demand:

> COUNTY LUNATIC ASYLUM – A notice has been issued from the Visiting Committee of the Gloucester County Lunatic Asylum to the authorities of the various parishes, stating, that in consequence of the crowded state of the institution, and the progress of certain alterations, no more pauper patients can at present be received. We understand the Asylum, although it has been much enlarged of late, is now more crowded than it has been for years past, - a fact which we much regret, for it confirms the statement which has become so popular, that lunacy is on the increase.[154]

Later this urgent need to accommodate more poor patients at Horton Road led to the foundation of the Barnwood House Institute for the Insane. This was a private asylum for fee-paying patients who would previously have been housed in separate wards at

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[150] Abel-Smith, *The Hospitals*, p.17.
[151] Loudon, 'Childbirth,' p.212.
[152] I. Hollingsbee, 'Samuel Hitch, M.D. (1800-1881), *Tewkesbury Historical Society Bulletin*, No.13(2004), p.33.
[153] *Ibid,* p.34.
[154] *Gloucester Free Press & Weekly Advertiser,* 18 August 1855.

Horton Road. Barnwood House opened in 1860 and quickly established a reputation for liberal and progressive attitudes toward patient care and treatment. It was part of the second wave of specialist institutions that appeared in the 1860s which Granshaw suggests were set up by 'ambitious entrepreneurs, but something of outsiders, unable to secure central positions that they desired within the medical profession.'[155] Whatever the motives behind their emergence, the raft of new institutions that emerged in the 1860s changed the healthcare landscape of the city, creating new medical roles and opportunities and bringing in patients from far-afield for treatment.

An institution of a different sort appeared shortly after Barnwood House and owed its creation to very different motives. The St Lucy's Home, founded in 1864 by a layman, Thomas Gambier Parry of Highnam Court (the father of Charles Hubert Parry, the composer), 'as a Home for Sisters and Nurses of the Church of England, whose work is to tend the sick, comfort the dying, teach the ignorant, and to minister peace to those in trouble.'[156] St Lucy's provided trained nurses to attend the sick at £1 1s per week or 5s per day (monthly nurses at £5 5s for the month). Its mission was to 'work gratuitously amongst the poor earning its maintenance by receipt of payment for nursing in the families of others, and by subscriptions in aid of its many purposes of charity.'[157] St Lucy's nurses were also missionaries, sent into poor households not only to comfort and tend the sick but to persuade them through their piety and diligence to embrace the Anglican faith. In 1867, it was reported that:

> Six nurses have joined it. One of them has been trained in Queen Charlotte's Lying-in Hospital. Cases of cancer, and scarlet fever, rheumatic, and brain fever, and many other serious complaints have been nursed…classes of girls have been instructed in religious and secular subjects; young women have been helped to prepare for confirmation, and others have been brought to adult baptism; the sick and bed-ridden have been visited, and the dying have been attended and comforted.[158]

St Lucy's was founded at a time when the expansion of institutional healthcare was fuelling demand for trained professional nurses. Once again, this was no straightforward example of supply emerging to meet demand. Although doctors at the

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[155] L. Granshaw, ''Fame and Fortune by Means of Bricks and Mortar': The Medical Profession and Specialist Hospitals in Britain, 1800-1948 in L. Granshaw and R. Porter (eds), *The Hospital in History* (London, 1990), p.202.
[156] *Gloucester Journal,* 5 February 1870, p.6.
[157] [Unknown], *Gloucester Directory,* ([Unknown] 1867), p.40.
[158] *Ibid*.

Infirmary had campaigned for improved nursing standards when in 1865 a proposal to admit St Lucy's nurses as pupil nurses went before a meeting of the governors it proved highly divisive and met with determined resistance.[159] Despite St Lucy's being an Anglican order, it was alleged that 'the Protestant feeling of the country has very much been invaded by Homes of this character…a time must arrive when a stand must be made against them,' with St Lucy's 'condemned as an institution from which Popery is to flow into the hospital.'[160] The incident is one example of how non-commercial factors could impact upon the supply of healthcare and thus distort the dynamics of any medical marketplace.

St Lucy's also ran an orphanage in Hare Lane and in 1866 a children's hospital was established as a separate medical institution in a building adjacent to the nurses' home.[161] The St Lucy's Home of Charity Children's Hospital was modelled on Great Ormond Street and was set up 'for the sick children of the poorer classes in the county of Gloucester.'[162] From its opening in October 1867 to the end of 1870, it had treated 421 in-patients and 3,198 out-patients (who were received at a house in Bell Lane). The hospital accepted children aged between two and ten as in-patients and from infancy to twelve as out-patients and proudly stated 'no orders or recommendation are necessary. The poverty of the parents and the suffering of the child are the title to admission.'[163] Children with smallpox, those who were incurable, or just required rest, were not admitted.

The same year the Gloucester Eye Institution opened and owed its foundation to another layman; W.H. Hyett of Painswick.[164] Originally operating from a house in Clarence Street, it moved to two houses in Market Parade in 1867.[165] In 1871, it was reported that 'patients have come from all the towns and villages of Gloucestershire,

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[159] C. Helmstadter, 'Early Nursing Reform in Nineteenth-Century London: A Doctor-Driven Phenomenon,' *Medical History*, No. 46, No.3 (2002), p. 325.
[160] *Gloucester Journal*, 18 February 1865, p.4.
[161] By 10 February 1870, the Children's Hospital had treated 2,820 in- and out-patient cases (entry was not restricted to Gloucester residents). *Gloucester Journal,* 12 February 1870, p.5.
[162] *Gloucester Journal,* 27 October 1866, p.5.
[163] *Gloucestershire Chronicle,* 22 April 1871, p.3.
[164] The Eye Institution was short lived: it closed in 1878 and its cases were transferred to the Infirmary. In the year 1869-1870 it treated 460 cases (220 males and 226 females), 213 of whom were recorded as cured - *Gloucester Journal*, 30 April 1870, p.6.
[165] 'Gloucester Hospitals' in Herbert, *The City of Gloucester,* pp.269-275.

and even from South Wales, Worcestershire, Herefordshire, Cambridgeshire, and such distant parts.'[166] This wide catchment is a reminder that healthcare migration was a feature of Gloucester's healthcare economy during the Age of Reform, and that it did not just involve wealthy patients. The Eye Institution had treated 483 patients in 1870, only 252 of whom were from Gloucester (224 were male and 239 were female). It claimed to have cured 240 of these and relieved a further 159.[167] In 1878, it amalgamated with the Infirmary.

Rising demand came contemporaneously with escalating costs and waning fortunes for the landed aristocracy and gentry, who had traditionally funded such institutions. All Gloucester's healthcare institutions faced financial pressures at one time or another, but they intensified as demand increased and treatments became more complicated and expensive. An 1870 committee report for the Eye Institution declared that 'this was the first year the expenditure of the institution had been brought anywhere near its annual receipts.'[168] Nevertheless, the temporal trend was toward increasing institutional provision allowing more patients to be treated and more medical roles to be created.

The emergence of this raft of new institutions, together with increasing demand experienced by existing ones, lends support to Hardy's claim that 'people increasingly sought medical care for illness in the years after 1860.'[169] By 1870 institutions were making a considerable contribution to the overall therapeutic effort in Gloucester. It remained the case however that, excepting Barnwood House, all of them existed to treat the poor and in Gloucester, as elsewhere, 'the white-collar class of worker could obtain no form of hospital treatment before 1880. They were in the unfortunate position of being too wealthy to merit admission to voluntary hospitals, too proud to enter an infirmary, and too poor to afford expensive home nursing.'[170] Many of Gloucester's residents would thus never encounter institutional care as patients, not because they rejected their treatments, but because they were ineligible. This arbitrary segmentation of demand does not sit well within the medical marketplace paradigm and it shows how structural forces constrained the autonomous agency of the consumer, whose attitude

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[166] *Gloucestershire Chronicle,* 24 June 1871, p.3.
[167] *Ibid.*
[168] *Gloucester Journal,* 30 April 1870, p.6.
[169] A. Hardy, *Health and Medicine in Britain since 1860* (Basingstoke, 2001), p.29.
[170] F.F. Cartwright, *A Social History of Medicine* (London, 1977), p.163.

toward institutions was often ambivalent. There was clearly a fear and stigma associated with being admitted, but at the same time, most of Gloucester's institutions struggled to cope with the numbers of people trying to access them. It is questionable as to whether the public really found any of the limited alternatives preferable. This is a subject we will return to in chapter six.

We have seen in this overview that in the nineteenth-century institutions became increasingly numerous and important to the overall supply of healthcare but their other, less obvious, role was in facilitating the rise of the medical profession – something we have seen has been cited as instrumental to the demise of the medical marketplace.

3.4.1 The role of institutions in the professionalisation of medicine

The relatively small numbers of patients they treated belies the true importance of Gloucester's healthcare institutions, which assumed a crucial role in the organization and professionalisation of medicine in the county. The Infirmary particularly became a centre of teaching, training and research at a time when 'there was a snowballing of interest in the formalisation of medical education.'[171] It 'was recognised by London teaching hospitals as one of the 15 county infirmaries competent to participate in training students' and as such became the epicentre of medical education and intra-professional networking in the county.[172] This role developed partly as an unintended consequence of the Apothecaries' Act, which 'however deficient it was in 1815, pointed directly to the mass monitoring, standardization, and rote testing which characterizes modern medical education.'[173] After the Act, as the medical curriculum gradually became more comprehensive, apprenticeship declined in importance relative to formal structured training. Increasing numbers of medical men were taking both the Society of Apothecaries qualification (the minimum required to practice) and College of Surgeons qualifications, the so-called 'College and Hall'; this fuelled demand for structured medical and surgical training and transformed hospitals from repositories for the sick poor to 'places where medical students were trained and patients treated by physicians

[171] Corfield, p.160.
[172] Christmas, p.208.
[173] S.C. Lawrence 'Private Enterprise and Public Interests: Medical Education and the Apothecaries' Act, 1780-1825,' in R. French and A. Wear (eds), *British Medicine in an Age of Reform* (London, 1991), p.67.

and surgeons who were most interested in producing new medical knowledge.'[174] More doctors undertaking more of their training in hospitals fostered a professional *esprit de corps.* For the Infirmary's consultants, their careers 'rested upon tutelage of pupils, social connections or entrepreneurial activity as well as medical expertise.'[175]

Whereas in the wider community doctors were often treated variously with scepticism, amusement and contempt, their increasing dominance of hospitals allowed them to form and consolidate a professional power base and 'the hospital was becoming the bastion from which the consultant surgeons and physicians could reach out to dominate the profession as a whole.'[176] Here consultants could specialise and whereas in previous centuries, 'specialization in medicine…was neither common nor admired'[177], the rise of hospital medicine meant 'the nineteenth century saw the development of the specialism which has become so characteristic of present-day medicine.'[178]

As the epicentre of medical orthodoxy in the county, the Infirmary was vigorously defended by its medical staff against the incursion of any heretical medical theories, something that shows just how important it had become to their professional interests. This was exemplified in 1856 when one of the governors of Gloucester Infirmary published a pamphlet advocating the addition of a homeopathic wing:

> My proposal is, that a ward for the treatment of patients on the Homeopathic system should be opened, in order to test a practice, which its adherents maintain, *is based upon defined and scientific principles*, and which they advocate for the following reasons.
>
> 1. Because, to a labouring man *especially*, time being money, the treatment which effects the speediest cure is to him the most valuable. This it is asserted is proved by medical statistics of Hospitals to be in favour of Homeopathy. "The average number of days which the patients remain in Allopathic Hospitals being from twenty eight to twenty nine, whereas in the Homeopathic Hospitals from twenty to twenty-four days. *
> 2. Because, the debilitating effects of drug Medicine, is so great that a discharge from an Allopathic Hospital is frequently followed by weeks and months of weakness, which, aggravated by poverty renders the last state of the patient worse than the first. Homeopathy produces no such results. It is not *necessary to half-kill, in order to cure,* and even when a cure is not effected, no prostration of strength ensures from its treatment.

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[174] Carpenter, pp.30-31.
[175] Cherry, p.31.
[176] N. Parry and J. Parry, *The Rise of the Medical Profession: A Study of Collective Social Mobility* (London, 1976), p.139.
[177] I. Loudon, 'Medical Practitioners 1750 -1850 and Medical Reform in Britain' in A. Wear (ed.), *Medicine in Society* (Cambridge, 1992), p.239.
[178] E. H. Ackerknecht, *A Short History of Medicine, s*econd edition, (London, 1982), p.194.

> 3. Because, much less time suffices to effect a Homeopathic cure, thus considerably curtailing the expenditure: and this expenditure is still further reduced by the disuse of drugs and stimulants, as the following will show.
>
> * "It is evident that if the duration of treatment can be shortened, a greater number of patients may be benefitted by the present outlay. In the Northampton Infirmary, e.g. 855 patients are retained 42 days, whilst the average time in Homeopathic Infirmaries is only 21 days. Therefore 1,170 instead of 855 patients might be benefitted by the introduction of Homeopathy." - Dr Pearce's letter to the Governors of the Northampton Infirmary.[179]

Despite this carefully reasoned and quite compelling case, the proposal was soundly dismissed by the staff and governors and no homeopathic doctor was ever employed by the Gloucester Infirmary.

The concentration of medical knowledge and power into the physical and intellectual space of the Infirmary made honorary posts highly-prized. These posts offered professional recognition and opportunities to meet wealthy governors, donors and subscribers.[180] The reality of medical life was that 'to become established, contacts were needed'[181] and although Jewson claimed patronage declined in the nineteenth century, a successful medical career still depended upon these connections.[182] Porter saw that 'an honorary appointment to a hospital would help elevate a practitioner into the genteel bracket as well as affording him close contact with his betters and the prospect of new lucrative high-class custom from subscribers.'[183] In the hospital 'doctors would have the opportunity to mix with the great and the good in local society'[184] and according to Granshaw:

> …hospital positions enabled doctors to become well known amongst leading lay people: medical men built up their private practice through their links with the hospital and its well-off governors. The profession as a whole respected those in hospital positions, and hospital surgeons found themselves at the top of the medical tree.[185]

Marland similarly found in Huddersfield that 'there is no doubt that medical practitioners were very much helped on their way by an honorary hospital post, in terms

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[179] Anonymous, *Homeopathy Contrasted with Allopathy: A letter addressed to the Governors and subscribers of the Gloucester Infirmary, by a Governor* (Cheltenham, 1856).
[180] N.D. Jewson, 'The Disappearance of the Sick-Man from Medical Cosmology, 1770-1870,' *International Journal of Epidemiology*, Vol.38, No.3 (June 2009), pp.622-633.
[181] D. Porter and R. Porter, *Patient's Progress: Doctors and Doctoring in Eighteenth-Century England*' (Cambridge, 1989), p.119.
[182] Jewson, 'The Disappearance of the Sick-Man,' pp. 622–633
[183] Porter, 'The Gift Relation,' p.162.
[184] Cockayne and Snow (eds), p.xix.
[185] L. Granshaw, 'The Rise of the Modern Hospital in Britain' in A. Wear (ed.), *Medicine in Society* (Cambridge, 1992), p.205.

of practice-building opportunities, social prestige, clinical experience, the ability to take on pupils, and to develop a consulting practice.'[186] The lack of remuneration was offset by 'a number of compensations…the principle one being prestige; many hospital staff built up profitable private practices based on their success in the hospital.'[187] For these reasons, Digby placed 'hospital post or government appointment' at the top of 'a hierarchy of esteem,' with 'poor law appointments at the bottom'[188] and as Tomkins observed, 'there could be brisk competition for honorary posts.'[189]

The process through which hospital appointments were filled gives an important insight into their importance to the professional ambitions of doctors. The chance of securing an Infirmary post was greatly enhanced if the candidate had familial ties, or a professional relationship (perhaps forged in training at one of the great London teaching hospitals or at the Infirmary itself) with an incumbent medical man, or board member. Abel-Smith noted how 'just as the governors purchased or inherited their position of honour in the hospital, so the practice grew up of the honorary medical staffs handing on their posts to close relatives or selling the right to succession by charging exorbitant apprenticeship fees.'[190] Bradley and Dupree concluded that for outsiders 'the probability of gaining one of these coveted posts was minimal – it was widely felt, and not without reason, that nepotism, patronage, and wealth were the main factors behind appointments.'[191] Marland found that 'in Huddersfield medical practitioners would have to be already in something of an elite position in the local medical and social hierarchy before they acquired an honorary post.'[192] She further suggested that 'the holders of honorary medical posts were selected…not just on the basis of any medical knowledge and skills that they might have been seen to possess, but also on the basis of their social acceptability and personal bearing. The medical officers on the charities were to be first and foremost 'gentlemen,' and as such representative of the middle-class lifestyle and interests.'[193]

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[186] H. Marland, 'Lay and Medical Conceptions of Medical Charity During the Nineteenth Century: The Case of the Huddersfield General Dispensary and Infirmary' in J. Barry and C. Jones (eds), *Medicine and Charity Before the Welfare State* (London, 1991), p.159.
[187] Woodward, p.23.
[188] Digby, *The Evolution of British General Practice*, p.14.
[189] A. Tomkins, ''The Excellent Example of the Working Class,' p.15.
[190] Abel-Smith, *The Hospitals*, p.19.
[191] Bradley and Dupree, p.428.
[192] Marland, 'Lay and Medical Conceptions, p.159.
[193] Marland, *Medicine and Society*, p.332.

The evidence from Gloucester strongly supports such conclusions. Successful candidates for honorary posts tended to have undertaken at least part of their training at the Infirmary and be already well-known to the governors and subscribers. Buchanan Washbourn, for example, trained at Guy's and became one of the Consulting Surgeons to the Gloucester Infirmary. He was a Fellow of the Royal College of Physicians and the grandson of Thomas Washbourn; one of the founders of the firm of Washbourn, Morgan and Rose, a prominent chemists and druggist, who had used his success as a tradesman to found a banking and medical dynasty.[194] Similarly, George Washbourn Charleton, the long-standing (1833-1868) House Surgeon and Resident Apothecary to the Infirmary and later a Consulting Surgeon from 1868 to 1881, was the son of a former Sheriff and Mayor Shadrach Charleton.[195] His mother was also the sister-in-law of Thomas Morgan of the firm of Washbourn, Morgan and Rose.[196] William Henry Fletcher and Ralph Fletcher who both held Infirmary posts were the sons of Ralph Fletcher, a long-serving Consulting Surgeon to that institution. To have practised privately in the city beforehand also seems to have counted in a candidate's favour; illustrating how interconnected were the fortunes of general practice and hospital consultancy at this time.

The value of Infirmary posts is illustrated by the way in which they were jealously guarded. Emblematic are the events that occurred with the expansion of the Infirmary in 1827 in response to overcrowding. To cater for the extra beds, it was proposed to increase the number of surgical consultants from two to four. This prompted Ralph Fletcher, one of the existing incumbents, to write to the press to express his opposition to the proposal. Somewhat bizarrely, Fletcher tried to argue that an increase in numbers would dilute the surgical expertise available to patients and that:

> It has been thought, that the *diffusion* of these high qualities among more Surgeons would be more beneficial to society, this is another proof of the fatal system of generalising. The diffusion of knowledge is generally desirable; but there are many kinds of it, and different circumstances, under which it cannot be safely diffused. A little reflection will show this in the present case. The materials of experience in your Hospital, must be confined to a certain quantity; and it is clear that the quantity of high talent extracted, must be in proportion to these materials. Divide this among many, and it will be in such small

[194] *Gloucester Citizen,* 6 August 1892, p.3.
[195] Family correspondence and papers, mainly of G. W. Charleton, surgeon, 1826-1844; and of H. Charleton, naval officer, 1829-1861, Gloucestershire, GA, Charleton family of Gloucester. MSS D4432.
[196] *Gloucester Citizen,* 6 August 1892, p.3.

> proportions, as to be of little value in these trying and difficult occasions to which I have alluded…[197]

The ensuing row involving both doctors and governors was played out through the medium of the press, with one contributor, styling himself 'no quack,' getting at the root of the matter:

> It is equally astonishing to me, that any Governor can for a moment suffer his mind to be biased by the representations of *those individuals,* who cannot be considered as *disinterested men,* but who, as is very natural, must be expected to yield to that strong propensity of human nature – *the love of self.*
>
> It is quite unnecessary to dwell in the least on that *absurd notion* that the community would be injured by our having more Hospital Surgeons, as it must be evident to every *impartial person,* that a contrary effect would result.'[198]

Brown has found that 'for much of the eighteenth and early nineteenth century, appointments to medical charities, though nominally elections, were, for the most part, negotiated through informal networks and client relationships' and Infirmary candidates made no effort to conceal familial and professional connections when canvassing support for their applications.[199] Newspapers published the candidates' statements and the endorsements they received, as well as the reporting the voting process. In 1833, when two infirmary surgeons, Ralph Fletcher and William Cother, resigned one of the candidates, Mr Drayton, complained that political affiliations were prejudicing the selection process:

> One of your late surgeons benevolently and *gratuitously* advises me to spare my time and labour, and return to London; the other tells me, "Drayton it is of no use; if a gentleman of the combined talents of Abernethy, Cline, and Cooper was to offer himself, he would not succeed; it is a question of Blue and Yellow!"
>
> I know the case is desperate; but as I have often seen the patients recover after sentence of death has been pronounced upon them by eminent men I shall, therefore, neither pursue the advice of the one nor credit the opinion of the other, but stand the Ballot on the 11th September.
>
> On that day the Country will learn, and the *Poor* also, whether the Nobility and Gentry of the County of Gloucester, who subscribe to the Infirmary, in numbers between *five and six hundred*, when they advertise for *Four* surgeons to their *destitute* Institution, (which has on average 162 In-Patients, and in the course of the year 1831-2 admitted 187 Accidents,) elect them for their talents or their politics.

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[197] *The Glocester Herald,* 1 October 1827.
[198] *Ibid,* 8 October 1827.
[199] M. Brown, 'Medicine, Reform and the 'End' of Charity in Early Nineteenth-Century England,' *English Historical Review*, Vol.124, No.511 (November 2009), p.1366.

> Mr J.W. Wilton having objected to the notice in my circular, for my Experience in *operative* Surgery, my knowledge in this department of our art was derived from the practical wisdom of Frye, Abernethy, and Lawrence.[200]

Messrs Wilton, Fletcher, Playne and Buchanan were elected, but a protest was raised by Alfred Wood, who claimed he had polled one vote more than Buchanan.[201] A subsequent investigation, reported in detail in the press, revealed the potential for confusion and corruption in the convoluted system of proxy voting. Buchanan's election eventually stood.

A second example also illustrates the intensity of competition for posts. In 1858, two infirmary surgeons again resigned and this time four candidates came forward. One, George Lovegrove, was a former Dispensary medical officer and pupil of one of the retiring surgeons. He was also a serving Justice of the Peace and possibly a relation of the County Coroner, Joseph Lovegrove.[202] Another was the Alfred Wood that had been disappointed in 1833, who since 1853 had been the business partner of James Peat Heane, who later became Mayor. John Pleydell Wilton was the son of the John William Wilton who had been elected in 1833. The other two candidates were Ryves Graves, a Surgeon to the Dispensary, and Caleb Barrett who 'was perhaps not so well known to them [the Governors] as the other candidates.'[203] No one came forward to second Barrett's nomination.[204] It was reported that:

> Mr Henry [*sic*] Evans seconded Mr. Wilton's nomination. He said he had known Mr. Wilton from early youth; but, though he claimed a strong personal friendship both for him and for his father, he need not say that if he entertained the slightest misgiving as to the candidate's perfect competency for the discharge of the duties of the office he sought to fit, he (Mr. Evans) would not be there to promote his election.
>
> …Mr. Graves said he came before them [the Governors], to a certain extent, under some disadvantage as compared with Messrs. Wilton and Lovegrove. He did not imagine for a moment that he could do away with early associations or local ties; but he did to a certain extent hope to come forward and stand in the breach of party feeling, and do away with some of that political feeling which creeps into these appointments.
>
> Mr. Wilton also expressed his thanks to his proposer and seconder for the terms in which his name had been mentioned, his proposer [his father] having stated that he could speak personally of his (Mr Wilton's) fitness to perform the duties of his profession. With regard to what Mr. Graves had remarked, the Governors around him would agree that on

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[200] *Gloucestershire Chronicle,* 31 August 1833, p.2.
[201] *Gloucestershire Chronicle,* 14 September 1833, p.2.
[202] He was also the uncle of a future Infirmary surgeon, Thomas Smith Ellis.
[203] *Gloucestershire Chronicle,* 14 September 1833, p.2.
[204] He did later become a surgeon to the Infirmary in 1861.

> no occasion of an election had there ever been less political feeling that on this occasion (hear, hear).[205]

Lovegrove and Wilton were duly elected with 255 and 231 votes respectively, Graves receiving only 76.[206]

Those fortunate enough to be appointed to posts at the Infirmary clung on to them. John Baron, Hardwicke Shute, Thomas Hickes, and Thomas Evans all enjoyed long tenures. The point is well-illustrated by Appendix I, which details the medical staff of the Gloucester Infirmary and the Gloucestershire Eye Institution between 1815 and 1870. The duties of a consulting physician or surgeon were not arduous. In the 1840s, 'physicians and surgeons, one of each, used to attend in turn every Thursday morning at eleven o'clock, to examine new patients and to report on those already in, whilst they attended on Saturdays at the same time, to prescribe for their out-patients.'[207]

A much heavier burden fell upon the more junior Resident Apothecary (titled House Surgeon and Apothecary from 1827 onwards), who assessed incoming cases, was perpetually on-call in the wards, received a derisory salary of £40 per annum (lower for example that that paid in 1818 to the Surgeon to the County Gaol, which was £40 19s 6d for the year) and was forbidden from undertaking private practice.[208] As Woodward pointed out, 'the apothecary was very much the underprivileged member of the medical profession; the hospitals took advantage of the situation.'[209] The inferiority of the role was emphasised in rules such as those of the Norfolk and Norwich hospital, which specified that 'the apothecary had to be a single man aged less than 45…he could not prescribe without the direction of the physicians and surgeons and could not practice outside the hospital; he could never leave the hospital without reporting to the Matron

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[205] *The Cheltenham Chronicle and Parish Register and General Advertiser for Gloucester,* 17 August 1858, p.6.
[206] Graves' opportunity came three years later in 1861 when he was appointed as an Acting Surgeon. He became a Consulting Surgeon in 1878.
[207] Frith, p.12.
[208] *The Glocester Herald*, 29 May 1819.
[209] Woodward, p.28.

and had to be back by 10 p.m., and he was responsible for providing a substitute in case of illness or special leave.'[210]

Outside of the major institutions, other roles were available and even though these were of lower status they too were sought after. Some, such as friendly society and sick club posts were treated with disdain by doctors, who found it humiliating to be employed by working-class people. Nevertheless, they offered advantages to those prepared to overcome their snobbery.[211] Brown found that:

> …the top medical men of the locality, those with the wealthiest private practices and hospital posts, did not normally take up appointments as club surgeons…these positions were frequently filled by either newcomers to the area or recently-qualified men, who saw friendly society appointments as one way of establishing themselves in the locality and as a means of support, while they built up a private practice.[212]

In Gloucester, friendly society posts normally had no shortage of applicants. For example, when the Gloucester Union Friendly Society decided in 1837 to appoint two surgeons, Alfred Wood, John Wilton, Charles Clutterbuck and James Peat Heane all applied (Wood and Wilton being successful).[213] Such was the value attached to official appointments of any kind that medical men often held more than one and sometimes several simultaneously. Digby has suggested the rationale behind this behaviour was that:

> A general practitioner's professional viability was facilitated if…he could discover a local niche for practice, and progressively exploit the local environment through social networking with key personnel and organizations, thus creating a good organizational 'fit' between doctor and community. A territorial principle operated whereby a doctor tried to monopolize as many local professional openings as possible, thus excluding competitors from his…practice area.[214]

Ambrose Cookson was a particularly prolific collector, serving variously as Surgeon to the City Prison, County Gaol, and Workhouse, as well as to the Dispensary. He was not alone in doing so and, as Midwinter observed elsewhere, 'there was a considerable use of pluralism.'[215] Thomas Hickes was Surgeon to the County Gaol and the Lying-in Hospital, Honorary Assistant Surgeon to the First Gloucester Engineer Corps, as well as

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[210] V.M. Crosse, *A Surgeon in the Early Nineteenth Century: The Life and Times of John Green Crosse* (Edinburgh, 1968), p.129.
[211] Digby, *The Evolution of British General Practice*, p.14; Bynum, *Science and the Practice of Medicine,* pp.198-199.
[212] Brown, *Performing Medicine*, pp.194-195.
[213] *Gloucestershire Chronicle,* 19 November 1836, p.3.
[214] Digby, *The Evolution of British General Practice*, p.67.
[215] E.C. Midwinter, *Victorian Social Reform* (Harlow, 1968), p.35.

a Magistrate, Councillor (East Ward), Member of the Board of Health, Burial Board and Cemetery Committee. Alfred Wood, as well as being a Surgeon to the Infirmary, was the Superintendent of Barnwood House Institution for the Insane, a Council Member of St Lucy's Home of Charity, a J.P. and an ex-officio Guardian of the Poor. In 1861, out of nineteen physicians and surgeons listed in the census, only one, John Neville, appeared not to have held any official position.[216]

Connections fostered through official appointments were useful to doctors trying to assert their professional status and consolidate and organise themselves at a local level. Another manifestation of this process was the formation of professional groups and societies – something that Brown has claimed 'played a vital role in constructing medicine as a collective and collaborative endeavour'.[217] Corfield has noted how, from the eighteenth century onwards, 'local groups of doctors began to meet regularly to promote their professional interests.'[218] The volume of activity in this area supports Shortt's analysis that 'the local practitioner…began to see science not as a threat but as a positive defence for his professional activity.'[219] Brown believed 'the proliferation of medical societies and medical journals in the 1820s and 1830s… played a crucial role in the construction of medicine as a discrete disciplinary domain,'[220] and Marland observed how 'the nineteenth century witnessed an unprecedented growth of medical organisations set up both to further scientific knowledge *and* to pursue professional goals.'[221] Inkster has described how 'broad social as well as intellectual engagement' was important at a time when 'networking amongst the city's social and political elite, and demonstrating one's accomplishments and learning beyond medicine, as a gentleman [had] lost none of its importance.' [222] Petersen has similarly argued that 'a liberal and classical education was the mark of a mid-Victorian gentleman. For medical men, it was the basis for a claim to genteel status and the key to social acceptance.'[223]

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[216] At the time of the census Neville was aged 60 so may have retired having practised elsewhere.
[217] Brown, *Performing Medicine*, p.10.
[218] Corfield, p.160.
[219] S.E.D. Shortt, 'Physicians, Science, and Status: Issues in the Professionalization of Anglo-American Medicine in the Nineteenth Century,' *Medical History,* Vol.27, No.1 (1983), p.66.
[220] Brown, *Performing Medicine*, p.162.
[221] Marland, *Medicine and Society*, p.304.
[222] I. Inkster, 'Marginal Men: Aspects of the Social Role of the Medical Community in Sheffield 1790-1850' in in J. Woodward and D. Richards, (eds), *Health Care and Popular Medicine in Nineteenth-Century England* (London, 1977), pp.128-163.
[223] M. J. Petersen, *The Medical Profession in Mid-Victorian London* (Berkeley, CA, 1978), p.56.

According to Elliott, 'the acquisition of natural knowledge was undertaken as part of a broad Enlightenment educated civility' and local scientific societies allowed doctors to both cultivate this attribute and assert their independence from the London elite.[224] Gloucester's medical men appear to have been at least as active in this respect as those Elliott encountered in his study of Derby, where 'perhaps a third of the medical men active between 1790 and 1850 were significant supporters of scientific culture and institutions.'[225] Among the organizations they patronised were the Gloucester Scientific and Literary Association, to which the surgeon J. P. Wilton was elected President in 1866[226] (and of which another medical man Thomas Buchanan Washbourn, was Honorary Treasurer);[227] the Zoological, Botanical and Horticultural Society of Cheltenham;[228] and the Gloucester Society for the Cultivation of Natural History, of which John Baron was a Committee Member and later the President.[229] Samuel Hitch, the resident Medical Superintendent at the County Lunatic Asylum from 1828 to 1845, meanwhile founded The Royal Medico-Psychological Association in 1841.[230]

Other groups were more political in nature, defending the interests of the profession and organising support for medical reform at a local level. Here Corfield has suggested that 'the ecumenical weft of [these] voluntary societies counter-balanced the traditional warp of the medical corporations.'[231] A few Gloucester medical men joined the Provincial Medical and Surgical Association (the forerunner of the British Medical Association), formed by Charles Hastings at Worcester Infirmary in July 1832. The first anniversary meeting of the Association (held in Bristol) was attended by Mr Carden from Gloucester and doctors Conolly, Sully, and Baron from Cheltenham.[232] Henry Rumsey was later its President. Locally, the Gloucestershire Medical Association was founded in the 1840s, when pressure for medical reform was again growing. Formed to defend the interests of provincial doctors and petition Parliament

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[224] Elliott, 'The Origins of the 'Creative Class', p.366.
[225] P. Elliott, 'Medical Institutions, Scientific Culture and Urban Improvement in Late-Georgian England: The politics of the Derbyshire General Infirmary' in J. Reinarz (ed.), *Medicine and Society in the Midlands, 1750–1950* (Birmingham, 2007), p.35.
[226] *Gloucester Journal,* 20 October 1866, p.5.
[227] *Gloucester City and County News,* 30 September 1863.
[228] *Gloucestershire Chronicle*, 22 October 1836, p.3.
[229] J. Baron, 'Address to the Gloucester Society for the Cultivation of Natural History,' *The Midland Medical and Surgical Reporter, and Topographical and Statistical Journal*, Vol. 1 (1828-9), pp.416-423.
[230] 'Gloucester Hospitals' in Herbert, *The City of Gloucester*, pp.269-275.
[231] Corfield, p.160.
[232] *Gloucestershire Chronicle*, 27 July 1833, p.3.

whenever another medical Bill was in the offing,[233] its declared aims were to 'uphold the character and legitimate interests of the profession, and to promote social and friendly feelings amongst its members.'[234] The Association became the political mouthpiece of the profession across the county. At its Annual General Meeting in 1844, 'several professional gentlemen resident in the county, but not members of the association were present' to hear a discussion of Sir James Graham's Medical Bill.[235] Speakers included Hardwicke Shute. The Association also organised opposition to the new Charter of the Royal College of Surgeons.[236]

Interestingly, medical associations also took upon themselves a policing role. Brown found that the York Medical Society 'acted as the primary determinant of medical orthodoxy at local level'[237] and in 1863, Thomas Evans, then physician to the Gloucester Infirmary, was called to answer charges from the Herefordshire Medical Association, of 'having met a Mr Woodyall in consultation in the beginning of November in the case of Mr. Shepherd of Wellington.'[238] It was alleged by an anonymous source that 'Mr. Woodyall is a Druggist trading in this City and not possessing any qualification to practice...[and] that they were not unanimous in opinion and that eventually Dr Evans gave way.'[239] Evans refuted the allegation, demanded to know the identity of his accuser and questioned his accountability to the Association. How the case ended is unknown, but the incident shows that these organizations, ostensibly set up in a spirit of camaraderie and professional unity, could also be divisive. These self-policing activities appear to reflect the fact that 'self-regulation…became increasingly central to the definition of a profession,'[240] but they have strangely so far attracted comparatively little attention from historians, Marland

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[233] Anonymous, 'Gloucestershire Medical Association: Petition to the House of Commons,' *Provincial Medical and Surgical Journal*, Vol.1, No.22 (1841), p.367.
[234] *Gloucester Journal,* 28 November 1840, p.3.
[235] *Gloucester Journal,* 5 October 1844, p.2.
[236] William Morgan Meyler, Charles Clutterbuck, Ambrose Dawson Cookson, James Peat Heane, Herbert R. Williams and Peter Goullet, all signing a petition declaring their opposition to the new Charter. Anonymous, 'Charter of the College of Surgeons: Gloucestershire Petition,' *Provincial Medical and Surgical Journal*, Vol.9, No.17 (1845), pp.265-266.
[237] Brown, *Performing Medicine,* p.201.
[238] Copy letter of complaint from the Herefordshire Medical Association against Dr Thos. Evans of Gloucester for taking the opinion of a Mr Woodyatt, a druggist of Hereford, who was not qualified to practice, and Evans's replies, 1863, Gloucestershire, GA, Vizard and Son of Monmouth, solicitors, MS. D637/II/3/C6.
[239] *Ibid.*
[240] Corfield, p.177.

finding that 'the attempts of local groups of medical men to organise and raise their professional status [has not] received much attention, especially outside the capital.'[241]

As well as joining, or forming, groups or societies, an obvious way in which to demonstrate both one's professional credentials and the broader attributes of a learned gentleman was through publication. Roberts has linked writing for publication with a specific need to be seen as 'a "man of science" – a dedicated observer of the regularities and pathological irregularities of nature.'[242] Gloucester's medical men were regular contributors to the *Midland Medical Reporter* and submitted articles on surgical, medical and general science topics.[243] John Baron, a Physician to the Infirmary and a Fellow of the Royal Society, wrote a noted biography of Edward Jenner,[244] as well as scientific papers such as *An Enquiry, illustrating the Nature of Tuberculated Accretions of Serous Membranes, and the Origin of Tubercles and Tumours in different Textures of the Body* (1819).[245] His fellow physician Ralph Fletcher wrote widely on surgery, psychosomatic illness, cruelty to animals,[246] mental health, and diseases of the throat.[247] Another Infirmary physician, Thomas Evans, gave public lectures at the Gloucester Mechanics Institution one of which was entitled *The Diffusion of Knowledge among all classes.*[248] Meanwhile, the surgeon James Peat Heane authored a pamphlet entitled *On Death-bed*; a critique of the Christian 'good death' from a free-thinking perspective.[249] Most prolific and influential was Henry Rumsey, one-time surgeon to the Dispensary, who based upon his experiences there, wrote numerous monographs, essays and articles on state medicine and medical treatment for the poor for both medical and lay audiences.[250] Jacyna has argued that 'the role of publications as a form of self-

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[241] Marland, *Medicine and Society*, p.252.
[242] M.J.D. Roberts, 'The Politics of Professionalization: MPs, Medical Men, and the 1858 Medical Act,' *Medical History,* Vol.53, No.1 (January 2009), p.55.
[243] Contributors included John Baron, Alfred Wood, Ralph and William Fletcher and J. Bedwell.
[244] J. Baron, *The Life of Edward Jenner* (London, 1827).
[245] *Cheltenham Chronicle*, 25 May 1819.
[246] D. Stevens, 'The Casebook of Ralph Fletcher, M.D. (1780-1851),' *Gloucestershire History,* No.10 (1996), pp. 11-12; *Gloucester Journal*, 2 December 1848, p.4.
[247] *Gloucestershire Chronicle,* 31 January 1835, p.3.
[248] 'Inaugural lecture, delivered to the Gloucester Mechanics' Institution, on 29 Oct. 1846 by Thomas Evans, M.D. President, Senior Physician to the Gloucester Infirmary, and Consulting Physician to the Gloucester Dispensary,' 1846, Gloucestershire, GA, MS N20.14(1) GS.
[249] J.P. Heane*, On Death-Beds* (undated), Gloucestershire, GA, V8.17GS.
[250] Michael Brown has described Rumsey's *Essays on State Medicine* (1856) as 'the most systematic and ambitious exposition of state-regulated health care ever conceived in nineteenth-century Britain' - M. Brown, 'Medicine, Reform and the 'End' of charity', p.1375.

advertisement needs to be reconsidered. Too often it is assumed that technical works were produced solely for professional consumption… [whereas] judicious publication on technical topics could enhance a practitioner's standing with prospective patients as well as impressing his peers.'[251] Cumulatively, these developments and the other aspects of medical practice discussed so far, point toward the continued importance of patronage and increasing professionalisation. Gloucester's doctors actively cultivated professional connections, as well as the broader accoutrements of learned gentlemen. Both were essential to a successful career.

Evidence of the rising status and influence of the profession at local level can also be found in the changing way in which medical men chose to self-identify. In the 1841 census, none of Gloucester's doctors listed their qualifications, instead giving their occupation simply as 'physician' or 'surgeon.' It was thus not possible to differentiate in the census the qualified from the unqualified and it appears qualified medical men did not feel the need to do so. This was possibly partly the 1815 Apothecaries Act had only applied to those not in practice when it came into force and consequently the earlier generation, who lacked any formal qualifications, were still occasionally practising, as was the case of an individual recorded in William Mitchell's diary in the 1840s, described as 'an old and old-fashioned practitioner. It was believed he had no diploma or certificate of knowledge and efficiency but had started practice after an apprenticeship. As one might open a greengrocery shop.'[252] Ten years later a transformation had occurred – only four practitioners now described themselves generically, the remainder either stating their qualification(s), or their affiliation to a professional body (Table 3.4).[253] It seems unlikely this was a deliberate change of nomenclature *vis-à-vis* the census, but more likely represents a broader change in the way doctors viewed themselves. For Corfield 'qualification brought status.'[254] By 1851, further medical reform was firmly on the political agenda and the prospect of regulation based upon qualifications and affiliation to one or more of the medical

[251] S. Jacyna, ''Mr Scott's case': A View of London Medicine in 1825' in R. Porter (ed.), *The Popularization of Medicine 1650 – 1850* (London, 1992), p.277.
[252] C. Eagle and P. Kinnear (eds), *A Victorian Clergyman: The Diary of William Michell 1830 – 1917* (Bemerton, 2010), p.30.
[253] Two as 'surgeon,' one as 'surgeon Royal Navy,' and one as 'general practitioner.'
[254] Corfield, p.156.

Colleges had perhaps focussed the minds of practitioners more upon their educational attainments and collegiate associations.

A related trend observable through census returns was that toward joint medical and surgical qualifications. By 1871, six out of the 23 medical men recorded in the census held both a medical and surgical qualification or described themselves as 'physician and surgeon.'[255] In 1841, there had been none.[256] Fissell identified earlier evidence of this in Bristol, where in the late eighteenth century 'several surgeons obtained mid-career Aberdeen M.D.s in attempts to improve their status.'[257] In 1841, the term 'general practitioner' did not appear in the census returns; practitioners describing themselves either as 'physician' or 'surgeon' (incidentally never as apothecary). By 1851 (Table 3.4), the term was used seven times. As discussed in chapter two, the role had existed *de facto* for many decades, so its late appearance in the census is curious. It could be merely a matter of semantics, but it may also represent a tangible manifestation of the separation occurring between community general practice and hospital consultancy. The fact that medical men chose to identify themselves as general practitioners *in the census* suggests that the term had acquired specific attributes recognised beyond the profession itself. Waddington has suggested that 'the new terminology reflected the emergence of a new role, and one that could not be fitted into the traditional professional structure,' but this cannot have been the only instrumental factor this late on.[258] 'Apothecary,' with its pejorative association to trade, had already fallen into disuse by 1841 (trade directories and newspapers dating from the 1820s and 30s also make no use of the term). The only exception was 'House Surgeon and Apothecary,' an archaic title still, as has been seen, in use at the Infirmary and presumably intended to convey the subordinate status of the post (and presumably to justify its poor remuneration).

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[255] Henry Peacock, George Charleton, Rayner Batten, William Mann, Alfred Wood, and John Campbell.
[256] Alfred Wood acquired his M.D. later. J. Churchill, *The London and Provincial Medical Directory* (London, 1870).
[257] Fissell, p.62.
[258] I. Waddington, 'General Practitioners and Consultants in Early Nineteenth-Century England: The Sociology of an Intra-Professional Conflict' in Woodward and Richards, p.182.

Table 3.4 Medical practitioners' occupations recorded in the 1851 Census

NAME	OCCUPATION
Ralph Fletcher	Physician Graduate of Edinburgh Practicing
Thomas Evans	Physician Graduate of Edinburgh
William White Williams	Superintendent, Licentiate of the Royal College of Physicians in London, M.R.C.S.L.
John Manley	Assistant Medical Officer M.D. Edin.
Robert Niblett	M.R.C.S. & L.A.C. General Practitioner
William Evans	Surgeon, Royal Navy
William Wathen	Surgeon
William Henry Fletcher	Surgeon F.R.C.S.E. [or L?]
George Johnstone	Surgeon L.R.C.S. Edin. L.A.S. Lond. General Practitioner
Ambrose D. Cookson	Member of College of Surgeons London
George Hampton	General Practitioner
Alfred J. Wood	Fellow Roy. Coll. Surgeons & Lic. Apoth Comp.
William M. Meyler	Member of College of Surgeons London, practising as a General Practitioner
Fortescue J. Morgan	Surgeon M.R.C.S.E., L.A.S.
Thomas C. Buchanan	General Practitioner, F.R.C.S.E.
Thomas Hickes	M.R.C.S., L.A.C. London
Alfred Clarke	Surgeon & Apothecary M.R.C. of S. in London, L.S. of the A. Co. in London
John W. Wilton	Magistrate Fellow R.C.S.E. practising in general practice & surgeon
George Washbourn Charleton	Resident Surgeon Fellow of Royal College of Surgeons, Licentiate of Society of Apothecaries practices at Gloster Infirmary
James Peat Heane	Member of Royal College of Surgeons
Charles Clutterbuck	M.R.C.S.L. Li.A.C.L. General Practitioner
Charles Neale	Surgeon
Wyldbore Rumsey	Surgeon F.R.C.S.

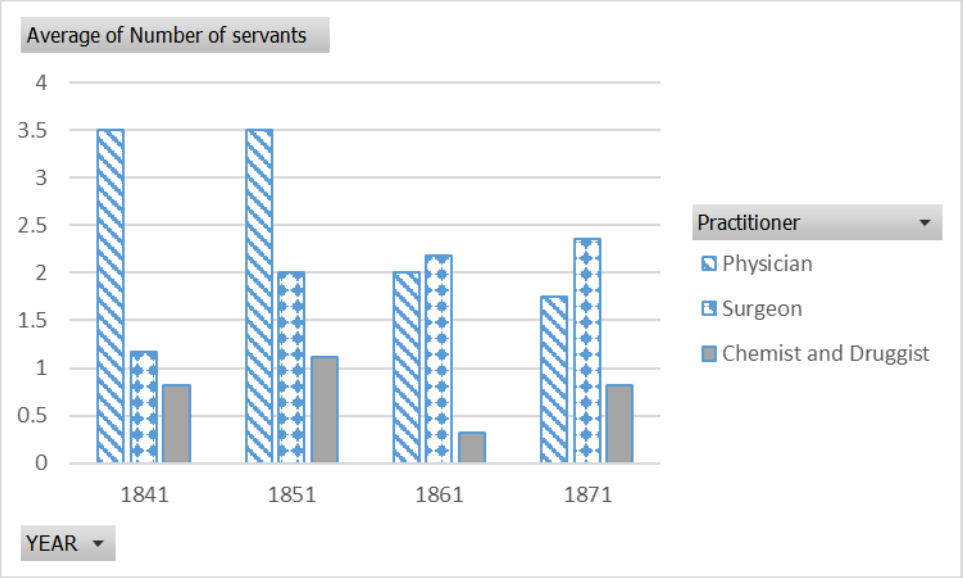
Source: Ancestry.com, *1851 Census* [database on-line]. Provo, UT, USA: Ancestry.com Operations Inc, 2005. Original data: Kew, The National Archives, *Census Returns of England and Wales, 1851*, HO 107.

A proxy indicator of the narrowing of the social disparity between physician and surgeon can be found in the numbers of domestic servants they kept (Figure 3.5). Brown noted a clear difference between the average number of servants employed by Bristol physicians in 1851 (3.21) and surgeons (2.96).[259] In Gloucester, the average

[259] Brown, 'The Providers of Medical Treatment,' p.307.

number of servants employed by physicians fell after 1851, whereas there was an interesting rise in the number employed by surgeons, which may reflect an improvement in status.[260] By 1871, it was a surgeon, Ryves Graves, who employed the highest number of household servants (6), quite a rise in fortunes for someone who had once been a humble Dispensary surgeon.

Figure 3.5 Average number of servants employed by medical practitioners, 1841–1871



Note: Excludes practitioners who were recorded as resident at their location of employment e.g. the Superintendents of the County Asylum and the House Surgeon and Apothecary at the Infirmary.

Source: Ancestry.com, *1851-1871 Census* [database on-line]. Provo, UT, USA: Ancestry.com Operations Inc, 2005. Original data: Kew, The National Archives, *Census Returns of England and Wales,* HO 107.

If competition for institution posts points toward the importance of these places to medical careers, and the formation of groups and societies, and authorship of scientific publications, to increasing aspirations, the impact of this in terms of the visibly rising status of the profession is apparent in the prominent position Gloucester's medical men took civic life. Here there is a contrast with Marland's finding that 'few medical men in Wakefield and Huddersfield became actively involved in political affairs'[261] and Smith's assertion that 'doctors rarely became magistrates.'[262] Several Gloucester doctors served as aldermen, councillors, justices of the peace, magistrates, Poor Law guardians and school governors (a few chemists and druggists, and a dentist,

[260] Doctors with medical and surgical qualifications or memberships were counted as physicians.
[261] Marland, *Medicine and Society*, p.348.
[262] Smith, p.376.

Charles Fox, also served).[263] While more studies of the political activities of doctors are needed to reach any firm conclusions, it is possible the notorious corruption and inertia of Gloucester's civic administration, and the numerous public health issues it failed to deal with, encouraged doctors to become involved in local politics to try to make a difference. It is equally possible they were also simply opportunists who recognised the benefits these offices could bring in terms of connections and status. Possibly it was a mixture of both.

In terms of their affiliation, Gloucester's doctors tended to be Liberals. Taking one example, the surgeon Charles Clutterbuck was elected as a Liberal Councillor after the new Municipal Corporation was established in 1835, before being elected as the Mayor of Gloucester in 1851.[264] Four other medical men held that office between 1815 and 1870 (Hardwicke Shute, William Cother, William Morgan Meyler, and James Peat Heane (Figure 3.6)).[265] In 1863, of fourteen city magistrates, four were medical men and another qualified doctor (James Lovegrove) was the Coroner.[266] Interestingly, Whitfield found similar levels of engagement in his study of Bristol dispensaries.[267]

Figure 3.6 James Peat Heane, Mayor of Gloucester, 1863.
Source: Gloucestershire Archives SR503/DY10675/327GS

[263] Fox becoming a councillor for the East Ward, and a member of the Watch Committee, Cemetery Committee and Park Committee during the 1860s.
[264] *Gloucestershire Chronicle*, 2 January 1836, p.3; *Gloucester Journal,* 15 November 1851, p.3.
[265] Marland, *Medicine and Society,* p.348.
[266] *Gloucester City and County News,* 7 October 1863.
[267] M. Whitfield, *The Dispensaries: Healthcare for the Poor Before the NHS. Britain's Forgotten Health-Care System* (Bloomington, IN, 2016).

The rising status of Gloucester's medical practitioners can also be seen in the respect accorded to them in local newspapers. In 1869-1870 a testimonial for the surgeon Thomas Hickes attracted 1,200 subscribers, a significant proportion of whom were, apparently, from the working-classes. It raised £183 in recognition of Hickes' 'kindness to the working classes of this city' and his 'often giving from his purse to assist the poor people.'[268] When the physician Thomas Evans, whose career in Gloucester spanned five decades, died in 1880 at the age of 79, his obituary in the *Gloucester Journal* attested that 'his chief characteristic was the thorough and painstaking care with which he treated every case upon which he was consulted and that, combined with great kindliness of nature and thoughtfulness for others, secured him a leading place in the medical profession.'[269] One newspaper from the time of his death claimed Evans' 'name was a "household word" in the county.'[270] Similarly, the obituary for Ryves Graves described how 'he was well known and deeply valued, not only in his profession, not only as a magistrate and a resident in this city, but as the personal friend of a very large number of persons. His face will be missed by poor as well as rich; his kindly words we shall many of us listen for in vain; his ready and skilful treatment we can look for no more.'[271] Even accounting for an inevitable degree of hyperbole, there is a genuine sentiment of respect in these accounts.

Overall, in this section we have seen that Gloucester's rapidly expanding urban population increased demand for institutional healthcare so that despite the emergence of a raft of new institutions, supply could not keep pace with demand, which had to be managed by restricting eligibility. Despite the appearance of new specialist institutions, there were still gaps in institutional provision and nothing like a comprehensive healthcare system yet existed. However, we have seen that institutional healthcare cannot be evaluated simply in terms of the number of patients treated; these bodies were intrinsic to the structure of healthcare provision in Gloucester, the hub of intra-professional networking, and the nexus between the medical profession and the elite citizens of the city and county. They were thus an essential component in the emergence of a recognisably modern healthcare system. Increasingly, they fostered scientific medicine in which the plurality and diversity of the early modern era had no

[268] *Gloucester Journal*, 26 March 1870, p.8.
[269] *Gloucester Journal*, 5 June 1880, p.5.
[270] *Gloucester Citizen,* 3 January 1881, p.4.
[271] *Gloucester Journal,* 8 April 1882, p.5.

place. Marland and Jewson, amongst others, have linked the decline in the importance of lay patronage to medical careers to the rise of professional authority fostered in institutions. For the new hospital consultant, intra-professional networking was the key to career advancement.[272] The changing ways in which doctors in Gloucester chose to represent and organise themselves was therefore not unrelated to the contemporaneous rise in the number and influence of healthcare institutions.

As charitable concerns, institutions operated on a not-for-profit basis and this impacted upon the way they treated patients – not as autonomous consumers but as recipients of charity. Furthermore, they managed demand by imposing arbitrary restrictions on eligibility in accordance with the world view of their founders and benefactors. Rolls identified how 'underneath the wave of philanthropy there lies an inevitable degree of self interest on the part of subscribers and donors.'[273] Consequently. it has now become *de rigeur* to regard nineteenth-century philanthropy sceptically as an instrument of social control. This is unfair, but Rolls was correct; charitable acts did inevitably reflect the personal priorities and prejudices of benefactors as much as the needs of recipients. The introduction of moral criteria, often based on crude assumptions, in determining who could and could not access treatment repudiates any notion of this as a free market in healthcare. Instead, if a holistic view of healthcare economy is taken that includes institutions, clearly parts of it were shaped by structural bureaucracy. The 'consumers' of institutional healthcare, although they exhibited a degree of agency in the ways in which they found to work the system, did little to shape the overall complexion of that system. Thus, institutions are incongruous entities for the medical marketplace paradigm to assimilate and the case can be made that they are better accommodated by a model that visualises a *stratified healthcare economy*. However, to make the case for such a reinterpretation, this chapter must now look at healthcare in the commercial sphere, the area in which the conventional medical marketplace model would be expected to have more traction.

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[272] Marland, *Medicine and Society*; M. Brown, *Performing Medicine*.
[273] R. Rolls, *The Hospital of the Nation: The Story of Spa Medicine and the Mineral Water Hospital at Bath* (Bath, 1988), p.8.

3.5 The commercial healthcare economy of Gloucester in the Age of Reform

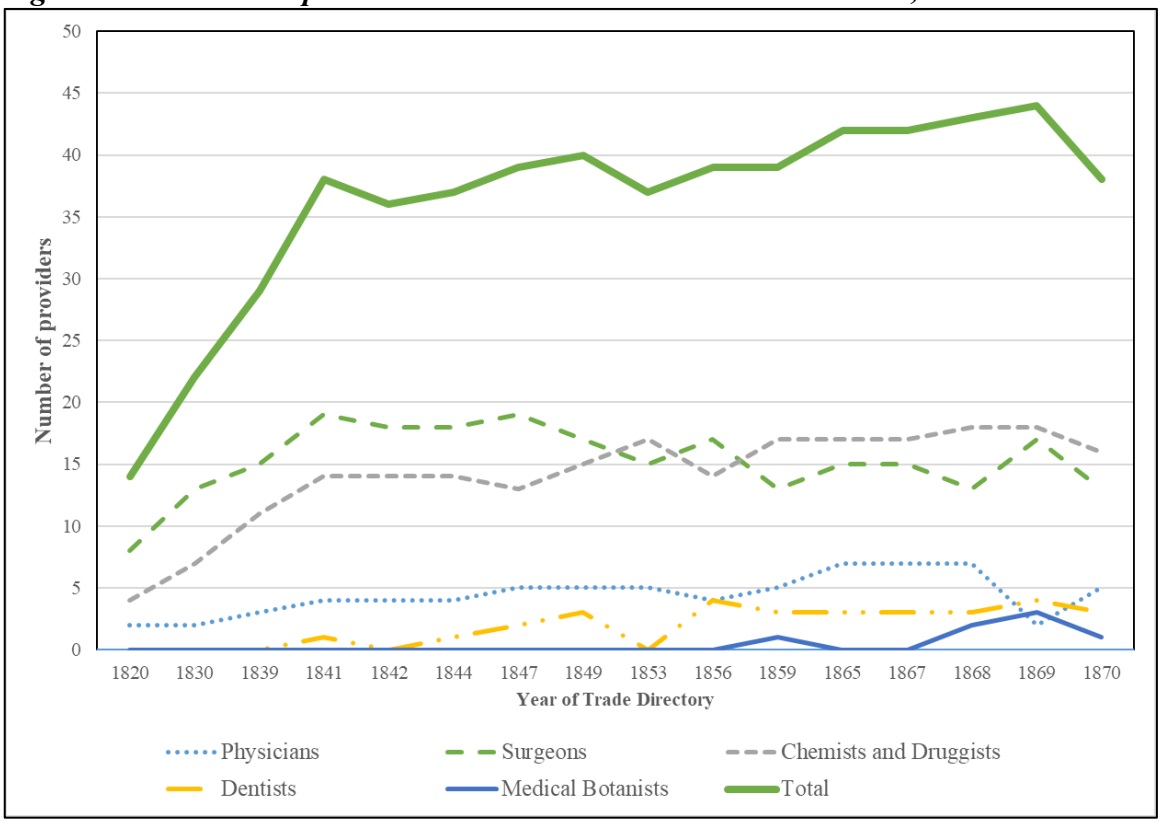
This section comprises a quantitative survey of healthcare suppliers based primarily upon an analysis of trade directories, medical directories and census records. The supply of healthcare is deconstructed into component suppliers and temporal changes in the composition of supply observed. As discussed earlier, the methodology allows scope for comparison to similar studies, such as that of Bristol undertaken by Brown.[274] The bulk of the section deals with medical practitioners and chemists and druggists as these two groups were by far the most numerous. A general discussion of overall numbers and how these changed in the period is followed by a series of thematic discussions covering distribution, place of birth, longevity, and numbers per head of population. Other providers, such as medicine vendors and various 'irregulars', are then discussed separately before conclusions are drawn.

Looking then at the number of suppliers in Gloucester, Figure 3.7 shows the various providers listed in trade directories published between 1820[275] and 1870.[276] It is immediately obvious that doctors (specifically surgeons) and chemists and druggists dominated the supply of healthcare well before the mid-century reforms that brought regulation to the market. The numbers of both increased dramatically between 1820 and 1840, before then assuming a flatter trajectory thereafter and apparently falling slightly at the end of the period. There were eight surgeons listed in 1820, rising to nineteen by 1841.[277] Similarly, numbers of chemists and druggists rose from four in 1820 to fourteen in 1841. This dramatic early trend appears to accord with that detected by Marland in her study of Wakefield and Huddersfield.[278] The slight decline in the number of doctors toward the end of the period meanwhile may lend some support

[274] Brown, 'The Providers of Medical Treatment,' p.298.
[275] R. Gell and T. Bradshaw, *Gloucestershire Directory* (Gloucester, 1820) is the earliest held by Gloucestershire Archives (GA 650SL).
[276] Where one trade directory entry covered more than one practitioner operating from the same premises e.g. The Quintin brothers (dentists) this has been counted as one practice - this is not the same as the census, where each practitioner listed was counted separately.
[277] The 19 includes the house surgeon and apothecary at the Infirmary whose contract prohibited him from taking private patients (Gloucester Infirmary, *Rules for the Government of the General Infirmary at Gloucester, 1851* (Gloucester, 1851), p.24., and the superintendent of the lunatic asylum, who resided at the asylum.
[278] Marland, *Medicine and Society*, p.255.

Waddington's claim that 'in the two decades following the 1858 [Medical] Act, there was…a marked reduction in the provision of qualified medical care to the population.'[279]

Figure 3.7 Healthcare providers listed in Gloucester trade directories, 1820–1870

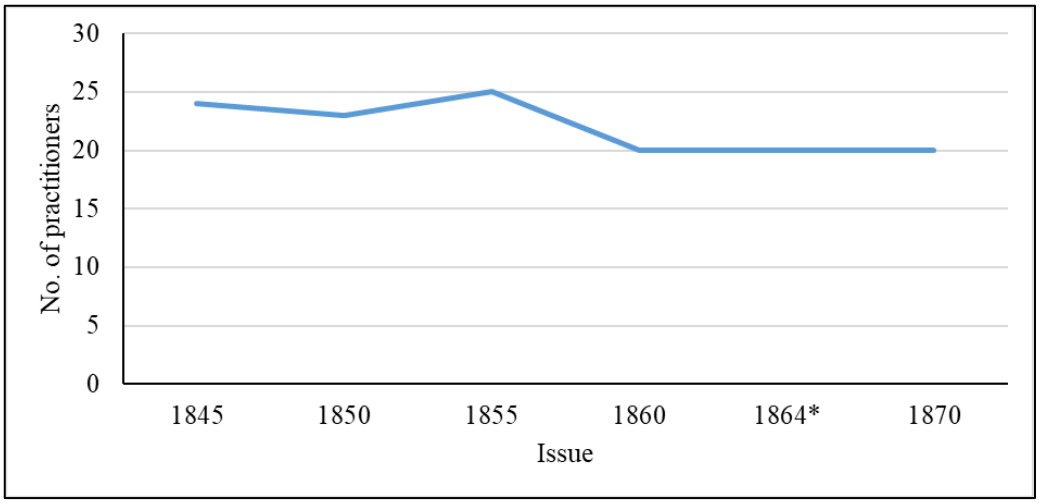


In the case of doctors, from 1845 onwards it is possible to cross-reference the trade directory data with Churchill's *London and Provincial Medical Directory* (Figure 3.8). These data show the combined numbers of physicians and surgeons remained relatively stable between 1845 and 1855, then fell between 1855 and 1860 before stabilising again through to 1870. There were minor discrepancies in both numbers and trend between the trade and medical directories. For example, *Hunt's Commercial Directory* recorded nineteen physicians and surgeons in 1849[280], whereas the *London and Provincial Medical Directory* (LPMD) recorded twenty-three in 1850.[281] Similarly, in 1870, *Kelly's Directory* listed six physicians and twelve surgeons[282] and the LPMD

[279] I. Waddington, *The Medical Profession in the Industrial Revolution* (Dublin, 1984), p.148.
[280] E. Hunt & Co., *Hunt & Co.'s Commercial Directory; for the Cities of Gloucester, Hereford, and Worcester, etc.* (London, 1849).
[281] J. Churchill, *The London and Provincial Medical Directory* (London, 1850).
[282] Kelly and Co., *Kelly's Directory of the County of Gloucester* (London, 1870).

twenty physicians and surgeons.[283] Elsewhere however, the numbers did correspond, for example, *Pigot's Directory* of 1844 listed four physicians and eighteen surgeons, [284] the same number as the 1845 edition of the LPMD.[285]

Figure 3.8 Numbers of medical practitioners (physicians and surgeons) listed in the London and Provincial Medical Directory for Gloucester, 1845-1870



*The 1865 edition held in the Royal College of Physicians library had been withdrawn for rebinding.

Source: J. Churchill, *The London and provincial medical directory* (London, 1845-1870).

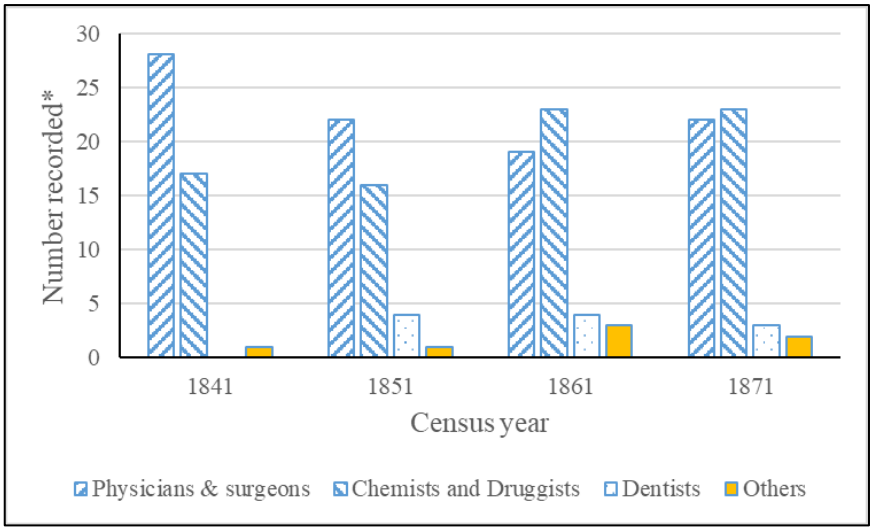
Most of the doctors practising in Gloucester were surgeons. The number of physicians, as was the case elsewhere, remained very small and the 200 per cent increase in their numbers between 1820 and 1861 only equated to a rise from two to six. In 1851, there were four, a similar number to Moore's count of five in Shrewsbury the same year.[286] Physicians occupied the most prestigious institutional appointments and privately catered predominantly (but not exclusively) for the wealthy. Fissell found that in eighteenth-century Bristol 'they were few in number and remained insignificant to health care in the city as a whole.'[287] This remained the case in nineteenth-century Gloucester, but it belies the influence they exerted over the profession.

From 1841 onwards, data from the trade and medical directories can be further cross-referenced with census records (Figure 3.9). The 1841 census recorded three

[283] J. Churchill, *The London and Provincial Medical Directory* (London, 1870).
[284] Pigot & Co., *Royal National and Commercial Directory and Topography* (Manchester, 1844).
[285] J. Churchill, *The London and Provincial Medical Directory* (London, 1845).
[286] R. Moore, *Shropshire Doctors & Quacks* (Amberley, 2011), kindle edition, Chp.4.
[287] Fissell, p.62.

physicians and twenty-five surgeons and apothecaries practising in Gloucester.[288] This was a somewhat higher number than the four physicians and nineteen surgeons listed in the 1841 trade directory and may partly reflect the fact that it is not always possible to differentiate from the census those doctors active in practice from the retired or inactive.[289] However, in 1851 the number recorded in the census was very similar to that in the 1850 edition of the LPMD (twenty-two compared to twenty-three).[290] Unlike the trade and medical directories, the census returns also captured apprentices, assistants and medical students. Their numbers are important because Smith believed that over-stocking of the medical marketplace was 'partly the outcome of the unlimited right of GPs to take apprentices.'[291] In Gloucester however, in 1841, 1861 and 1871 there were only two students or assistants and three in 1851.

Figure 3.9 Healthcare suppliers identified in census returns 1841-1871[292]



Source: Ancestry.com, *1851 Census* [database on-line]. Provo, UT, USA: Ancestry.com Operations Inc, 2005. Original data: Kew, The National Archives, *Census Returns of England and Wales, 1851*, HO 107.

[288] The analysis included the Gloucester Registration District and some neighbouring parishes to ensure everyone who was likely to be practising in Gloucester was detected.
[289] Both sets of numbers include the House Surgeon and Apothecary to the Infirmary and the Resident Physician/Superintendent to the Lunatic Asylum.
[290] J. Churchill, *The London and Provincial Medical Directory* (London, 1850), p.224.
[291] Smith, p.375.
[292] Note: the figures quoted in this study were taken from an analysis of the actual returns, rather than the *Population Tables* produced by HMSO (see Table 3.6). There are significant differences, which appear to result from the different ways in which medical practitioners and druggists have been counted. In the case of medical practitioners, the difference appears to be due to the *Population Tables i*ncluding non-practising doctors, apprentices and medical students. For druggists, similarly the *Population tables* appear to have included apprentices and assistants. This would make sense, as the tables were concerned with the occupational classification of the general population, rather than counting the numbers of discrete businesses.

The geographical distribution of doctors is important but, as Biddle identified, 'the significance of the geographical distribution of provision within a locality, and what this might tell us about the relationship between providers and consumers, has been largely overlooked' in earlier studies.[293] The clustering of Gloucester's doctors in small enclaves restricted to a few nearby streets suggests both that they each held, or aspired to, a similar socio-economic status and that they were a close-knit group. This is not perhaps what would be expected of a fiercely competitive marketplace. Barton Street, Clarence Street and Eastgate Street were favoured addresses (Figure 3.10), but all the city's medical men lived close to the town centre and the principle healthcare institutions - the Infirmary, Dispensary and workhouse. Brown similarly found in Bristol that 'where individuals lived must have been influenced to some extent by where they practised.' [294] However, whereas Biddle found in his study of Portsmouth that 'middle and upper-class patients were doctors' most profitable clients…poorer districts produced less demand for doctors and so fewer doctors located in them,' Gloucester appears to have been small and compact enough for this not to matter and their distribution did not change appreciably between 1841 and 1871.[295] The inference is that a stable and close-knit professional community existed well before the supposed watershed of the 1858 Medical Act.

Roughly equivalent to medical practitioners in numbers, and arguably equally significant in terms of their contribution to overall healthcare provision, were the chemists and druggists. In chapter two it was discussed how this group 'must have included a range of individuals with very different aspirations and outlooks.'[296] As with doctors, this is evidenced by changes to the way in which members of the trade chose to self-identify in the census. In the 1841 census, all either identified themselves as 'chemist' *or* 'druggist.' In 1851, seven identified as 'chemist and druggist,' two as 'chemist,' one as 'dispensing chemist' one as 'veterinary surgeon and druggist,' and five as 'druggist.' As might be expected, Gloucester's chemists and druggists were clustered around the main shopping area, centred upon The Cross, and throughout the period from 1841 to 1871 their distribution changed little (Figure 3.11).

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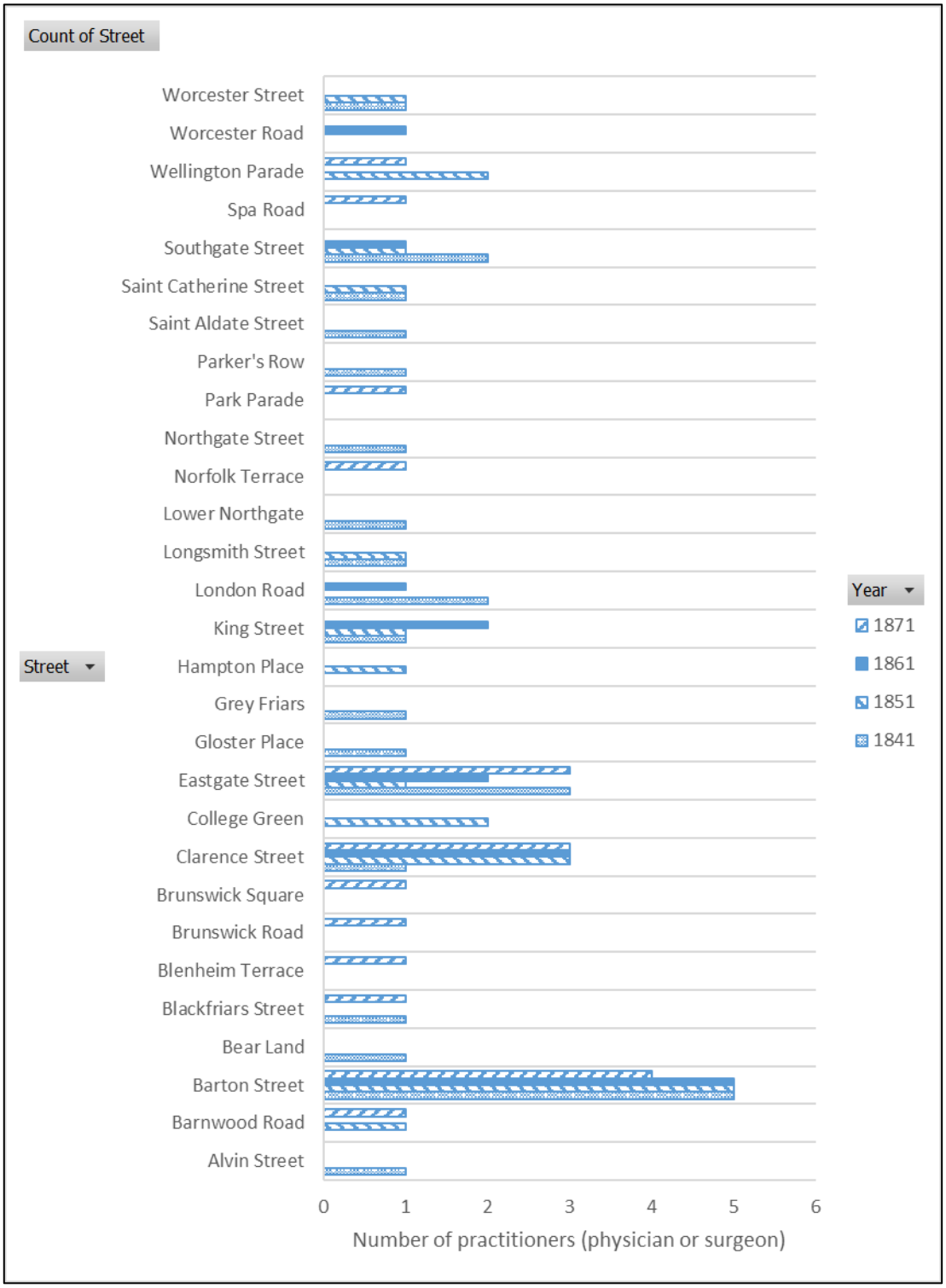
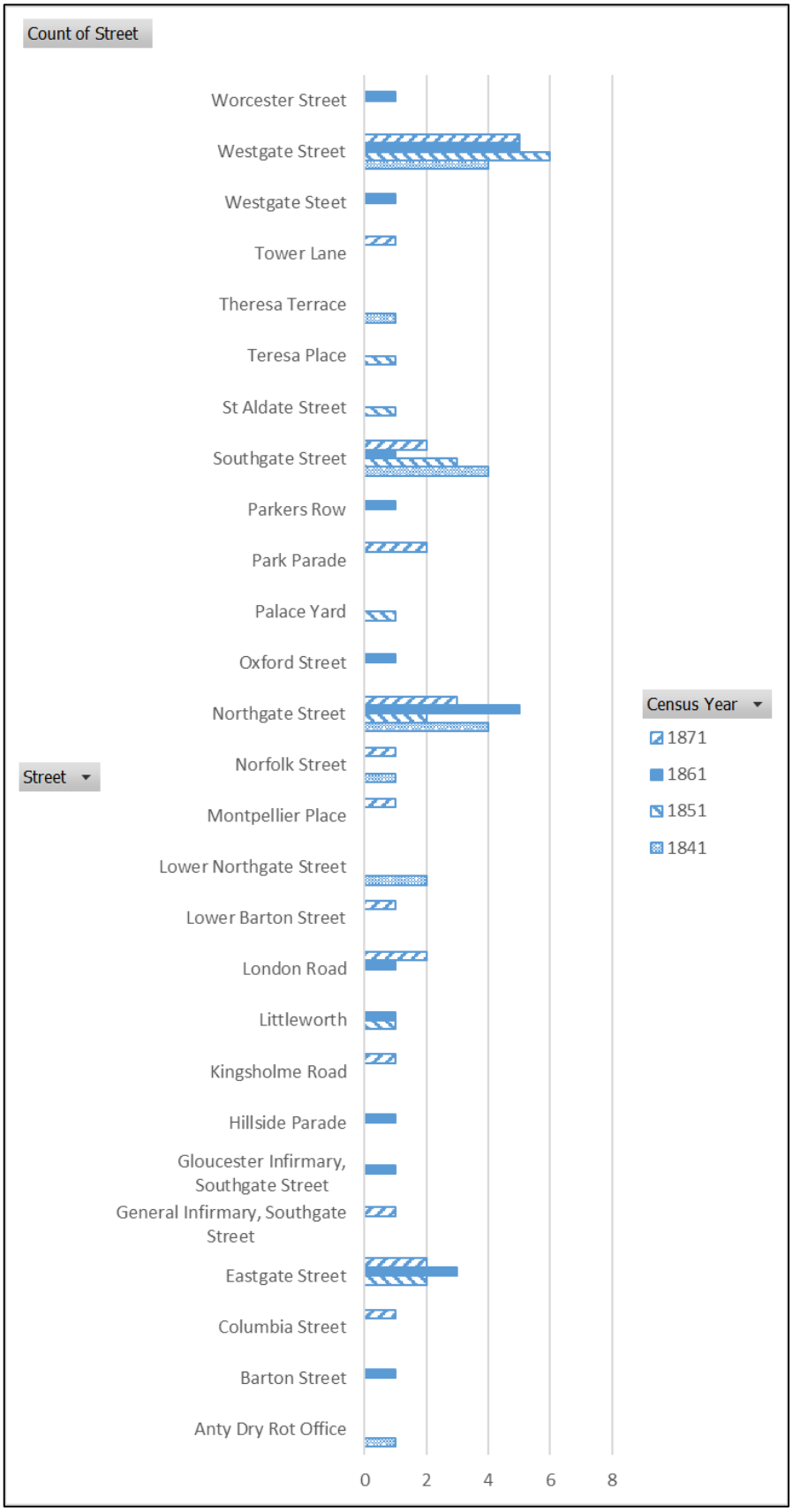
[293] Biddle, p.67.
[294] Brown, 'The Providers of Medical Treatment,' p.308.
[295] Biddle, p.237.
[296] Brown, 'The providers of medical treatment,' p.311.

Figure 3.10 Distribution of medical practitioners in Gloucester, 1841–1871



Source: Ancestry.com, *1851 Census* [database on-line]. Provo, UT, USA: Ancestry.com Operations Inc, 2005. Original data: Kew, The National Archives, *Census Returns of England and Wales, 1851*, HO 107.

Figure 3.11 Distribution of chemists and druggists in Gloucester, 1841–1871



Source: Ancestry.com, *1851 Census* [database on-line]. Provo, UT, USA: Ancestry.com Operations Inc, 2005. Original data: Kew, The National Archives, *Census Returns of England and Wales, 1851*, HO 107.

Chemists and druggists were very much a part of the retailing community, and in 1841, were to be found in Northgate/Lower Northgate (6), Southgate (4) and Westgate (4) Streets. By 1861, the numbers in Southgate Street had declined (1) and the number in Eastgate (3) Street had increased and a few more shops were starting to appear further out from The Cross, for example in Barton Street and London Road, the main areas of urban expansion, a position that remained largely unchanged by 1869 as Table 3.5 below shows:

Table 3.5 Gloucester Chemists and Druggists in 1869

Name	Address
Edward Berry	The Cross, Westgate Street
Henry Maine Jenkins	18 Eastgate Street
Henry Meadows	15 Westgate Street
Joseph Medd	42 Westgate Street
Thomas Millard	56 Westgate Street
Mrs Jane Maria Millington	Lower Barton Street
Thomas Pearce	Westgate Street
George Walter Polden	75 Northgate Street
Prosser and Trenfield	Westgate Street
William Stafford	10 Northgate Street
James Tucker	95 Northgate Street
John Vick & Co.	11 Southgate Street
Joseph Ward	45 Eastgate Street
William Edward Willis	78 Northgate Street
Stephen Wingate	25 Southgate Street

Source: Kelly & Co., *Post Office Directory of Chemists and Druggists: Containing lists of the chemists and druggists throughout England, manufacturing chemists, wholesale druggists, patent medicine vendors and manufacturers, and every trade in connection therewith* (London, 1869), p.123.

Census data show a slight decrease in the number of chemists and druggists from seventeen in 1841 to sixteen in 1851 before rising to twenty-three in 1861,[297] remaining at this number in 1871.[298] Throughout, discrepancies were noted between the census and the trade directories, which list fourteen chemists and druggists in 1841,[299] seventeen in 1853[300]; seventeen again in 1859[301]; and sixteen in 1870.[302] The census numbers appear to be larger because they recorded households, not businesses, and thus

[297] Includes one practising chemist and druggist whose occupation was recorded as 'gentleman.'
[298] Includes one wholesale chemist and one veterinary surgeon and chemist.
[299] L. Bryant, *Directory for the City of Gloucester* (Gloucester, 1841). [GA GMS 185].
[300] Slater, Pigot & Co., *Slater's Royal National Directory and Topography* (London, 1853).
[301] Harrison, Harrod, & Co., *Harrison, Harrod, & Co.'s Bristol Post Office Directory and Gazetteer with the Counties of Gloucestershire and Somersetshire* (London, 1859).
[302] Kelly (1870).

include those not currently trading, or who were employed by someone else. Apprentices and assistants identifiable as such were not counted in these numbers. The rise in the number of chemists and druggists recorded in the trade directories between 1820 (4) and 1839 (11) equated to a 175 per cent increase – a dramatic trend if the earlier number was accurate and one which would substantiate Loudon's assertion that 'the public welcomed the druggist and flocked to him in increasing numbers.'[303] Marland believed their popularity lay in the fact that 'self-medication was still attractive to many groups of society, and the chemist catered very much for this demand.'[304] Interestingly, the sources reveal that a few of these shops were run by women – the pharmacy trade providing one of the few respectable sources of employment for middle-class women. The earliest census record of a female chemist and druggist dates from 1851, Ann Rose having inherited the business from her husband Charles sometime around 1847, the firm being renamed A. Rose and Sons. Later, when the Gloucester druggist Frederick Millington died his widow Jane successfully took over the shop, becoming Gloucester's sole female chemist and druggist in the 1861 census.[305] She was still running the business in 1871 when she married one of her assistants, Walter Trigg.[306]

By 1870, Gloucester's chemists and druggists had achieved near parity in numbers with doctors (sixteen to eighteen), approximating to Brown's finding that in Bristol in 1851, where 'the total number of chemists and druggists was close to that of qualified medical practitioners'[307] and Marland's finding in Wakefield and Huddersfield that 'by 1866, the ratios were one to one.'[308] Looking at the trend up to 1840, the data also mirror Marland's discovery of 'a considerable growth in the numbers of chemists and druggists…especially in urban areas.'[309] Interestingly, the sharp increase in

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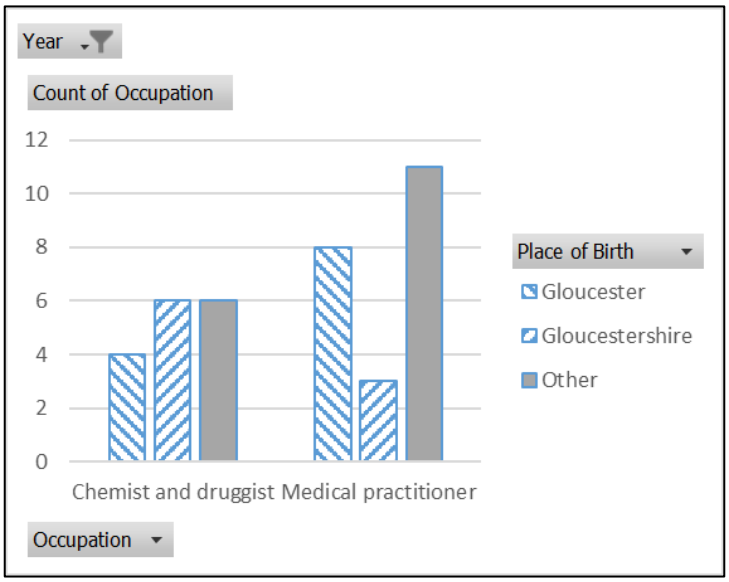
[303] Loudon, 'Medical Practitioners 1750-1850', p.231.
[304] H. Marland, ''The Doctor's Shop': The rise of the chemist and druggist in nineteenth-century manufacturing districts' in L.H. Curth (ed.), *From Physic to Pharmacology: Five Hundred Years of British Drug Retailing* (Aldershot, 2006), p.104.
[305] A third female chemist and druggist Louisa Selina Brown appeared briefly in the trade directories for 1867 and 1868 - [Unknown], *Gloucester Directory,* and Slater & Co., *Slater's Royal and National Commercial Directory and Topography of the Counties of Gloucestershire, Monmouthshire and North and South Wales, and a Classified Directory of the Town of Liverpool* (Manchester, 1868).
[306] *Gloucestershire Chronicle*, 23 December 1871, p.4.
[307] Brown, 'The Providers of Medical Treatment,' p.311.
[308] H. Marland, 'The Medical Activities of Mid-Nineteenth Century Chemists and Druggists, with special reference to Wakefield and Huddersfield,' *Medical History,* Vol.31, No.4 (1987), p.421.
[309] H. Marland, 'The Medical Activities,' p.419.

numbers seen prior to 1850 then stabilised between 1861 and 1871, despite the population continuing to rise. Using the census data, there was only a 35 per cent rise in their numbers between 1841 and 1871, amounting to at most six extra shops.[310] Thus, at a time when the numbers of medical practitioners had plateaued so did the number of chemists and druggists, raising the possibility that chemists and druggists were not necessarily responsible for constraining medical numbers but were themselves affected by the same factors that had arrested the rise in the number of doctors. This has implications for the supposed rivalry between the two groups; something that will be explored further in chapter five.

Questions over competition are raised again when looking at another proxy indicator, place of birth, which was recorded by the census from 1851.[311] Birthplace provides a rough indicator of geographical mobility in the economy and it might be expected that the more intense the competition in the system, the greater the number of individuals who would be working away from their home town or region. Figures 3.12 to 3.14 below break down the birthplaces of medical practitioners and chemists and druggists into those born in Gloucester, Gloucestershire and elsewhere for each census year from 1851 to 1871.

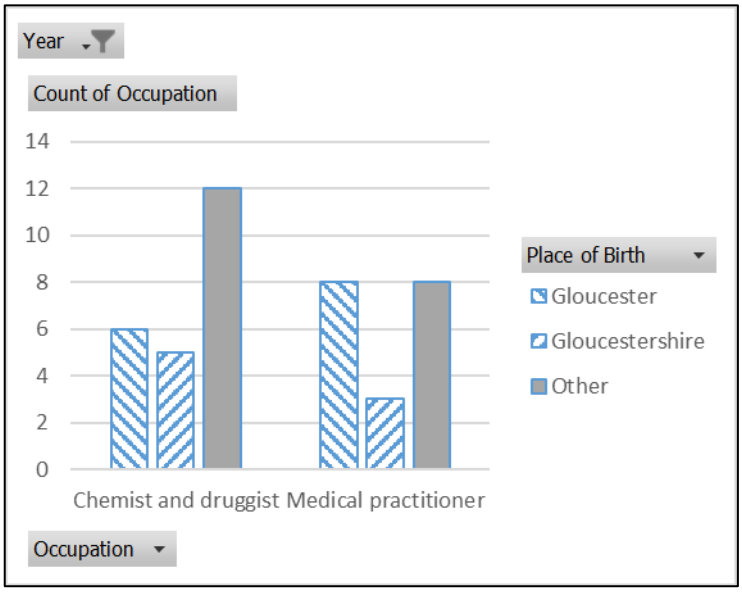
Figure 3.12 Occupations by place of birth, 1851



Source: Ancestry.com, *1851 Census* [database on-line]. Provo, UT, USA: Ancestry.com Operations Inc, 2005. Original data: Kew, The National Archives, *Census Returns of England and Wales, 1851*, HO 107.

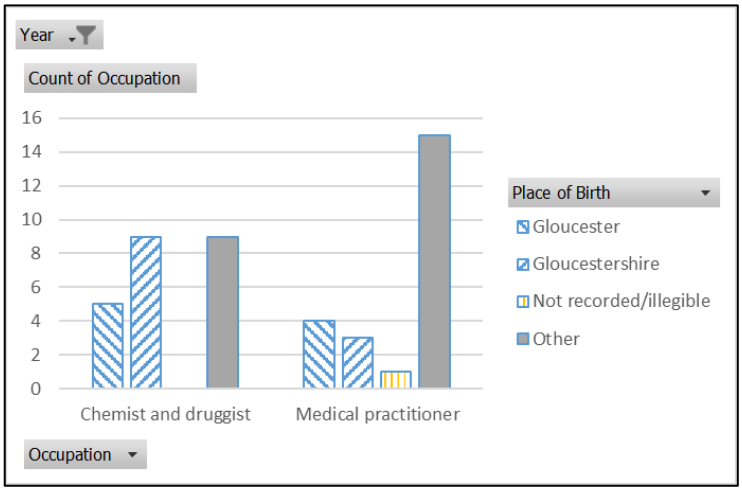
[310] Based on census figures.
[311] Prior to 1851 the census did not record place of birth.

Figure 3.13 Occupations by place of birth, 1861



Source: Ancestry.com, *1851 Census* [database on-line]. Provo, UT, USA: Ancestry.com Operations Inc, 2005. Original data: Kew, The National Archives, *Census Returns of England and Wales, 1851*, HO 107.

Figure 3.14 Occupations by place of birth, 1871



Source: Ancestry.com, *1851 Census* [database on-line]. Provo, UT, USA: Ancestry.com Operations Inc, 2005. Original data: Kew, The National Archives, *Census Returns of England and Wales, 1851*, HO 107.

In 1851, half of Gloucester's medical practitioners[312] were born in the city or the county, in 1861 the figure rose to 59 per cent, but then fell sharply to 30 per cent in 1871. This may suggest that as medicine evolved as a profession and became more technically demanding, familial connections declined as a factor in the appointment of doctors in favour of professional qualifications and relevant experience. It is interesting that this sharp decline occurred at a time when competition appeared to be receding and

[312] Includes physicians, surgeons and apothecaries.

the number of practitioners in the city had actually reduced slightly. In the case of chemists and druggists,[313] in 1851, 63 per cent were born in Gloucester or Gloucestershire, in 1861 the figure fell to 48 per cent before rising again to 61 per cent in 1871, indicating that a different dynamic was at work. In a trade that depended upon personal relationships between retailer and customer rather than professional recognition, reputations were built over a working life, even over successive generations. Thus, chemists and druggists had more incentive to stay in a locality where they were known than doctors. As was found earlier with doctors, Gloucester's chemists and druggists lived where they worked and this, together with their longevity (discussed next), and place of birth, suggests many were well-integrated into their local community and could draw upon shared ties to place and people, offering a trusted and respected community healthcare resource. All of which challenges the stereotype of the trade then being peddled by the medical establishment.

Looking next at the longevity of careers we find a mixed picture. Looking firstly at doctors, comparing the 1841 and 1851 census returns, in 1841 there were 28 physicians and surgeons practising in Gloucester, in 1851 there were 22. Of the 28 in 1841, 15 had disappeared by 1851 (54 per cent). This appears to be a significant turnover. However, six of these practitioners were over 60 by 1851 and may well have retired,[314] subtracting them reduces the turnover to 32 per cent. Some held what might be considered stepping-stone posts in 1841, such as William Atkinson (aged 25) who was a surgeon to the Dispensary. Another young practitioner who had moved on by 1851 was William Bradley (aged 20). The other medical practitioner aged under thirty in the 1841 census was Alfred Clarke, who went on to enjoy a long career in Gloucester. In addition to William Bradley, Thomas Renwick (aged 38 – surgeon) and William Nash (aged 30 – surgeon) also appear to have left no corroborating record of having practised in Gloucester. Only Atkinson and Bradley could be said to fit the stereotype of a young practitioner struggling and failing to find a foothold in an overcrowded market. Taking a five-yearly sample of medical directories from 1845 to 1870, of 49 practitioners listed during this period, 34 appeared more than once.[315] On

[313] Includes pharmaceutical chemists, chemists, chemists and druggists, wholesale chemists and druggists.
[314] It is not easy to tell from the census who was active and who was retired except when occasionally 'not in practice' was stated.
[315] J. Churchill, *The London and Provincial Medical Directory* (London, 1845-1870).

balance, these data suggest that once established, most of Gloucester's medical men enjoyed reasonably lengthy careers in the city (Table 3.6).

Table 3.6 Number of appearances in census returns for providers appearing more than once, 1841 to 1871

Occupation	Number of appearances		
	Two	Three	Four
Physician	2	0	1
Surgeon	6	4	4
Chemist & Druggist	8	4	2
Grand Total	**16**	**8**	**7**

Source: Ancestry.com, *1851-1871 Census* [database on-line]. Provo, UT, USA: Ancestry.com Operations Inc, 2005. Original data: Kew, The National Archives, *Census Returns of England and Wales,* HO 107.

With respect to trade directories, because they do not cover every year of the period 1815 to 1870 and are very infrequent prior to the 1840s, it is not possible to use them to chart the longevity of individual careers in Gloucester with any real confidence. Between 1820 and 1870 trade directories listed a total of 12 physicians[316], 51 surgeons, 51 chemists and druggists[317], 10 dentists[318], and 4 medical botanists/herbalists; a total of 131 healthcare providers. Of these, 3 physicians, 15 surgeons, 5 chemists and druggists and 2 medical botanists/herbalists appeared in only a single directory (excluding those who appeared only in 1820 or 1870, being the first and last year examined).[319] 58 per cent of physicians, 46 per cent of surgeons and 52 per cent of chemists and druggists appeared in five or more trade directories.[320] At a point when the numbers of medical

[316] Some physicians were recorded as surgeons and some surgeons as physicians in different trade directories and at different points in their career. The figures are based upon their recorded profession at their first appearance, excepting Ralph Fletcher, who was recorded as a surgeon in 1830, but appears to have always been a physician and surgeon. The figures include medical practitioners who were based at institutions who did not practice privately.

[317] Includes pharmaceutical chemists, dispensing chemists, etc.

[318] One dentist was also a chemist and druggist (H.M. Jenkins) and has been counted in the numbers for both.

[319] The numbers exclude those appearing for the first time in 1870, the last year covered as they may have continued in subsequent editions. Two surgeons who appeared only once in 1820 have also been excluded as they may have been in practice in previous years. Where a business was taken over and continued trading from the same premises under a different proprietor these are also excluded.

[320] Based upon the TOTAL number including 1820 and 1870. Where a business was taken over and continued trading from the same premises under a different proprietor this was counted as a single business in the total from which the percentage is derived. It should be noted that these percentages must be regarded as an underestimate of longevity, as businesses at both ends of the timeframe would be 'cut short' by excluding appearances outside the timeframe and are also distorted by the irregularity in the interval between surviving trade directories.

men in the city first began to level off, Robson's 1839 trade directory listed 18 physicians and surgeons, of whom 16 (89 per cent) were still listed as practising in *Pigot's* 1842 directory.[321] Four new practitioners appeared in Gloucester between 1839 and 1842 (Alfred Clarke, Ambrose Dawson Cookson, John Heath and Robert Munn). All four were still present in 1844, but only two remained by 1849 (Ambrose Cookson and Alfred Clarke).

With respect to the chemists and druggists, of the four that appeared in *Gell's* 1820 trade directory, all were still trading in 1844, and three of them in 1849. Newcomers during this period were less successful. Of seven new chemists and druggists appearing in the trade directories between 1830 and 1839, three had disappeared by 1849. The trend continued in the census era. Of sixteen chemists and druggists present in the 1851 census, eight had disappeared by 1861 (of which three it should be noted were by then over 60); of twenty-three in 1861, fourteen were not recorded in 1871 (of which two were by then over 60).[322] Looking at these numbers, it appears that competition may have been more intense among chemists and druggists than among medical practitioners. However, the overall number of formal healthcare providers in the city[323] only increased by one from 45 in 1841 to 46 in 1871, while at the same time, the population of the Gloucester Registration District increased by some 55 per cent from 26,815 to 41,641.[324] A broadly similar picture emerges from the trade directories, one of which listed 37 providers in 1841[325] and another 34 in 1870.[326] These findings are in sharp contrast to the earlier period from 1820 to 1839, which saw an increase in overall numbers from 14 to 29.[327] Thus, once this period of rapid increase ceased the long-term trend was one of relative stability. Overall, the longevity of both doctors and chemists and druggists does not conjure a vision of intense competition and

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[321] Pigot & Co., *Royal National and Commercial Directory and Topography* (Manchester, 1842); Robson & Co., *Robson's Commercial Directory of London, Bedfordshire, Buckinghamshire, Cambridge, Gloucester, Hunts, Norfolk, Oxon, Suffolk & Wiltshire* (London, 1839).

[322] It should be noted that some of these businesses may have survived under new ownership or mergers.

[323] Physicians, surgeons, chemists and druggists.

[324] Includes chemists and druggists, cuppers, dentists, medical botanists, physicians and surgeons. GB Historical GIS / University of Portsmouth, Gloucester RegD/PLU through time | Population Statistics | Total Population, A Vision of Britain Through Time. www.visionofbritain.org.uk/unit/10029739/cube/TOT_POP [Date accessed: 10th January 2016]

[325] Bryant.

[326] Kelly (1870).

[327] The 14 in 1820 is almost certainly an underestimate due to the under recording of providers by the compiler of the trade directory.

there appears no obvious inverse correlation in their numbers. Rather, what this looks like is something much more akin to a stratified, stable and structured healthcare economy. However, to be confident of this some further exploration of the extent of competition is needed.

Figures for the number of suppliers per head of population are commonly cited as a measure of competition. Before looking at the figures for Gloucester it is necessary to highlight the significant flaws that exist in this approach. The discrepancies between trade directories, medical directories, census enumerators books, and published census tables mean that depending upon the source used ratios can vary significantly. King and Weaver have argued that 'conventional ways of "measuring" this panorama, in terms of the absolute numbers of doctors or the level of doctor-patient ratios, provide at best a partial guide to the contours of local medical life.'[328] In any case, as Lane found in her earlier analysis of Samuel Simmons 1783 *Medical Register* for Birmingham, 'these men saw patients from beyond the town as well as those from the rest of the county who attended the new hospital there.'[329] This number of doctors per head of population is not a reliable measure of competition and, as when figures are quoted they are not always accompanied by detailed information as to how they have been derived, they must be treated with caution. Nevertheless, as competition has been identified as a key feature of the medical marketplace and ratios to head of population have been cited so widely, it is necessary to engage with this area of debate and to provide comparative data for Gloucester.

Using the population figures in Table 3.2 and the trade directory listings, and looking first at the ratio of doctors[330] to head of population, the ratio in 1820-21 was 1:1,786, this fell to 1:1,487 in 1830-31 and 1:1,165 by 1841 (or 1:958 using census data), but thereafter increased (using trade directory data) to 1:1,892 by 1870-71,[331] which was lower than the 1:1,128 nationally cited by Digby for 1861.[332] Between 1820-21 and 1841 the growth in the number of doctors outstripped the increase in

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[328] S. King and A. Weaver, 'Lives in Many Hands: The Medical Landscape in Lancashire, 1700-1820,' *Medical History,* Vol.44, No.2 (April 2000), p.199.
[329] Lane, 'The Medical Practitioners of Provincial England,' p.354.
[330] Physicians and surgeons.
[331] The first date shown is that of the trade directory and the second the census year where no directory could be found matching the census year. In 1841 there was a directory for that year.
[332] Digby, *The Evolution of British General Practice*, p.27.

population, unlike Wakefield and Huddersfield in the same period, where Marland found that 'their numbers failed…to keep up with the large population growth of the two towns.'[333] Nevertheless, in 1830-31, the ratio of 1:1,487 meant, if the trade directories are correct, there were significantly fewer doctors per head of population in Gloucester than in the United Kingdom as a whole, for which Loudon calculated a ratio of 1:1,000 in 1834.[334] Similarly, in 1841, the ratio for Gloucester was 1:1,165, still significantly lower than the 1:926 for England as a whole again cited by Loudon.[335] There were far fewer doctors per head of population in Gloucester in 1841 than in York (a city with which Gloucester shared some similarities at this time) where a figure of 1:462 was cited by Brown.[336] As might be expected of a city, there were however more doctors per head of population than the 1:2,000 cited by Moore for the *county* of Shropshire in 1835.[337] However, it is perhaps the disparity between Gloucester and Cheltenham that is most striking.

Although published census summary tables appear to over-estimate the number of doctors actually *in practice*, they can be useful for comparative purposes. Looking at the figures for 1851 (Table 3.7), Gloucester Registration District had a population of 32,045 and Cheltenham Registration District 44,184; approximately 38 per cent larger. The tables show Gloucester as having 27 medical practitioners[338] and 24 druggists,[339] whereas Cheltenham had 94 regular medical practitioners and 49 druggists; 248 per cent and 104 per cent higher respectively. Applying these numbers, in Gloucester, the ratio of regular practitioners to head of population was 1:1,187, in Cheltenham it was 1:470, akin to that of London, where Loudon found the ratio was 1:419.[340] By way of comparison, Brown's data for Bristol in 1851 produce a ratio of 1:1,352.[341]

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[333] Marland, *Medicine and Society*, p.255.
[334] I.S. Loudon 'James Mackenzie Lecture: The Origin of the General Practitioner,' *Journal of the Royal College of General Practitioners* (January 1983), p.16.
[335] Loudon, *Medical care*, p.215.
[336] Brown, *Performing Medicine*, p.115.
[337] Moore, Chp.4.
[338] 'Physician,' 'surgeon' and 'other medical men.'
[339] The summary tables overestimate the numbers, as they include those not in practice, visiting and/or students and assistants.
[340] Loudon, *Medical Care*, p.215.
[341] Includes 'physicians with hospital or dispensary appointment (2), surgeons with hospital or dispensary appointments (9), qualified "surgeons" with no major appointments (32). Brown, 'The Providers of Medical Treatment, p.309.

Furthermore, an extraordinary 37 of Cheltenham's 94 doctors identified themselves as physicians, whereas in Gloucester there were only five.

Table 3.7 Numbers of practitioners in 1851

GLOUCESTER Registration District (population 32,045)				**CHELTENHAM Registration District** (population 44,184)			
Class	**Occupations**	**males 20+**	**females 20+**	**Class**	**Occupations**	**males 20+**	**females 20+**
Class III (3)	Physician	5		Class III (3)	Physician	37	
	Surgeon	22			Surgeon	57	
	Other Medical Men	6			Other Medical Men	9	
Class III (6)	Druggist	24	2	Class III (6)	Druggist	49	1
	Others dealing in drugs and surgical instruments	0	0		Others dealing in drugs and surgical instruments	2	1

Source: HMSO, *Census of Great Britain, 1851, population tables* (HMSO, 1854).

The reason for this enormous disparity almost certainly lies in the different socio-economic complexion of the two neighbours. Cheltenham was an affluent spa-town with a large population of wealthy invalids, whereas, as discussed earlier, Gloucester was a predominantly working-class industrial port. Waddington found that 'cathedral, seaside and spa towns offered a better livelihood to medical men…[and] throughout the nineteenth century these towns attracted more practitioners, per head of population, than industrial areas or thinly populated rural districts.'[342] In this case spa seems to have trumped cathedral. A proportion of Cheltenham's medical men were likely not permanent residents, instead following wealthy patrons according to the dictates of the Season. While in residence, they likely attracted a significant proportion of Gloucester's limited supply of wealthy fee-paying customers. Indeed, Drs Baron and Rumsey both left Gloucester for this trade later in their careers and interestingly many of those who remained did not rely solely upon their income from practice.[343]

[342] Waddington, 'General Practitioners and Consultants,' p.173.

[343] The physician Hardwicke Shute for example, already wealthy in his own right improved his fortune further by marrying the Honourable Marianne Wolf, daughter of Lord Viscount Kilwarden in 1809. In 1842, he mortgaged the 'annuity or yearly rent charge of Five hundred pounds [on]…the town the Castle Town and lands of Newland and the town and lands of Knockabrick otherwise Knockabrook and the town and lands of Buck and Hounds all situate in the County of Dublin,' together with two assurance policies, for £1,300 plus interest. He had taken out similar mortgages for £700 plus interest in 1840 and £360 plus interest in 1841. John Baron, another Gloucester physician, was a partner in The Gloucestershire Banking Company. Charles Brandon Tyre, a surgeon at the Infirmary, had been one of the principal investors in the Gloucester and Berkeley Canal Company and also owned quarries on

Cockayne and Snow found a similar situation in East Anglia where the poverty of rural areas meant 'country practitioners needed a side-line. Some surgeons were part-time farmers and others were part-time medical teachers.'[344]

For general practitioners, the total population within their practice area was probably largely irrelevant; what really mattered to them was how many amongst that population were full-fee-paying customers. These ratios per head of population highlight again the findings of previous studies that 'great variation in levels and even trends of GP provision occurred.'[345] Gloucester appears to have been a less competitive environment than the average nationally, and markedly less so than Cheltenham, London, or York.[346] If as appears to be the case, the city was unable to support continued growth in the numbers of medical men and chemists and druggists, the question then arises as to who else was catering for its rapidly expanding population. If this was a medical marketplace, defined by diversity, plurality, choice and competition, surely a wide range of alternative healthcare suppliers would fill the un-met needs of a rapidly expanding urban population? However, excepting chemists and druggists, very few irregular suppliers appear in either the trade directories or the censuses. Given the part-time, iterant nature of some forms of irregular practice, it is possible some were either overlooked or recorded with different occupations in the census returns, but this alone cannot account for their near total absence and should not be translated into a case for their (invisible) presence. What the available evidence suggests is that they were not there, at least not in substantial numbers.

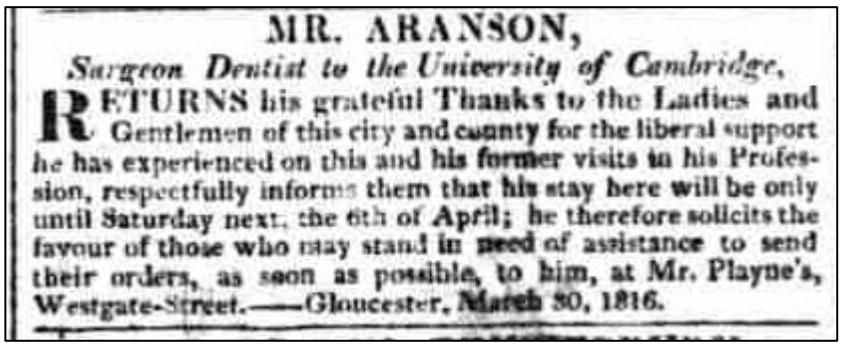
Leckhampton Hill. Another surgeon, James Peat Heane moved into property development by developing Hampden Place (off Barton Street) as a residential street in the 1840s. Sources: Shute family: 'Mortgage of an annuity and several Policies of Assurance for securing £1,300 and Interest,' 5 November 1842, Gloucestershire, GA, Whitcombe and Gardom of Gloucester, solicitors, MS D134/F16; *Gloucestershire Chronicle*, 15 February 1845, p.2; H. Conway-Jones, *Gloucester Docks: An Illustrated History* (Gloucester, 1984), pp.9-18; Gloucester, 1835-1985: Topography,' in Herbert, (ed.) *A History of the County of Gloucester: Volume 4, the City of Gloucester* (London, 1988), pp. 221-241. British History Online http://www.british-history.ac.uk/vch/glos/vol4/ [Date accessed: 6 October 2016].

[344] Cockayne and Snow (eds), p.xv.

[345] Cherry, p.41.

[346] The ratios may well be higher, as not all doctors listed in the census returns would have been involved in private practice, meaning the number of practitioners per head of general population would have been lower and the ratio of head of population to practitioner consequently higher. For example, the post of Superintendent of Gloucestershire Asylum was a full-time, specialist post, the holder of which would have at most a limited private general practice.

Taking dentists, one of the principal components of the medical fringe (dentistry was still an unqualified trade in the mid-nineteenth century) as an emblematic example, it was not until 1841 that a dentist (S. Tibbs) was listed in a Gloucester trade directory.[347] In the 1851 census, only four were listed, two of whom combined dentistry with other trades (broker and jeweller).[348] Up to 1871, the number never rose any higher. Such low numbers may support the conclusion reached by Bishop and Geiber that 'this invisibility is almost certainly a result first of the scarcity of numbers of true dentists compared with other medical disciplines…and second, of the ubiquity of the dental function, when the greatest part of dental healthcare was tooth-drawing.'[349] Neither the trade directories nor the census however support Bishop and Geiber statement that an 'explosion of dental practice outside the metropolitan centres' occurred in the aftermath of the 1815 Apothecaries Act.[350] Dentists were often itinerant and the advertisements of those visiting the city frequently appeared in the Gloucester press (Figure 3.15). However, these advertisements tended to emanate from a very small number of practitioners; Mr Lewis 'a dentist from Bath,' for example, who advertised in 1814 and was still placing advertisements in 1827.[351] This suggests that the numbers captured in the census, while not complete, were fairly representative.



MR. ARANSON,

Surgeon Dentist to the University of Cambridge,

RETURNS his grateful Thanks to the Ladies and Gentlemen of this city and county for the liberal support he has experienced on this and his former visits in his Profession, respectfully informs them that his stay here will be only until Saturday next, the 6th of April; he therefore solicits the favour of those who may stand in need of assistance to send their orders, as soon as possible, to him, at Mr. Playne's, Westgate-Street.——Gloucester, March 30, 1816.

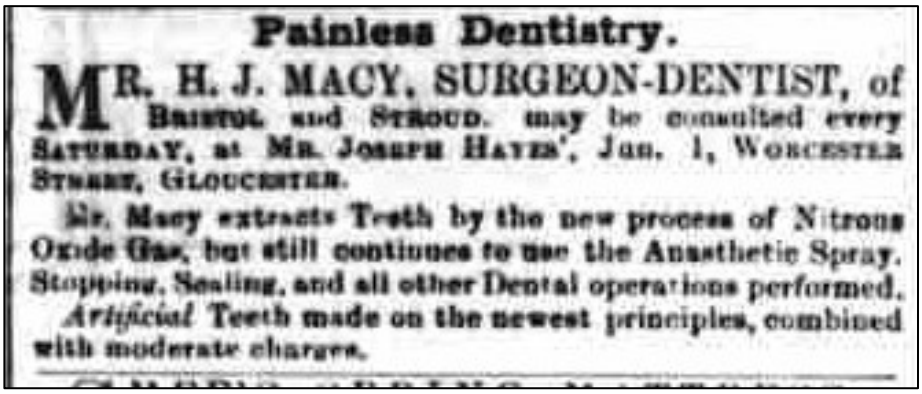
[347] Bryant (1841).

[348] Two of the four dentists listed in 1851 were French citizens, sons of the French Consul; Adolphus and Augustus Quintin. The pair practised separately in the city from the late 1840s into the 1870s.

[349] M.G.H. Bishop and S. Gelbier, 'Ethics: How the Apothecaries Act of 1815 Shaped the Dental Profession. Part 1. The Apothecaries and the Emergence of the Profession of Dentistry,' *British Dental Journal*, Vol. 193, No.11 (December 2002), p.629.

[350] *Ibid,* p.631.

[351] *The Glocester Herald,* 9 July 1814.



Painless Dentistry.

MR. H. J. MACY, SURGEON-DENTIST, of Bristol and Stroud, may be consulted every Saturday, at Mr. Joseph Hayes', Jun. 1, Worcester Street, Gloucester.

Mr. Macy extracts Teeth by the new process of Nitrous Oxide Gas, but still continues to use the Anæsthetic Spray. Stopping, Sealing, and all other Dental operations performed.

Artificial Teeth made on the newest principles, combined with moderate charges.

Figure 3.15 Two advertisements placed by itinerant dentists

Source (top): *Gloucester Journal,* 1 April 1816, p.3. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

Source (bottom): *Gloucester Journal,* 19 March 1870, p.1. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

Other 'irregular' practitioners to appear in the 1841 census were a midwife, Frances Wall (still practising in 1851), and a cupper, James Dowding of Littleworth. By the time of the 1851 census, a medical botanist, Jesse Wood, was listed. In 1861, a "lecturer on magnetism", William Henry Chadwick, was recorded, together with his wife, described as a "lecturer on phrenology" at 10 Edwy Parade (where they had a visitor who was also a "lecturer on phrenology"). The 1871 census recorded an herbalist, Jane Robinson, and a medical herbalist, Daniel Davies, but there was no record of John Gardner, who was trading from 43 Northgate Street at this time (Figure 3.16).

As mentioned earlier, some historians have pointed out that trade directories 'tend on the whole to understate the size of the medical fringe,' because only those with fixed retail premises tended to be listed and even then, recording was sometimes erratic.[352] For example, the medical botanist Jesse Wood appeared in the 1851 census but did not appear in a trade directory until 1859, and the two herbalists recorded in the 1871 census had not appeared in the 1870 edition of *Kelly's Directory*, whereas John Gardner was listed. One 1856 trade directory listed an optician (G. Rimmell)[353], while an 1869 edition listed three medical herbalists (including Daniel Davies and John Gardner)[354],

[352] Marland, 'The Medical Activities,' p.417.
[353] Kelly (1856).
[354] Bretherton, *Bretherton's Almanac and Gloucester Directory* (Gloucester, 1869).

but only John Gardner was listed the following year (along with another optician, John Gouldar).[355] There was no listing for Robinson or Davies. The irregular practitioners listed in *Kelly's Directory* of 1870 (Table 3.8 below) all traded from fixed premises in and around the city centre.[356]

Figure 3.16 John Gardner's shop at 43 Northgate Street

Source: Copy of a photograph showing the entrance to the first Methodist church in Northgate Street, n.d. [from original dated pre-1877]. Gloucestershire Archives D3987/13 reproduced by kind permission of Gloucester Methodist Circuit.

Interestingly, these same directories do list some irregulars in Cheltenham, including galvanists, mesmerists and phrenologists.[357] Again, this suggests none were present in Gloucester, rather than them having been excluded either inadvertently or as editorial policy. Having said this, there were some omissions, such as the hygeist, Mr C. Chubb, who traded from premises at 7 Worcester Street in 1832[358] and the Botanical Dispensary that opened in Southgate Street in 1856 under the management of Dr H. Jones.[359] Brown believed that in Bristol 'the low number of unqualified practitioners

[355] Kelly (1870).
[356] Kelly (1870).
[357] Brown, 'The Providers of Medical Treatment,' p.313.
[358] *Gloucester Journal,* 4 August 1832.
[359] *The Gloucester Mercury*, 13 December 1856.

recorded may result partly from the methods of data collection'[360] and speculated as to whether 'Bristol had an unusually low number of irregular practitioners, and, if so, why.'[361] If Gloucester, as it appears, was a similar case it is conceivable that a low number of irregular practitioners was in fact normal.

Table 3.8 Irregulars in Gloucester, 1870

Forename's	Surname	Occupation	Address
George Frederick	Fox	Dentist L.D.S.	Clarence Street
Joseph Henry	Macy	Dentist	Frome Cottage, Stroud & Worcester Street
Adolphus	Quinton	Dentist	12 Eastgate Street
John	Gardner	Medical Botanist	43 Northgate Street
John	Gouldar	Optician	Southgate Street

Source: *Kelly's directory of the county of Gloucester* (London, 1870).

Occasionally glimpses of irregulars do appear in other sources; a press report of the Barton Fair of 1855 commented that '…the inevitable quack doctor, drove a roaring trade.'[362] Although associated with fairs and mops, a small number of these itinerant quacks were probably abroad in the city at any one time and as Brown concluded 'there were, no doubt, many others on the fringe of some form of medical practice.'[363] One such was a 'Dr Clifford,' who in 1828 described himself as a 'botanist' who 'may be consulted in the most obstinate diseases incident to the human frame, however secret or important,' and who could be consulted at a 'Mr. Randel's' in Southgate Street.[364]

Sometimes the activities of these irregulars drew press attention, usually when malpractice of some kind was alleged, as was the case when the *Gloucester Free Press & Weekly Advertiser* reported in the same year that:

> A quack doctor, named Thomas Morris, has been committed to trial by the coroner of Penkridge, charged with the manslaughter of Mr. Thomas Henshawe, a licensed victualler, and Joseph Day, a sheepshearer, and general farm-servant, both residents of Pankridge, who foolishly sought the impostor's advice, and partook of his deadly decoctions.[365]

Similarly, in 1859 an action was brought by the surgeon Robert Blagden against one John Burton. Charles Clutterbuck, another Gloucester surgeon, gave evidence for the

[360] Brown, 'The Providers of Medical Treatment,' p.313.
[361] *Ibid.*
[362] *Gloucester Journal*, 29 September 1855, p.3.
[363] Brown, 'The Providers of Medical Treatment,' p.303.
[364] *Gloucester Mercury,* 31 December 1828.
[365] *Gloucester Free Press & Weekly Advertiser,* 14 July 1855.

prosecution. The case revolved around Burton, who it was claimed was illiterate and 'a man without any education at all' having feloniously declared himself to have been practising medicine before 1 August, 1815 when he had in fact been a 'billy spinner' and 'had only gone "quacking" in the last ten or twelve years.'[366] The reasons Blagden gave for bringing the prosecution was 'to see his profession distinguished for its purity as well as skill' and 'to have the profession ridded of an improper character.'[367] What irked the medical man was not that Burton's practices were injurious (Blagden claimed to have no knowledge of him personally), but that Burton was not a gentleman. Such cases were not frequent and by far the most significant competition to regular doctors came from other doctors, chemists and druggists and retailers who sold medicines as a side-line to their main business. The latter included all of Gloucester's newspaper offices.

Newspapers had a long history as medicine vendors, Porter concluding that they 'were particularly significant as mouthpieces for proprietary medicines.'[368] Brown found that in eighteenth-century Bath, 'newspaper proprietors were important wholesale and retail vendors. In most cases, the printer was also the proprietor, and the medicines advertised were available from the printing office and from the distributors of the newspaper.'[369] Evidencing this, in 1815, the range of medicines stocked by one Gloucester printer, J. Roberts of Westgate Street (publisher of *The Glocester Herald*), rivalled that of any chemist and druggist (Appendix II). These vendors, who clearly stocked a comprehensive array of remedies, were not quacks, they were respectable retailers and likely were not regarded by customers as an alternative to regular medicine but as an adjunct to it in a way not dissimilar to supermarkets that sell over-the-counter healthcare products today. Rather than any great mid-nineteenth-century watershed, this trade continued into the twentieth century; a clear continuity from the early-modern epoch.

It is difficult to quantify numbers of medicine vendors in any systematic way because trade directories and census returns record only the principle trade(s) of the business or householder. Perfumers and hairdressers were to be found selling products

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[366] *Gloucester Journal,* 25 June 1859, p.3.
[367] *Ibid.*
[368] R. Porter, *Quacks, Fakers & Charlatans in English Medicine* (Stroud, 2000), p.54.
[369] P.S. Brown, 'The Venders of Medicines Advertised in Eighteenth-Century Bath Newspapers,' *Medical History*, Vol.19, No.4 (October 1975), p.352.

for skin diseases and hair loss, and jewellers (as noted earlier) sometimes doubled as opticians or dentists but could go unrecorded. Brown noted that 'some of the many hawkers of unspecified goods may have sold medicine and advice, or women described as nurses or midwives may have acted well beyond that capacity.'[370] In the early nineteenth century, medicines were not differentiated or defined by any regulatory requirements, nor were they seen as necessarily separate from food, dietary supplements, or cosmetics by the public. Tomkins pointed out how 'alcohol of all kinds and sugar were both used widely in the treatment of illness in the eighteenth century' and this situation continued well into the nineteenth.'[371] There was nothing intrinsically odd about buying medicines from a grocer or a street vendor, and advertisements for condiments, tea, and baby food show that these products were all sold by chemists and druggists and grocers alike. Porter and Porter found 'wherever money was to be made out of medicine, the opportunity was seized. Shoals of shopkeepers sold drugs, not least opiates and the score or two of nostrums advertised non-stop in the columns of provincial newspapers, newsagents providing the main retail outlet for them.'[372] One Gloucester chemist, Samuel Hayward, appeared in the 1861 census as a 'chemist and sauce manufacturer,' a sideline that eventually became his principal trade The presence of these part-time medicine vendors can sometimes be glimpsed from newspaper advertisements (which list them as stockists), or for example, an 1859 notice of removal for one William Harris, a boot and shoe manufacturer, which stated him also to be a 'Licensed Agent for Morison's Patent Medicines.'[373]

As well as the various strata of commercial medicine suppliers and therapists, there were the caring occupations and an unknown number of informal care providers. Although, as discussed earlier the decision was taken to exclude nurses and midwives from the census of suppliers, they were important providers of both formal and informal care, making a significant contribution to overall healthcare provision throughout the Age of Reform, and they will be discussed in chapter six. Overall, the body of evidence presented here does not provide any convincing evidence of a medical marketplace characterised by plurality, diversity, choice and competition. What has started to

[370] Brown, 'The Providers of Medical Treatment,' p.303.
[371] Tomkins, ''The Excellent Example of the Working Class,' p. 215.
[372] Porter and Porter, *Patient's Progress*, p.24.
[373] *Gloucester Mercury,* 26 February 1859.

emerge is, rather than a commercial free-for-all of multiple types of supplier, a stratified healthcare economy dominated by regular doctors and chemists and druggists.

3.6 Conclusion

Chapter one identified numerous lacunae relating to the medical marketplace model, including its failure to convincingly accommodate institution healthcare provision and a general lack of clarity surrounding the key features of the model (plurality, diversity, choice and competition). This chapter has shown that by the Age of Reform, institutions played a pivotal role in Gloucester's healthcare economy, both as significant suppliers of healthcare to the poor, and in facilitating the process of professionalisation within medicine; something that arguably contributed as much to 'the rise of the medical profession' as any therapeutic advances. From the 1840s, growth in the supply of healthcare in Gloucester was in institutional provision, not the commercial sector, with new eye, psychiatric and children's hospitals appearing and expansion of the Infirmary. Although the numbers of patients treated in institutions remained relatively small, all struggled to meet demand. We have seen how these bodies did not operate in any straightforward way according to the laws of supply and demand and their admissions criteria were designed to restrict eligibility, reflecting both the moral prejudices of governors and the clinical interests of their doctors, as much as patient need. Posts at institutions were of vital importance to aspiring medical men, both to launch a professional career and as a springboard into civic life. The most advantageous and therefore the most highly prized were at the Infirmary. Virtually all of Gloucester's medical men held an official post of some sort and there was a hierarchy attached to them. Securing such a post was facilitated by familial connections and professional bonds forged in training. As the century progressed, professional qualifications, education and attainment appear to have become more important to doctors' sense of self-identity and are suggestive of the process of professionalization at work. Institutions can thus be regarded as important structural features within Gloucester's healthcare economy, and the locus of medical professionalization – here new professional roles, that of the hospital consultant and the new medical specialist, free of the taint of quackery - were forged. This process was underway well before the regulatory reforms of mid-century that, as we have seen, have been accredited with the demise of the medical marketplace.

In the commercial arena of community healthcare, the picture is more complex but again unequivocal evidence of the existence of a medical marketplace has been shown to be lacking. Instead what emerges is a segmented, or stratified, healthcare economy. There were multiple healthcare providers – doctors, chemists and druggists, medicine vendors, and a smattering of 'irregulars,' some of whom were quacks, but whether their presence equated to plurality, the extent to which they competed with each other and with regular providers, and thus how much of a competitive threat they represented to orthodox medical men, is all questionable. Looking at the numbers of qualified doctors, although the main source of competition came from within their own ranks, Gloucester appears not to have been a place where this competition was so intense as to mean 'many who entered medical practice in this period [1820-1850] hovered for years between bare subsistence and bankruptcy.'[374] There is little compelling evidence here to substantiate Digby's claim that 'the principal challenge faced by general practitioners was an over-supply of regular, trained doctors in relation to effective demand for their services,' something she claimed 'was worsened by the competition of specialists, and by large numbers of alternative practitioners of varied kinds.'[375] Rather the evidence tends to support Porter's assertion that ''overcrowding'…was less an objective fact than the gripe of vulnerable practitioners trying to convince legislators to restrict professional entry or ban rivals.'[376] Although the number of both regular doctors and chemists and druggists appears to have increased markedly up to around 1840, thereafter it did not keep pace with population growth and even fell slightly around 1870.[377] By 1860, chemists and druggists had achieved near parity of numbers with medical practitioners, affirming their position as major suppliers of healthcare to the city. However, there is no evidence that this was a factor in arresting the number of doctors. With no obvious inverse correlation in their numbers, it is possible to imagine a different kind of relationship between doctors and chemists and druggists than one of intense rivalry. This topic will be explored further in chapter five.

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[374] Loudon, *Medical Care*, p.259.
[375] Digby, *The Evolution of British General Practice*, p.23.
[376] R. Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present* (London, 1997), p.351.
[377] The numbers of chemists and druggists identified in the census returns did continue to rise (from 17 in 1841 to 23 in 1871) but as a guide to the numbers of discrete, active, independent shops the trade directories are probably a more accurate guide.

In Gloucester, the number of medical practitioners per head of population appears to have been below the national average and very far below that seen in neighbouring Cheltenham, which had a very different socio-economic complexion. Although, as a measure of competition, number per head of population has been shown to be crude and flawed, broadly it does suggest that Gloucester lacked the large and expanding reservoir of fee-paying customers needed to sustain an increase in medical numbers. A similar scenario likely affected chemists and druggists. Gloucester's socio-economic complexion thus discouraged over-stocking. Turnover of both doctors and chemists and druggists was steady but not dramatic and once established, longevity was a noticeable feature. Although under-recording cannot be dismissed as a significant factor, Gloucester was certainly not a place in which, to use Crellin's words, 'the enormous problem of quackery,' was readily discernible.[378] Instead, it appears regular doctors and chemists and druggists dominated the supply of healthcare, supplemented by a number of other medicine vendors, particularly newspaper offices, which sold medicines as a sideline to their main business. Gloucester's medical men mainly resided in a cluster of proximate streets close to the city's principle medical institutions. A significant proportion of them were born in the city, or in the wider county. Chemists and druggists meanwhile congregated on the main thoroughfares in the retail quarter centred on The Cross. These were not therefore shady, backstreet operators but successful businesses occupying prime retail space. They mainly lived above their shops and many were born in the county and worked from the same premises for many years. This does not suggest quackery, but rather integration as an important community resource, something that will be explored in more detail in chapter five. Doctors and chemists and druggists each formed close-knit groups held together by personal as well as professional ties.

Taking these findings into account, Gloucester did not obviously display the characteristics of diversity, plurality, choice and competition indicative of a medical marketplace. Rather the healthcare economy was structured, stable and hierarchical, and dominated by a relatively small number of doctors and chemists and druggists; not in short an environment in which one might hear Porter's 'Babel of the medical

[378] J.K. Crellin, 'Pharmaceutical History and its Sources in the Wellcome Collections 1. The Growth of Professionalism in Nineteenth-Century British Pharmacy,' *Medical History*, Vol.11, No.3 (July 1967), p.223.

marketplace.'[379] More analysis is however needed to be sure of such conclusions, beginning by looking at healthcare advertising; surely the most commercialized arena of all, where evidence of diversity, plurality, choice and competition, should be easiest to find.

[379] Porter, *Quacks,* p.84.

Chapter Four – Advertisers

4.1 Introduction

The analysis undertaken in the preceding chapter failed to find compelling evidence of a medical marketplace characterised by diversity, plurality, choice and competition. Institutional healthcare was found to have been an area of growth and although institutions treated relatively small numbers of patients they played an important role in the medicalization of healthcare and the professionalization of medicine, which has been cited as a key factor in the demise of the medical marketplace. The second part of the chapter looked at community healthcare: general practitioners, chemists and druggists and irregular providers. It was shown that early in the nineteenth century regular doctors and chemists and druggists were the dominant suppliers and other providers were relatively scarce and confined to certain distinct niches. Gloucester was relatively under-supplied with doctors compared, for example, to Cheltenham and competition, both within the medical profession and from without, does not appear to have been as intense here as some of the literature suggests. Rather than a medical marketplace, the evidence pointed toward a stable and stratified healthcare economy. This chapter will build upon these findings by looking at the most overtly commercialised area of healthcare: advertising and the proprietary medicines industry. Again, the chapter is necessarily long, as a thorough and detailed analysis is needed that searches for evidence of diversity, plurality, choice and competition in an area where it would surely be expected to be manifest.

The notion that 'the quack remedy and self-dosing took money out of the pockets of doctors' borders on a truism.[1] The stereotype of the proprietary medicine buyer is of an ignorant and reckless self-diagnoser and self-doser, but the reality is that these medicines met real and legitimate needs. According to Richards:

> Very early on, the quacks showed the advertising industry how important it was to instil in consumers a renewable craving for more and more standardized objects. They discovered that advertising, far from creating false needs, must be grounded in real ones.

[1] S. King, *A Fylde Country Practice: Medicine and Society in Lancashire, circa 1760–1840* (Lancaster, 2001), p.71.

> The aim of patent medicine advertising was not to create need out of thin air, but to locate quite legitimate needs – in this case the care of the body – and redefine them.[2]

Chapter two discussed how the proprietary medicines trade blossomed concurrently with the rise of the provincial press and mass-market print advertising. Richards has claimed that 'patent medicine could not exist without advertising'[3] and this was a period in which:

> …any person in this country could sell and advertise practically any medicine he liked, could put in it whatever he pleased, could call it by any name he fancied and claim for it anything and everything he wished the public to believe. The public were likewise free to buy any drug or pharmaceutical preparation they wished, in any quantity, without restriction from the chemist or the necessity of a medical prescription.[4]

However, Mackintosh has argued that most proprietary medicine manufacturers 'were regarded by their contemporaries as respectable tradesmen who ran profitable, long-term, businesses without involvement in irregular practice, or they were regular practitioners.[5] By the eighteenth century, 'the level of marketing skill, the ingenuity of salesmanship, the quality of promotional imagination could be remarkably impressive.'[6] Porter, while labelling proprietary remedies as 'quack medicines', acknowledged that they were 'among the very first standardized, nationally marketed, brand-name products.'[7] Chapter two identified how proprietary medicine manufacturers were innovators, pioneering bulk-buy discounting, the use of illustration, and eye-catching headline slogans. In Young's view, 'patent medicine manufacturers blazed a trail which later makers of soaps and cereals and cigarettes would follow'[8] and Nevett similarly argued that 'medicine vendors may well be regarded as the pioneers of modern marketing, branding their products, advertising them widely, and distributing them over large areas of the country.'[9]

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[2] T. Richards, *The Commodity Culture of Victorian England: Advertising and Spectacle 1851-1914* (Stanford, CA, 1990), pp.202-203.
[3] *Ibid,* p.182.
[4] S. Holloway, 'The Regulation of the Supply of Drugs in Britain Before 1868' in R. Porter and M. Teich (eds), *Drugs and Narcotics in History* (Cambridge, 1995), p.86.
[5] A. Mackintosh, 'The Patent Medicines Industry in Late Georgian England: A Respectable Alternative to both Regular Medicine and Irregular Practice,' *Social History of Medicine*, Vol.30, No.1 (May 2016), p.26.
[6] N. McKendrick, 'George Packwood and the Commercialization of Shaving' in N. McKendrick, J. Brewer and J.H. Plumb, *The Birth of a Consumer Society: The Commercialization of Eighteenth-Century England* (London, 1982), p.147.
[7] R. Porter, *Quacks, Fakers & Charlatans in English Medicine* (Stroud, 2000), p.55.
[8] J. M. Young, 'Patent Medicines: An Early Example of Competitive Marketing,' *The Journal of Economic History*, Vol.20, No.4 (December 1960), p.656.
[9] Nevett, p.24.

The aim of this chapter is to establish what place these products occupied in Gloucester's healthcare economy and to consider whether, and if so, in what ways, they support the existence of a medical marketplace. The focus of attention will be on what insights advertising can offer to the core themes of this study: particularly evidence of diversity, plurality, choice and competition. The efficacy of these products will only be considered is so far as it explains the behaviour of customers. Whereas previous studies have examined aspects of medical advertising in the provincial press, this has not been with a view to reappraising the medical marketplace paradigm and in this respect, the chapter represents an innovative and important contribution to the historiography.[10] After a discussion of sources and methods, a sample survey of advertisements appearing in the Gloucester press are analysed, discussing firstly the volume of healthcare advertising and looking for evidence of any temporal change, seasonal variation, and patterns of distribution of healthcare advertisements within newspapers. Thereafter, the chapter focusses on advertising techniques to highlight the ways in which advertisements were targeted toward specific groups in what, it will be argued, was a highly segmented, stratified, healthcare economy.

4.2 Sources and methods

For this chapter, a combination of quantitative and qualitative analysis was used; an approach that has featured only rarely in the literature, which has often relied upon emblematic examples to illustrate specific points, as for example in the work of Cody.[11] The sample survey approach used, while not in this case employing any statistically robust random sampling methodology, makes it easier to chart developments in advertising over the period and to draw some generalisable conclusions.[12] Gloucestershire Archives hold a quite comprehensive collection of local newspapers, from which the sample was drawn, and these are listed in Table 4.1 below:

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[10] H. Barker, 'Medical Advertising and Trust in Late Georgian England,' *Urban History*, Vol. 36, No. 3 (December 2009), pp.379-398; P.S. Brown, 'The Venders of Medicines Advertised in Eighteenth-Century Bath Newspapers,' *Medical History,* Vol. 19, No. 4 (October 1975), pp.352-369; P.S., 'Medicines Advertised in Eighteenth-Century Bath Newspapers,' *Medical History*, Vol.20, No.2 (April 1976), pp.152-168; [10] L. M. Cody, '"No Cure, No Money," or the Invisible Hand of Quackery: The Language of Commerce, Credit, and Cash in Eighteenth-Century British Medical Advertisements,' *Studies in Eighteenth-Century Culture,* Vol. 28, No. 1 (1999), pp.103-130.

[11] *Ibid.*

[12] *Ibid*, p.103.

Table 4.1 Gloucestershire newspapers included in the sample survey

Title	Copies held	Medium/Location
City of Gloucester Guardian	Sep-Dec 1859	Microfilm/GA*
Gloucester and Cheltenham Standard	Sep-Oct 1832	Microfilm/GA
Gloucester City and County News	Sep-Nov 1863	Microfilm/GA
The Glocester Herald	1801-1828 (some years missing)	Microfilm/GA
Gloucester Journal	1815-1868	Microfilm/GA
Gloucester Mercury	Aug 1828 – Mar 1829	Microfilm/GA
Gloucester Mercury	1860, 1863, 1864, 1867	Microfilm/GA
Gloucester Free Press & Weekly Advertiser	1855-1860, 1862-1868	Microfilm/GA
Gloucestershire Chronicle	1833-1868	Microfilm/GA
Gloucestershire Times & General Advertiser	1855	Microfilm/GA

Source: Gloucestershire Archives, *Gloucestershire Newspapers: A guide to national & local newspapers and their holdings* (Gloucester, 2012).

From the above titles, a representative sample of advertisements appearing between 1814 and 1870 was taken, selected by a combination of two methods.[13] Firstly, the main sample comprised all advertisements appearing in a single edition of a newspaper at five-yearly intervals, covering the longest running titles from 1815 to 1870 (Table 4.2). This included the *Gloucester Journal, Gloucestershire Chronicle, Gloucester Mercury, Gloucester Free Press & Weekly Advertiser* and *The Glocester Herald*. This exercise involved the transcription of all healthcare-related advertisements appearing in 27 newspaper editions. For the most part, the same month was used each time for each publication, but this did vary over time according to how many and which titles were in print in that year.

[13] As mentioned earlier, advisements from 1814 were selected to compare contents before and after the 1815 Apothecary's Act.

Table 4.2 Main sampling frame

Publication (red font = not digitised)	Year	Month	Date of sampled issue (first issue in month)	Total healthcare adverts
Gloucester Journal	1870	January	1/1/1870	21
Gloucestershire Chronicle	1870	April	2/4/1870	8
Gloucester Mercury	1870	August	6/8/1870	13
Gloucester Journal	1865	January	7/1/1865	12
Gloucestershire Chronicle	1865	April	1/4/1865	14
Gloucester Mercury	1865	August	5/8/1865	22
Gloucester Journal	1860	January	7/1/1860	12
Gloucestershire Chronicle	1860	April	7/4/1860	22
Gloucester Mercury	1860	August	4/8/1860	17
Gloucester Journal	1855	January	6/1/1855	14
Gloucestershire Chronicle	1855	April	7/4/1855	13
Gloucester Free Press & Weekly Advertiser	1855	August	4/8/1855	0
Gloucester Journal	1850	January	5/1/1850	16
Gloucestershire Chronicle	1850	July	6/7/1850	9
Gloucester Journal	1845	January	4/1/1845	11
Gloucestershire Chronicle	1845	July	5/7/1845	9
Gloucester Journal	1840	January	4/1/1840	12
Gloucestershire Chronicle	1840	July	4/7/1840	17
Gloucester Journal	1835	January	3/1/1835	10
Gloucestershire Chronicle	1835	July	4/7/1835	5
Gloucester Journal	1830	June	3/6/1820	8
Gloucester Journal	1825	June	6/6/1825	7
The Glocester Herald	1825	November	26/11/1825	2
Gloucester Journal	1820	June	5/6/1820	6
The Glocester Herald	1820	August	19/8/1820	5
*Gloucester Journal**	1815	April	3/4/1815	8
The Glocester Herald	1815	August	5/8/1815	2
			TOTAL	**295**

A secondary sample (see Appendix III) was drawn from consecutive editions of *The Glocester Herald, City of Gloucester Guardian, Gloucester City and County News, Gloucester Free Press & Weekly Advertiser* and *Gloucester Mercury,* the earliest edition sampled being the *Glocester Herald* of 19 February 1814. Each time a new advertisement appeared it was included, those that simply repeated from a previous edition were not. The purpose of this approach was to boost the number of early

advertisements and those from minor newspapers to try to improve the diversity of the sample and increase the number and variety of products sampled. This rationale for this was to identify any differences in advertising content between newspapers (none was in fact found). Other publications that circulated in Gloucester but were published elsewhere were excluded from both samples. Examples included *The Western Daily Press* (established 1858) and the *Wilts & Gloucestershire Standard* (established 1837).

The sampled advertisements were deconstructed into their component parts, which were then transcribed into a database under a series of field headings. These comprised headlines, claims made for the product, pricing and discounts, use of repetition, use of patents as a claim to legitimacy, warnings of counterfeit products, use of graphics and illustrations, testimonials and lists of stockists. This approach was designed to enable thematic analysis, for as McKendrick recognized 'minute dissection reveals much that is lost in the more general surveys.'[14] The logistical effort involved in transcribing the contents in this way restricted the size of the sample, but enough advertisements were included for robust conclusions to be drawn.

Advertisements were accessed either in digitised form via the *British Newspaper Archive*, or where no digitised version was available, from microfiche copies held at Gloucestershire Archives. Methodologically, this approach is similar that taken in Brown's study of eighteenth-century Bath newspapers, but my sample included all health-related products and services, not just medicines, and thus, for example, dentists, books and pamphlets, and invalid food are represented. [15] This approach is in keeping with the core principle to adopt a holistic approach, including the broadest spectrum of choices available to customers.

Every surviving newspaper title published in Gloucester between 1815 and 1870 was represented in the sample. Of these, the earliest still circulating in the nineteenth century was the *Gloucester Journal* established in 1722.[16] An 1867 trade directory described the *Journal* as:

> …one of the oldest provincial Papers in the kingdom…It circulates through the entire county, and also extensively in the adjoining counties of Hereford, Worcester, Somerset,

[14] McKendrick, 'George Packwood,' p.147.
[15] Brown, 'Medicines Advertised,' pp.152-153.
[16] The paper was owned by the Raikes family. Robert Raikes (1736-1811) took over from his father in 1757 and used the paper as a vehicle to promote his Sunday School movement.

> Monmouth and Oxford, and is therefore a most eligible medium for advertisements. It is liberal in politics and is attached to the Church of England, though freely open to communications of other religious communities. Great attention is given to the political, news, and literary departments; while the reports of local events are made a prominent feature.[17]

The other main local newspaper was the *Gloucestershire Chronicle*, established in 1833, described by the same source as being 'extensively circulated amongst the Gentry, Clergy, Yeomanry, and Trading Classes, being distinguished by the fullness and variety of its general news. It is essentially a Family Newspaper.'[18]

In total, advertisements for 605 products were transcribed, representing 464 separate advertisements and 350 discrete products.[19] This sample was considered sufficient to allow both cross-sectional and longitudinal analysis (Table 4.2). While the number of newspaper editions sampled was considerably less (132 compared to 636), in terms of the number of products (350 compared to 302), the sample was broadly comparable to that of Brown.[20] As already mentioned, advertisements were included provided they claimed some form of health benefit or offered health-related advice.[21] 268 of the 464 advertisements were for at least one proprietary medicine[22], 39 were for printed material,[23] and 33 advertised some form of treatment, excluding dentistry as shown in Figure 4.1.

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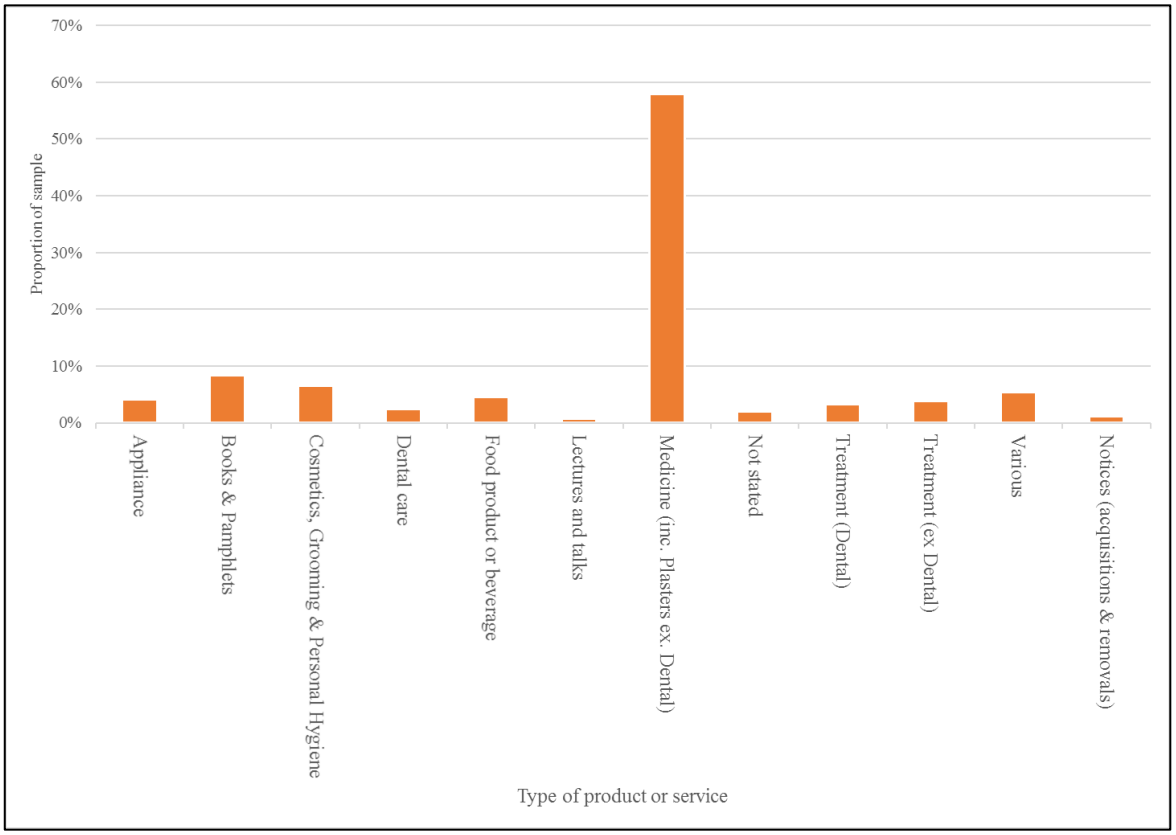
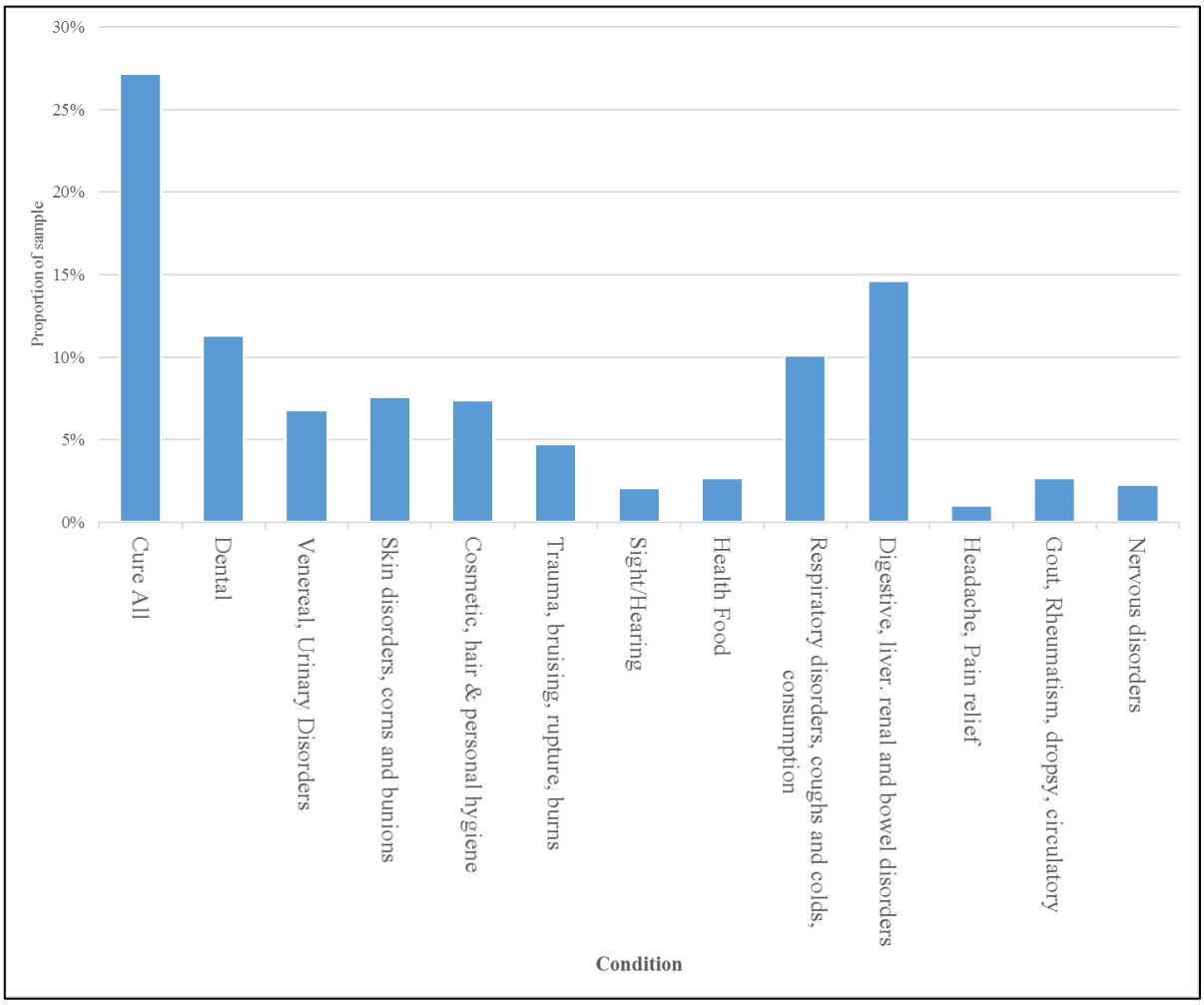
[17] [Unknown], *Gloucester Directory,* ([unknown], 1867).
[18] *Ibid.*
[19] Some advertisements were for multiple products and in the first sampling method some advertisements for the same product(s) were transcribed from different editions.
[20] Brown, 'Medicines Advertised,' pp.152-153.
[21] Some products advertised as being stocked by chemists and druggists, but which did not claim specific health benefits were not included, for example tea and tobacco. This approach broadly resembles that used by P.S. Brown who also found that 'occasionally it was difficult to decide whether a preparation was a cosmetic or a medicine; if a medicinal use was mentioned…the product was included' - Brown, 'The Venders of Medicines,' p.352.
[22] Excluding dental and cosmetic remedies.
[23] Book, pamphlet, or newspaper.

Figure 4.1 Composition of advertisement sample



In terms of the conditions the products in the sampled advertisements claimed to treat, the largest proportion (27 per cent) can be categorized as general cure-alls, while many others were cure-all products focussed upon a discrete system, e.g. a digestive, respiratory or nervous cure-all. Categorizing products that claimed to treat such a disparate array of conditions is problematic and inevitably a somewhat subjective exercise, but broadly the advertisements can be divided as shown below in Figure 4.2.

Figure 4.2 Composition of sample survey of advertisements by condition[24]



After cure-alls, remedies for digestive, renal, liver and bowel disorders were the next largest group (15 per cent); not perhaps surprising as most of these medicines, if they contained any active ingredient, were emetics or laxatives. They were followed by dental products and services (11 per cent).

In addition to qualitative and quantitative analysis of the advertisements themselves, some limited comparison of the volume of healthcare advertisements with those for other products and services was undertaken. This presented considerable difficulties due to the volumes involved and consequently, due to time constraints, could only be undertaken by comparing a specific month (January) of a specific source

[24] Includes only products, not literature, advice or treatment.

(the *Gloucester Journal*) in different years. There consequently remains scope for further analysis in this area.

4.3 Analysis of healthcare advertising

It has been said that 'the great paradox of the patent medicine system is that they existed both outside of and within mainstream medicine.'[25] As discussed in chapter two, patent, or proprietary, medicines were a ubiquitous feature of nineteenth-century healthcare; even pharmaceutical chemists sold them. For example, in Gloucester William Stafford, who became a pharmaceutical chemist in the 1850s, was listed as a stockist of amongst others, *Kearsley's Widow Welch's Pills, Dr. John Armstrong's Liver and Antibilious Pills, Ford's Pectoral Balsam of Horehound, Church's Cough Drops and Pectoral Pills* and *Dr. Jacob Townsend's American Sarsaparilla.* To regard them as entirely separate from prescription drugs would be misguided, not least because, as chapter five will show, customers self-medicated with prescription drugs, domestic remedies and proprietary medicines alike. Chemists and druggists sold proprietary medicines and dispensed medical prescriptions and it is likely customers saw the two as interchangeable options, rather than alternatives to each other. Reputable chemists and druggists, the likes of William Stafford, profited from their close links with the medical profession and enjoyed a position of trust in their communities. If proprietary medicines were all dangerous rubbish, as the medical establishment maintained, it is difficult to see why these established, trusted, businesses would continue to sell them over many decades. These products cannot be dismissed as quackery, foisted upon a vulnerable, undiscerning and cost-conscious public; they clearly had more to offer than this and only by identifying the true reasons for their appeal can their place in the healthcare economy be properly understood.

Surprisingly, 'despite the existence of some valuable research on medical advertising, we still know far too little about the relationship between advertising and the consumption of medical goods.'[26] According to Alexander and Akehurst, the period before 1850 has been treated as 'part of some primordial retail swamp'[27] and Barker

[25] Richards, p.183.
[26] Barker, 'Medical Advertising,' p.380.
[27] N. Alexander and G. Akehurst , 'Introduction' in N. Alexander and G. Akehurst (eds), *The Emergence of Modern Retailing, 1750-1950* (London, 1998), p.7.

highlighted how historically 'our understanding of the relationship between seller and buyer is limited'[28] and 'little attention has been paid to the reputation of inanimate objects, such as branded products, or in the context of individuals advertising their services in print.'[29] The attention of historians has often been directed toward the contribution of proprietary medicine manufacturers to the evolution of the modern advertising industry[30], or in popular histories, to the antics of the flamboyant personalities involved as 'evidence' of the Victorian public's boundless credulity. The sustained and vociferous complaints and warnings disseminated by the nineteenth-century medical establishment furnished copious material for the latter, but these sources are partial and misleading. Consequently, the relationship between proprietary medicines and orthodox medicine is still not well understood and it is possible that, rather than being viewed as an alternative to regular medical advice, they were peripheral or complementary products, more akin to today's herbal supplements.

Most proprietary medicine manufacturers were not medical heretics and tried to position their products within the orbit of mainstream medicine. Often their advertisements boasted of the proprietor's medical qualifications or appealed to orthodox medical theory in describing their product's efficacy. Young observed how 'with respect to orthodox medicine, patent medicine promoters were ambivalent. They condemned the regular doctor's barbarous methods, his exorbitant fees, his secret Latin prescriptions, his high degree of failure. Yet they sought a sort of respectability by pretending to medical degrees they did not possess.'[31] Frequently too, they appropriated the names of the great and the good of the profession, past and present, to legitimise their products and emphasised how their local agents were 'respectable medicine vendors.'

What customers thought about these remedies is difficult to establish as few left any explanation of why they bought them and Condrau's observation that 'the patient's point of view remains enigmatic' is nowhere more pertinent than in relation to the

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[28] Barker, 'Medical Advertising,' p.381.
[29] *Ibid*, p.383.
[30] For example, L. De Vries, *Victorian Advertisements* (London, 1968), D. Hindley and G. Hindley, *Advertising in Victorian England 1837-1901* (London, 1972), W.H. Helfand, J. Ittmann, I.H. Shoemaker, *Health for Sale: Posters from the William H. Helfand Collection* (New Haven, CT, 2011).
[31] Young, 'Patent Medicines,' p.654.

proprietary medicines industry.[32] The volume of sales alone confirms their role in Britain's healthcare economy was significant.[33] Although Brown warned that 'the medicines advertised in newspapers may give a biased sample of the whole range of proprietary medicines available to the public,' they are nevertheless a rich source of information and in the absence of first-hand testimony from customers, provide the best opportunity to understand the appeal of proprietary medicines.[34]

Throughout the Age of Reform, the press (ironically, as newspaper offices were one of their principle outlets) regurgitated medical warnings of the dangers posed by proprietary medicines and unqualified stockists. For example, an article that appeared in the *Gloucester Journal* in 1854 under the heading 'The Puff Direct,' lamented how 'the treatment of public gullibility has gone through as many changes as can be found in the history of any bodily disease. Quack doctors used to ride about on painted ponies: now they publish three hundred cures at once from grateful patients, and they employ as many men in a public shop, perpetually doing up pills.'[35] Such evidence has led to negative stereotyping of consumers. Cody, for example, concluded that 'it would seem that quack ads were aimed at the lower and middle reaches of society, groups particularly eager to make their way in the new marketplace and public sphere, but especially easily duped by lotteries and other risky schemes.'[36] Porter and Porter meanwhile suggested 'resort to such nostrums left little mark in letters or diaries, presumably because people were ashamed to admit to their vanity or gullibility.'[37] It is easy, with the benefit of hindsight, to regard those who purchased proprietary medicines as fools, but as E.P. Thompson warned, 'our only criteria of judgement should not be whether or not a man's actions are justified in the light of subsequent evolution' and certainly the 'evidence' is open to interpretation.[38]

The sophisticated language used in much proprietary medicine advertising, the references to the medical pantheon, and even the fact that advertisements were placed in

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[32] F. Condrau, 'The Patient's View Meets the Clinical Gaze,' *Social History of Medicine,* Vol. 20, No.3 (2007), p.529.
[33] Barker, 'Medical Advertising,' p.383.
[34] Brown, 'Medicines Advertised,' p.157.
[35] *Gloucester Journal,* 15 July 1854, p.3.
[36] Cody, p.121.
[37] D. Porter and R. Porter, *Patient's Progress: Doctors and Doctoring in Eighteenth-century England* (Cambridge, 1989), p.48.
[38] E.P. Thompson, *The Making of the English Working Class.* Penguin edition (London, 1980), p.12.

high-brow and popular newspapers alike, suggests these products were aimed at least in part at educated readers, setting them apart from the nostrums of the fairground quack. This is not evidence that the working-classes did not buy them, for as Golden noted, 'the first nationwide report on literacy in nineteenth-century England, published in 1840…notes that 67 per cent of males and 51 per cent of females were literate. The same census conducted in 1851 indicates that 69.3 per cent of males and 54.8 per cent of females in the whole nation were literate.'[39] However, it does suggest that the more erudite of these advertisements targeted a middle-class readership. King has argued convincingly that 'there is no doubt at all that middling families used quacks,' and this also appears true of proprietary medicines.[40]

For whatever reason, proprietary medicines had genuine and widespread appeal. Sales seemed impervious to the criticism reigning down from the medical establishment and some proprietors became rich and respected men.[41] It has been suggested that 'by any reckoning the English public bought more potions than it did legitimate drugs, and more pills per capita than any other nation in Europe. The makers of Beecham's Pills sold a million pills a day. Only alcohol was more popular and more widely available.'[42] Sales volumes alone testify to the importance of these products in the healthcare economy and to open virtually any Victorian newspaper is to be confronted by columns of advertisements for pills, ointments, oils, trusses and pamphlets. Mackintosh has estimated that 'something of the order of two million bottles or boxes of patent medicines were being sold annually in England and Wales by 1810.'[43] The ubiquity and influence of proprietary medicine advertising led Richards to conclude that 'writing a history of Victorian commodity culture without examining these advertisements in detail would be like writing literary criticism about books that one has not bothered to read.'[44] Bartrip has said that 'no reader of the Victorian press could avoid the plethora

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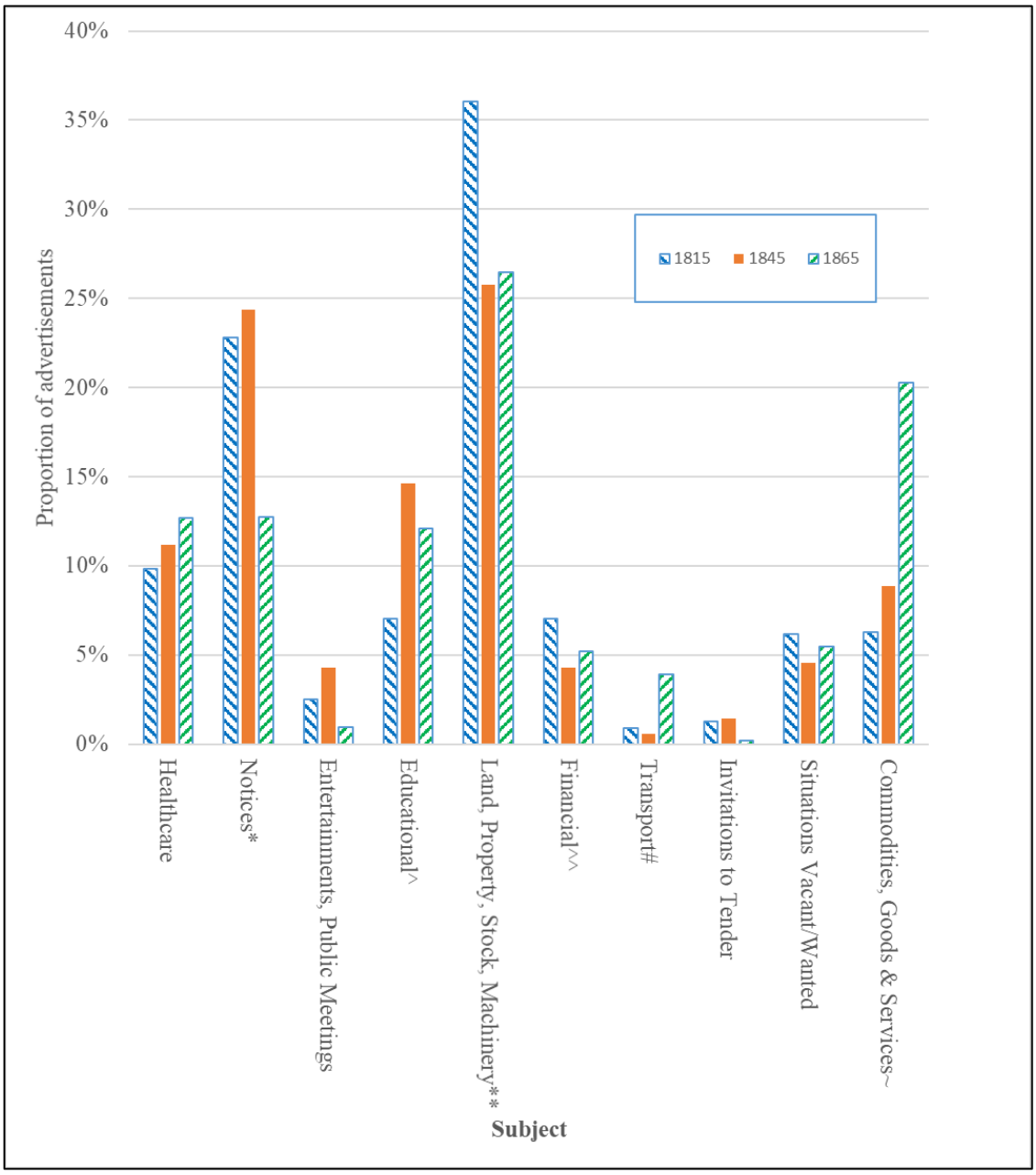
[39] C. J. Golden, *Posting It: The Victorian Revolution in Letter Writing* (Gainesville, FL., 2009), pp.68-69.
[40] King, *A Fylde Country Practice,* p.54.
[41] See for example: V. Holloway, *The Mighty Healer: Thomas Holloway's Victorian Patent Medicine Empire* (Barnsley, 2016); A. Blakeman, 'George Handysides: The Life & Times of the Little Known Newcastle Medicine Man,' *The Antique Bottle and Glass Collector Magazine.* http://www.glswrk-auction.com/mc28.htm [Date accessed: 5 October 2010]; R. Porter, ''Quackery' and the 18th-Century Medical Market' in R. Cooter (ed.), *Studies in the History of Alternative Medicine* (London, 1988), pp.1-27.
[42] Richards, p.172.
[43] Mackintosh, p.29.
[44] Richards, p.9.

of advertisements for products such as 'Du Barry's Delicious Health-Restoring Revalenta Aribica.'[45] Ueyama similarly described how 'the medical marketplace of this period abounded with both the patent medicines and "secret remedies" of the pharmaceutical manufacturers as well as with a plethora of technological devices similarly designed to reverse illnesses and produce health.'[46]

Advertisements for healthcare products and services accounted for a significant proportion of total advertising space in Gloucester newspapers throughout the Age of Reform. Figures 4.3 shows a breakdown of advertisements appearing in the *Gloucester Journal* during the month of January at three points: 1815, 1845 and 1865. As can be seen, healthcare advertisements increased as a proportion of all advertisements from 10 per cent in 1815, to 11 per cent in 1845 and 13 per cent in 1865. These figures suggest that the significant changes occurring in Gloucester described in chapter three had remarkably little impact upon the amount of healthcare advertising in the press as a share of overall advertising, or in terms of the overall number of advertisements, which also increased as more advertising space became available. Given the scientific progress of medicine in this period and the sustained antipathy of doctors this is in itself a significant finding, for these factors appear to have made little impression upon demand. What also stands out from these figures is the increase in non-healthcare related advertisements for commodities, goods and services over the period, from 6 per cent of advertisements in 1815 to 9 per cent in 1845 and 20 per cent by 1865. This point is important when looking at the evolution of advertising techniques discussed shortly.

[45] P. Bartrip, 'Quacks and Cash,' *History Today*, Vol.40, No.9 (September 1990), p.46.
[46] T. Ueyama, *Health in the Marketplace: Professionalism, Therapeutic Desires, and Medical Commodification in Late-Victorian England* (Palo Alto, CA), p.4.

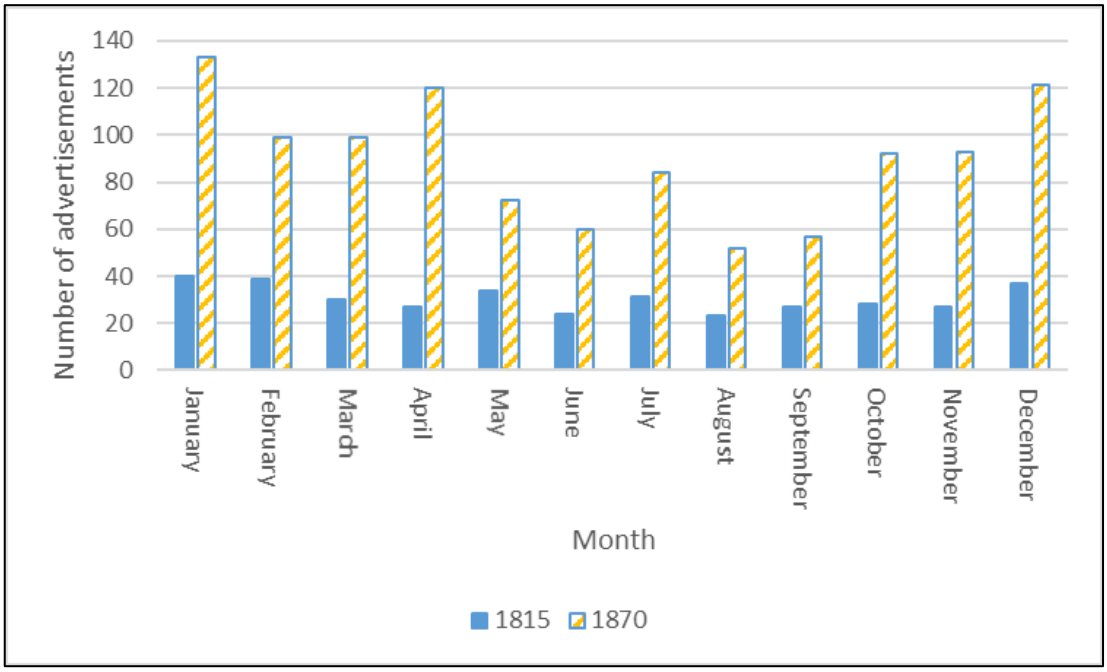
Figure 4.3 Advertisements appearing in the Gloucester Journal in the month of January by theme



*Includes legal, elopements, enclosures, petitions, notices to creditors (bankruptcies and deaths), lost/stolen and found, dividends, certificates, game, business removals, start-ups and partnerships, official meetings.
^Includes schools & colleges, tuition, lecturers (including medical).
**Includes land, property, business premises, bankrupt stock, tolls, timber, crops, fodder, farm and industrial machinery, and live/dead stock for sale, to let, or wanted.
^^Includes banks, insurance companies, shares, accounts, annuities, mortgages and lotteries.
#Includes shipping, coach, cart, railway service timetables, and tariffs.
~Includes veterinary services, books, pamphlets, magazines (non-medical), printing and stationery supplies, commodities (ex. agricultural), food and beverages, cloth and clothing, furniture, home décor and appliances, cosmetic and grooming products.

Figure 4.4 below shows that the absolute volume of advertisements for healthcare products and services increased significantly between 1815 and 1870. In 1815, the number of advertisements in a month (comprising either four or five weekly editions) peaked at 40 in January, while in 1870 it peaked at 133, again in January. This dramatic increase reflected growth in the overall number of advertisements, facilitated by a doubling in size of the *Gloucester Journal* from four to eight pages in the intervening period. Seasonality was found to affect the number of advertisements in both years, unsurprisingly peaking in the winter months, but with less explicable peaks in May and July in 1815, and April and July in 1870. Although overall, advertisements for healthcare products and services, particularly those for proprietary medicines, appeared in high volumes throughout the year in both, the degree of seasonal variation was noticeably more marked in 1870 than in 1815. The reasons for this are unclear, but it may be symptomatic of a more sophisticated use of advertising by manufacturers attuned more to seasonal fluctuations in demand.

Figure 4.4 Volume of healthcare advertisements* appearing in the Gloucester Journal in 1815 and 1870

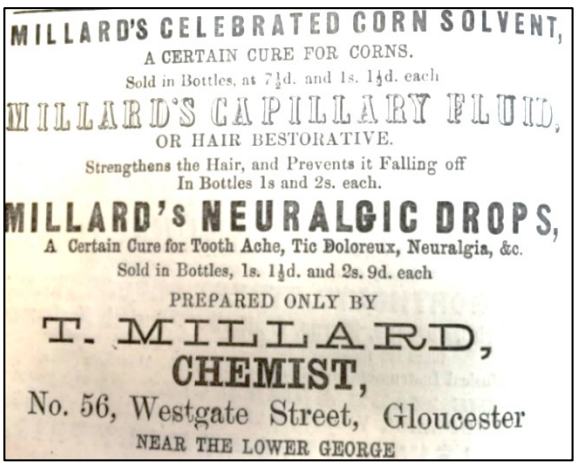


*Includes medical books but excludes cosmetics and food products not professing any health benefits and public notices/situations vacant relating to healthcare institutions.

Major players in the market, such as *Holloway's Pills* and *Ointment*, *Dr Solomon's Cordial Balm of Gilead*, *Dinneford's Pure Fluid Magnesia*, or *Marshall's Universal Cerate*, consistently occupied front-page space in the Gloucester press,

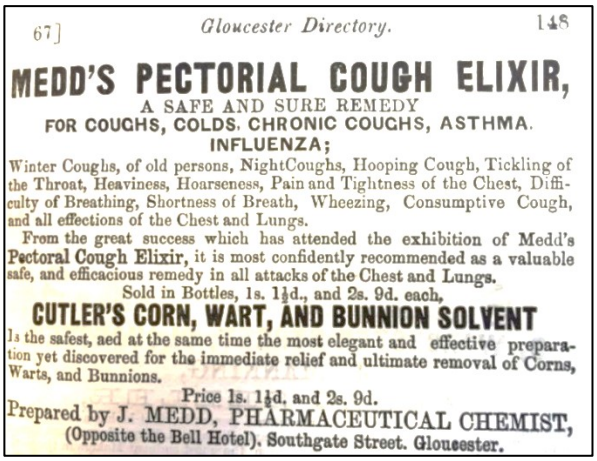
sometimes over a period of decades. In 1814, an advert for a Dr A. Lamert, which appeared on the front page of *The Glocester Herald,* exceeded 2,000 words in length.[47] This contradicts somewhat Loeb's contention that 'before mid-century advertisements were small, confined to the back pages and carried only by a few Victorian periodicals.'[48] In fact, fiscal policy encouraged longer advertisements, as a flat rate levy was charged regardless of length (3s 6d per item until 1833 when it was reduced to 1s 6d).[49] Contrary to Loeb's findings, it was well into the nineteenth century before advertisements for medicines (along with other household products) migrated to dedicated advertising sections in the back pages of provincial newspapers and then this was most likely due to evolving newspaper practices with more front-page space allocated to news and more local content being included.

Advertisements for healthcare products made locally were rare compared to those of the big, London-based, manufacturers. Among the few local products to appear in the sample were *Beetham's Corn and Bunion Plaster* and *Beetham's Hair Fluid*, produced in Cheltenham by the firm of Beetham and Company, and *Sydenham's Antibilious Aperient*, prepared by J. Rees, again of Cheltenham. Two examples of advertisements for Gloucester-made products are shown in Figure 4.5.


MILLARD'S CELEBRATED CORN SOLVENT,
A CERTAIN CURE FOR CORNS.
Sold in Bottles, at 7½d. and 1s. 1½d. each
MILLARD'S CAPILLARY FLUID,
OR HAIR RESTORATIVE.
Strengthens the Hair, and Prevents it Falling off
In Bottles 1s and 2s. each.
MILLARD'S NEURALGIC DROPS,
A Certain Cure for Tooth Ache, Tic Doloreux, Neuralgia, &c.
Sold in Bottles, 1s. 1½d. and 2s. 9d. each
PREPARED ONLY BY
T. MILLARD,
CHEMIST,
No. 56, Westgate Street, Gloucester
NEAR THE LOWER GEORGE

Source: [Unidentified] *Gloucester Directory* (unknown, 1867) GA GAL/K1

[47] *The Glocester Herald,* 23 July 1814, p.1.
[48] L. A. Loeb, *Consuming Angels: Advertising and Victorian women* (Oxford, 1994), p.7.
[49] Hindley and Hindley, p.10.



67] *Gloucester Directory.* 148

MEDD'S PECTORIAL COUGH ELIXIR,

A SAFE AND SURE REMEDY

FOR COUGHS, COLDS, CHRONIC COUGHS, ASTHMA, INFLUENZA;

Winter Coughs, of old persons, NightCoughs, Hooping Cough, Tickling of the Throat, Heaviness, Hoarseness, Pain and Tightness of the Chest, Difficulty of Breathing, Shortness of Breath, Wheezing, Consumptive Cough, and all effections of the Chest and Lungs.

From the great success which has attended the exhibition of Medd's **Pectoral Cough Elixir**, it is most confidently recommended as a valuable safe, and efficacious remedy in all attacks of the Chest and Lungs.

Sold in Bottles, 1s. 1½d., and 2s. 9d. each,

CUTLER'S CORN, WART, AND BUNNION SOLVENT

Is the safest, aed at the same time the most elegant and effective preparation yet discovered for the immediate relief and ultimate removal of Corns, Warts, and Bunnions.

Price 1s. 1½d. and 2s. 9d.

Prepared by J. MEDD, PHARMACEUTICAL CHEMIST,

(Opposite the Bell Hotel), Southgate Street. Gloucester.

Source: [Unidentified] *Gloucester* Directory (1867) GA GAL/K1

Figure 4.5 Advertisements for Millard's Neuralgic Drops and Medd's Pectorial Cough Elixir, 1867

Cost was probably a factor in this state of affairs, as newspaper advertising space was expensive and therefore, as Anderson explained, although 'many pharmacies produced their own proprietary remedies, which could be very profitable,…these were mainly limited to their own locality, so the products were there they just were not advertised.'[50] Evidence that local chemists were creating their own nostrums was found in a medical recipe book attributed to the Gloucester chemist Rose and Son and dating from c.1853, which contained generic recipes for 'cough drink,' 'injection for gonorrhoea,' 'balsam mixture,' and 'cold cream,' alongside ones for *Daffy's Elixir, Godfrey's Cordial, Hooper's Pills* and *Steer's Opodeldoc.*[51] In addition to medicines, Rose's also made veterinary products, perfume, beverages and condiments, dentifrice, hair care products, household cleaning products, and inks. Nevertheless, overall this was a market dominated by big national suppliers, who were important both as a source of revenue for the local press and as major suppliers of healthcare products to Gloucester's citizens. Analysis of advertising volumes can yield only limited information about the appeal of these products and about who might have bought them - for this, is necessary to look at the content and visual appearance of the advertisements themselves.

[50] M.H. Jepson, 'From Secret Remedies to Prescription Medicines: A Brief History of Medicine Quality' in S. Anderson (ed.), *Making Medicines: A Brief History of Pharmacy and Pharmaceuticals* (London, 2005), p.231.

[51] Photocopy of a prescription book belonging to [Charles] Rose's Pharmacy, Gloucester, n.d. c.1853, Gloucestershire, GA, Rose family of Gloucester, pharmacists, MS, D5529/1.

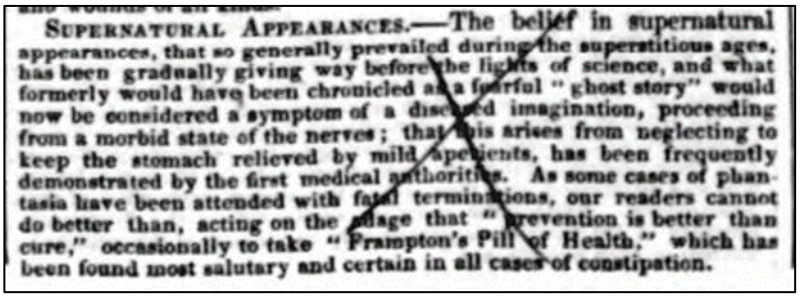
4.4 Advertising techniques

As mentioned in the introduction to this chapter, the longevity of many proprietary medicines suggests they had more to offer the public than simply 'puff,' but whether they represented genuine competition to other healthcare suppliers is less clear. The evidence presented in the last chapter appears to suggest the public recognized the value of regular doctors. However, there were also those excluded from accessing their services, and others who consciously rejected their offering. These were the people for whom alternatives might be most attractive. Proprietary medicine manufacturers had a keen sense of who these people were and targeted their advertising toward them with sophisticated and tailored messages. This section looks at the techniques used to reach these customers, comprising a series of thematic discussions covering trust and legitimacy, testimonials, counterfeiting, pricing, and segmentation in the market.

According to Young, proprietary medicine manufacturers 'realized that the first requirement of success was to be known. Thus, the quantity of advertising was important. Distinctive names printed in distinctive type induced customer familiarity.'[52] They were early adopters of banner headlines, memorable catchphrases and later illustrations, but at the start of the Age of Reform, before the emergence of printing technologies capable of reproducing high-quality illustrations and graphics, like all advertisers they relied upon narrative. At this time, 'advertisers…were still fumbling in the dark. Some of them thought that mere repetition was enough, and that it helped to sell their product if they simply printed its name over and over again on the same page.'[53] This was a simple technique, but its ubiquity suggests it was effective and as McKendrick pointed out, 'repetitive imprinting remorselessly pursued was, and is, the hallmark of the successful advertiser.'[54] Thomas Holloway, one of most successful Victorian advertisers, relied heavily on this technique, using it in conjunction with memorable phrases such as "All May Be Cured!!", "The Friend of All!!" and "The Miraculous Remedy!!", although he was overshadowed in this regard by Thomas Beecham's "Worth a Guinea a Box". Another technique favoured by Holloway was to supplement his front-page advertisement with a notice discretely inserted amongst the

[52] Young, p.654.
[53] J. Laver, *Victorian Advertisements* (London, 1968), p.6.
[54] McKendrick, 'George Packwood,' p.152.

news columns, presumably to catch the eye of readers who might otherwise ignore the adverts: something adopted by others such as *Frampton's Pill of Health* below.[55]

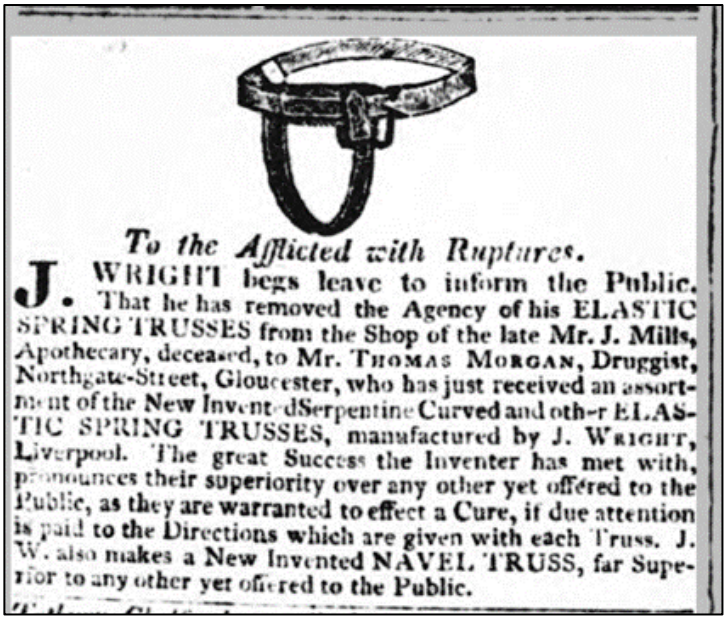


SUPERNATURAL APPEARANCES.—The belief in supernatural appearances, that so generally prevailed during the superstitious ages, has been gradually giving way before the lights of science, and what formerly would have been chronicled as a fearful "ghost story" would now be considered a symptom of a disordered imagination, proceeding from a morbid state of the nerves; that this arises from neglecting to keep the stomach relieved by mild aperients, has been frequently demonstrated by the first medical authorities. As some cases of phantasia have been attended with fatal terminations, our readers cannot do better than, acting on the adage that "prevention is better than cure," occasionally to take "Frampton's Pill of Health," which has been found most salutary and certain in all cases of constipation.

Figure 4.6 Advertisement for Frampton's Pill of Health, 1840[56]

Source: *Gloucestershire Chronicle,* 4 July 1840, p.4. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

By 1815, illustrations of a primitive sort were starting to be used in provincial newspaper advertising, an early example being the advertisement for *J. Wright's Elastic Spring Trusses* in Figure 4.7 below.



To the Afflicted with Ruptures.

J. WRIGHT begs leave to inform the Public, That he has removed the Agency of his ELASTIC SPRING TRUSSES from the Shop of the late Mr. J. Mills, Apothecary, deceased, to Mr. THOMAS MORGAN, Druggist, Northgate-Street, Gloucester, who has just received an assortment of the New Invented Serpentine Curved and other ELASTIC SPRING TRUSSES, manufactured by J. WRIGHT, Liverpool. The great Success the Inventer has met with, pronounces their superiority over any other yet offered to the Public, as they are warranted to effect a Cure, if due attention is paid to the Directions which are given with each Truss. J. W. also makes a New Invented NAVEL TRUSS, far Superior to any other yet offered to the Public.

Figure 4.7 Advertisement for J. Wright's Elastic Spring Trusses, 1815

Source: *Gloucester Journal,* 13 March 1815, p.1. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

Even rudimentary illustrations like this were difficult and expensive to reproduce at this time and the only other advertisers to use them regularly in the Gloucester press

[55] In this case the main advertisement had appeared on page 1.

[56] Why this advertisement was crossed through on the original image is unknown.

were insurance companies (reproducing their coats-of-arms). Illustration remained a rarity before the middle of the nineteenth century. When the technology improved in the 1860s *Holloway's Pills* advertisements started to display the trademark healer figure shown in Figure 4.8.

Figure 4.8 Detail from an advertisement for Holloway's Pills, 1865

Source: *Gloucestershire Chronicle,* 1 April 1865, p.7 Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

At this time illustrations quickly became commonplace and healthcare advertisers were matched in terms of the prominence, size, complexity of design, and overall visual impact by drapers, condiment manufacturers, brewers, and insurance companies. This is illustrated by Figure 4.9 dating from 1865, the same year as Holloway's illustration above.

Figure 4.9 Examples of evolution in advert design by 1865

Source: *Gloucester Journal*, 8 April 1865, p.3 Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

These advertisements, some placed by local businesses, eschewed the dense, verbose text still being used by many proprietary medicine manufacturers, in favour of short, succinct sentences combined with visually attractive lettering and illustration. The new wave was much more recognisably modern in its presentation and by 1870 much healthcare advertising was stale and unoriginal by comparison, was infrequently refreshed, and still using the smallest font possible. With few exceptions, looking at this issue through the prism of the Gloucester press, basic techniques of proprietary medicine advertising did not evolve significantly between 1815 and 1870, despite, as has been seen, their continuing to remain numerically significant. The reasons for this are unclear, but it does appear that proprietary medicine manufacturers decided for whatever reason not to invest in expensive techniques at least when advertising in the provincial press. In contrast, Figure 4.10 shows that when advertising in trade directories, some took a more ambitious approach, using decorative scrolling, illustration and embossed lettering. The doldrum in newspaper advertising did not last long and later firms such as Beecham's were again at the forefront of innovation: a turn-around that coincided with a six-fold increase in annual sales of proprietary medicines during the second half of the nineteenth century.[57]

[57] S. Anderson (ed.), *Making Medicines: A Brief History of Pharmacy and Pharmaceuticals* (London, 2005), Plate 19.

82 *Gloucester Directory.* [1867

PERSONAL ELEGANT REQUISITES

UNDER THE PATRONAGE OF ROYALTY.

AND THE ARISTOCRACY OF EUROPE.

ROWLANDS' MACASSAR OIL,

Of unparalled success during the last sixty years in promoting the Growth, Restoring and Improving the Human Hair.

It prevents Hair from falling off or turning grey, strengthens weak Hair, cleanses it from scurf and dandriff, and makes it beautifully soft, pliable, and glossy. In the growth of

THE BEARD, WISKERS, AND MUSTACHIOS,

it is unfailing in its stimulative operation. For Children it is especially recommended as forming the basis of a beautiful Head of Hair, while its introduction into the nursesy of ROYALTY, and the numerous Testimonials constantly received of its efficacy, afford the best and surest proofs of its merits.—Price 3s. 6d., 7s.; Family Bottles (equal to four small), 10s. 6d., and double that size, 21s.

ROWLANDS' KALYDOR,

AN ORIENTAL BOTANICAL PREPARATION,

For Improving and Beautifying the Complexion & the Skin.

This Royally-patronised and Ladies'-esteemed Specific exerts the most soothing, cooling, and purifying action on the skin, eradicates *Freckles*, *Tan*, *Pimples*, *Spots*, *Discoloration*, and other *Cutaneous Visitations*,

And Renders the Skin Soft, Clear, and Blooming.

During the heat and dust of summer, the frost and bleak winds of winter, and in cases of sunburn, stings of insects, or incidental inflammation, its virtues are universally acknowledged.—Price 4s. 6d, and 8s. 6d., per bottle.

WHITE AND SOUND TEETH.

Are indispensible to PERSONAL ATTRACTION, and to health and longevity by the proper mastication of food.

ROWLANDS' ODONTO,

OR PEARL DENTIFRICE,

COMPOUNDED OF ORIENTAL INGREDIENTS, IS OF INESTIMABLE VALUE IN PRESERVING AND BEAUTIFYING THE TEETH, STRENGTHENING THE GUMS.

And in giving a DELICATE FRAGRANCE TO THE BREATH. It eradicates Tartar from the Teeth, removes spots of incipient decay, and polishes and preserves the enamel, to which it imparts a PEARL-LIKE WHITENESS.—Price 2s. 9d. per Box.

Sold by A. ROWLAND & SONS, 20, Hatton Garden, London, and by Chemists and Perfumers.

☞Ask for "ROWLANDS'" Articles.

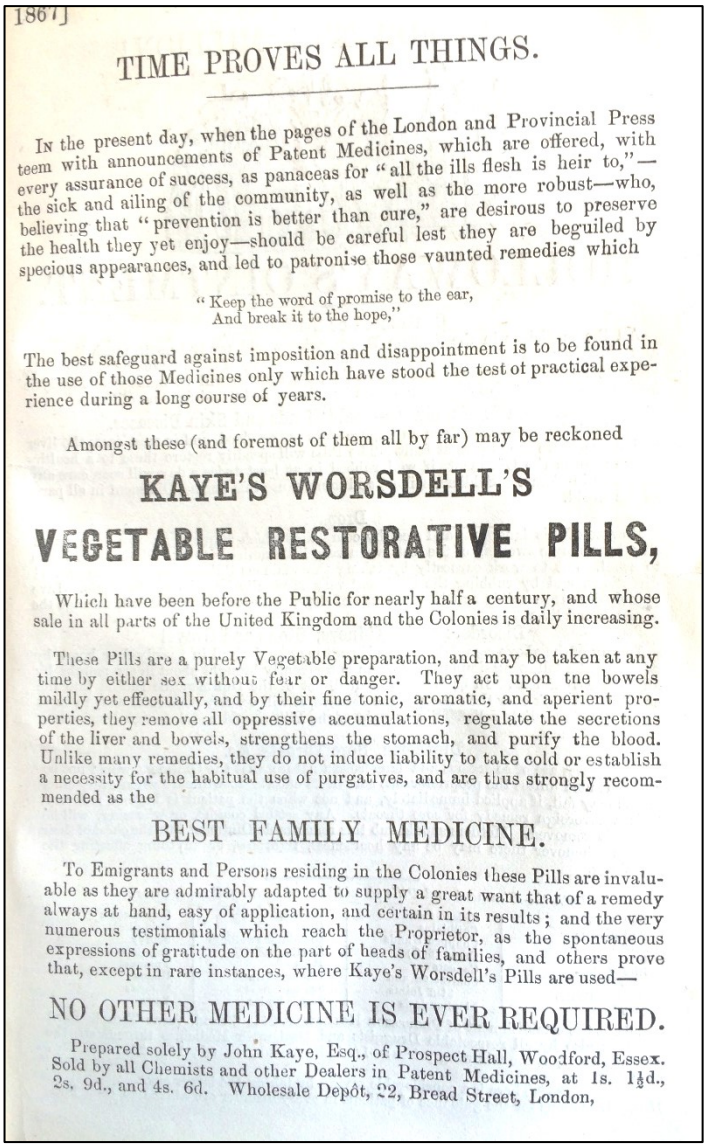
Figure 4.10 Advertisement for Rowlands' products, 1867

Source: [Unidentified] *Gloucester* Directory (1867) GA GAL/K1

4.4.1 Building trust and establishing legitimacy

Of paramount importance to manufacturers was to secure repeat custom. This required them to establish loyalty to their brand and the techniques they used to do this can tell

us much about the market in which they operated and the customers they were trying to attract. In the absence of any scientific trials to prove efficacy, brand reputation had to be secured and maintained by other means until the longevity of the product alone could confer a degree of trust. Once established, advertisements such as that for *Kaye's Worsdell's Vegetable Restorative Pills* shown in Figure 4.11, could under the heading 'TIME PROVES ALL THINGS,' urge the customer to trust 'those Medicines only which have stood the test of practical experience during a long course of years.'[58]



1867]

TIME PROVES ALL THINGS.

In the present day, when the pages of the London and Provincial Press teem with announcements of Patent Medicines, which are offered, with every assurance of success, as panaceas for "all the ills flesh is heir to,"—the sick and ailing of the community, as well as the more robust—who, believing that "prevention is better than cure," are desirous to preserve the health they yet enjoy—should be careful lest they are beguiled by specious appearances, and led to patronise those vaunted remedies which

"Keep the word of promise to the ear,
And break it to the hope,"

The best safeguard against imposition and disappointment is to be found in the use of those Medicines only which have stood the test of practical experience during a long course of years.

Amongst these (and foremost of them all by far) may be reckoned

KAYE'S WORSDELL'S

VEGETABLE RESTORATIVE PILLS,

Which have been before the Public for nearly half a century, and whose sale in all parts of the United Kingdom and the Colonies is daily increasing.

These Pills are a purely Vegetable preparation, and may be taken at any time by either sex without fear or danger. They act upon the bowels mildly yet effectually, and by their fine tonic, aromatic, and aperient properties, they remove all oppressive accumulations, regulate the secretions of the liver and bowels, strengthens the stomach, and purify the blood. Unlike many remedies, they do not induce liability to take cold or establish a necessity for the habitual use of purgatives, and are thus strongly recommended as the

BEST FAMILY MEDICINE.

To Emigrants and Persons residing in the Colonies these Pills are invaluable as they are admirably adapted to supply a great want that of a remedy always at hand, easy of application, and certain in its results; and the very numerous testimonials which reach the Proprietor, as the spontaneous expressions of gratitude on the part of heads of families, and others prove that, except in rare instances, where Kaye's Worsdell's Pills are used—

NO OTHER MEDICINE IS EVER REQUIRED.

Prepared solely by John Kaye, Esq., of Prospect Hall, Woodford, Essex. Sold by all Chemists and other Dealers in Patent Medicines, at 1s. 1½d., 2s. 9d., and 4s. 6d. Wholesale Depôt, 22, Bread Street, London,

Figure 4.11 Advertisement for Kaye's Worsdell's Vegetable Restorative Pills, 1867

Source: [unknown], *Gloucester Directory* (unknown, 1867).

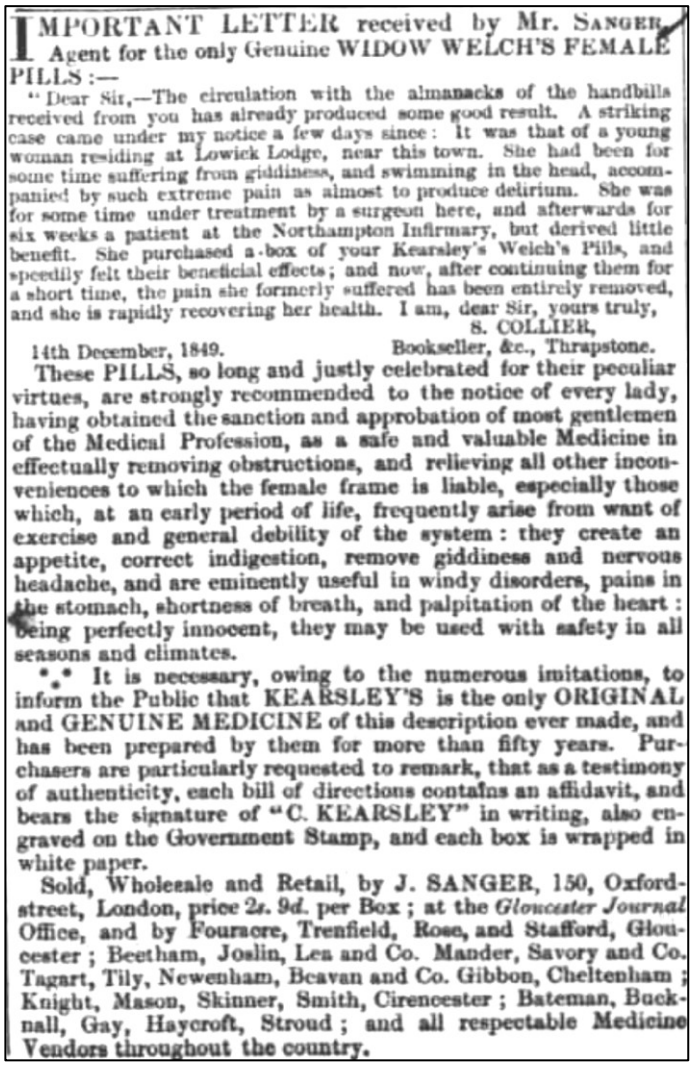
[58] [Unknown], *Gloucester Directory* ([unknown], 1867).

To get to this enviable point, Worth-Estes has noted how 'some manufacturers used their ads to explain just *how* their drugs worked, in terms consumers could readily understand.'[59] They also encouraged the purchaser to persevere with treatment and/or make dietary or lifestyle changes that would both give the maximum time for some positive effect to be noticed and for it to take credit from any spontaneous improvement, as well as encouraging purchasing of larger quantities. Advertisements commonly used pseudo-scientific language that required the customer to possess a degree of literacy and education that is suggestive of a middle-classes purchaser. Several approaches to establishing trust were then adopted, most common of which were:

- To claim a pedigree of use over generations through the acquisition of an 'original recipe' used by a wise-woman or healer.
- To claim the product to be the invention of one of the medical pantheon, past or present, supported by testimonials from suitably qualified 'experts' who had analysed its contents and could vouch for its efficacy.
- In a variant of the above, to promote the product having been 'discovered' in some exotic foreign land by an explorer or 'gentleman of fortune' who, recognising its curative powers, has generously brought it to market through the proprietor.

In an example of the first of these approaches, the makers of *Widow Welch's Pills* (Figure 4.12) claimed the product was 'the only ORIGINAL and GENUINE MEDICINE' 'prepared by them for more than fifty years.'[60] Other advertisements for this product claimed it to be 'prepared by Mrs Smithers, grand-daughter to the original proprietor Widow Welch, from the real family recipe, without the least variation whatever.'[61]

[59] J. Worth-Estes, 'The Pharmacology of Nineteenth-Century Patent Medicines,' *Pharmacy in History*, Vol.30, No.1 (January 1988), p.3.
[60] *Gloucester Journal*, 19 January 1850, p.1.
[61] *Gloucester Journal*, 13 January 1855, p.1.



IMPORTANT LETTER received by Mr. SANGER, Agent for the only Genuine WIDOW WELCH'S FEMALE PILLS :—

"Dear Sir,—The circulation with the almanacks of the handbills received from you has already produced some good result. A striking case came under my notice a few days since: it was that of a young woman residing at Lowick Lodge, near this town. She had been for some time suffering from giddiness, and swimming in the head, accompanied by such extreme pain as almost to produce delirium. She was for some time under treatment by a surgeon here, and afterwards for six weeks a patient at the Northampton Infirmary, but derived little benefit. She purchased a box of your Kearsley's Welch's Pills, and speedily felt their beneficial effects; and now, after continuing them for a short time, the pain she formerly suffered has been entirely removed, and she is rapidly recovering her health. I am, dear Sir, yours truly,

S. COLLIER,

14th December, 1849. Bookseller, &c., Thrapstone.

These PILLS, so long and justly celebrated for their peculiar virtues, are strongly recommended to the notice of every lady, having obtained the sanction and approbation of most gentlemen of the Medical Profession, as a safe and valuable Medicine in effectually removing obstructions, and relieving all other inconveniences to which the female frame is liable, especially those which, at an early period of life, frequently arise from want of exercise and general debility of the system: they create an appetite, correct indigestion, remove giddiness and nervous headache, and are eminently useful in windy disorders, pains in the stomach, shortness of breath, and palpitation of the heart: being perfectly innocent, they may be used with safety in all seasons and climates.

*** It is necessary, owing to the numerous imitations, to inform the Public that KEARSLEY'S is the only ORIGINAL and GENUINE MEDICINE of this description ever made, and has been prepared by them for more than fifty years. Purchasers are particularly requested to remark, that as a testimony of authenticity, each bill of directions contains an affidavit, and bears the signature of "C. KEARSLEY" in writing, also engraved on the Government Stamp, and each box is wrapped in white paper.

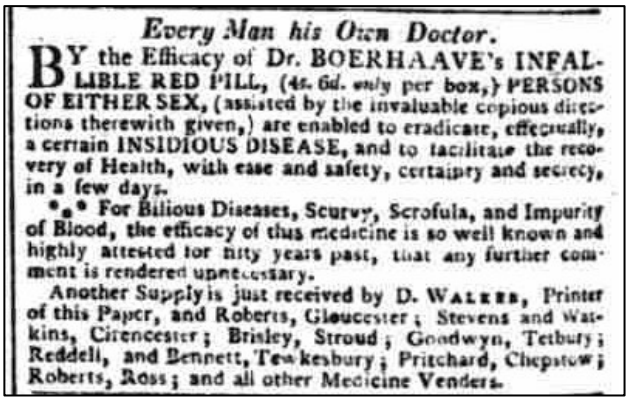
Sold, Wholesale and Retail, by J. SANGER, 150, Oxford-street, London, price 2*s.* 9*d.* per Box; at the *Gloucester Journal* Office, and by Fouracre, Trenfield, Rose, and Stafford, Gloucester; Beetham, Joslin, Lea and Co. Mander, Savory and Co. Tagart, Tily, Newenham, Beavan and Co. Gibbon, Cheltenham; Knight, Mason, Skinner, Smith, Cirencester; Bateman, Bucknall, Gay, Haycroft, Stroud; and all respectable Medicine Vendors throughout the country.

Figure 4.12 Advertisements for Widow Welch's Pills, 1850

Source: *Gloucester Journal*, 19 January 1850, p.1. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

By contrast, the 'great man' variation is illustrated by Figure 4.13, which in this case invoked the name of the famous physician Herman Boerhaave (1668-1738) of Leyden, who has been described as 'the leading medical figure in Europe during the early eighteenth century.'[62]

[62] G. Risse, 'Medicine in the Age of Enlightenment' in A. Wear (ed.), *Medicine in Society* (Cambridge, 1992), p.158.



Every Man his Own Doctor.

BY the Efficacy of Dr. BOERHAAVE's INFALLIBLE RED PILL, (4s. 6d. only per box,) PERSONS OF EITHER SEX, (assisted by the invaluable copious directions therewith given,) are enabled to eradicate, effectually, a certain INSIDIOUS DISEASE, and to facilitate the recovery of Health, with ease and safety, certainty and secrecy, in a few days.

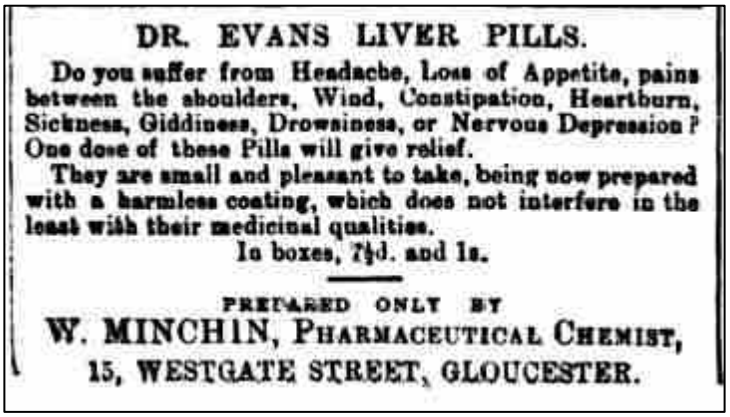
*** For Bilious Diseases, Scurvy, Scrofula, and Impurity of Blood, the efficacy of this medicine is so well known and highly attested for fifty years past, that any further comment is rendered unnecessary.

Another Supply is just received by D. WALKER, Printer of this Paper, and Roberts, Gloucester; Stevens and Watkins, Cirencester; Brisley, Stroud; Goodwyn, Tetbury; Reddell, and Bennett, Tewkesbury; Pritchard, Chepstow; Roberts, Ross; and all other Medicine Venders.

Figure 4.13 Advertisement for Dr Boerhaave's Infallible Red Pill, 1815

Source: *Gloucester Journal*, 28 August 1815, p.4. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

Most of the great physicians had products named after them by manufacturers who saw the commercial potential of their name, but interestingly medical men of local reputation could also be 'honoured' in this way. Thomas Evans' name, for example, had enough *gravitas* for Minchin the chemist to name a product after him, which was still on sale into the twentieth century (Figure 4.14).



DR. EVANS LIVER PILLS.

Do you suffer from Headache, Loss of Appetite, pains between the shoulders, Wind, Constipation, Heartburn, Sickness, Giddiness, Drowsiness, or Nervous Depression? One dose of these Pills will give relief.

They are small and pleasant to take, being now prepared with a harmless coating, which does not interfere in the least with their medicinal qualities.

In boxes, 7½d. and 1s.

PREPARED ONLY BY

W. MINCHIN, PHARMACEUTICAL CHEMIST,

15, WESTGATE STREET, GLOUCESTER.

Figure 4.14 Advertisement for Dr Evans Liver Pills, 1896

Source: *Gloucestershire Chronicle*, 29 February 1896, p.1. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

It has been claimed that doctors were motivated by 'financial gain' to lend 'their names to products, often of dubious quality.'[63] This practice was discouraged by the medical establishment for undermining the status of the profession but in reality, there

[63] K.A. Morrison, ''Dr Locock and His Quack': Professionalizing Medicine, Textualizing Identity in the 1840s' in L. Penner (ed.), *Victorian Medicine and Popular Culture* (London, 2015), p.10.

was little that could be done to prevent it. In addition, according to Morrison, 'the appropriation of the names of medical practitioners, both living and dead' amounted to 'rampant forgery.'[64] The fact that medical reputations carried sufficient weight to be used in this way is significant; it points toward the rising status of the profession and to the weight the public gave to qualified medical opinion. Importantly, it also demonstrates that manufacturers clearly believed their target customer possessed a level of education sufficient to be familiar with these names and the fields of medicine in which they specialised. This speaks of a degree of segmentation within the market that has yet to be properly explored by the historiography.

Thought, expense and effort also went into casting the proprietor as both a gentleman and a man of science, so that the proprietor's credentials could, in themselves, sell the product. Here a medical degree, however obtained, could be extremely valuable in conferring legitimacy and it is a testament to the rising status of medical qualifications that these entrepreneurs sought to acquire them. In addition, sometimes a publication, written by the proprietor was given away free with or for an additional fee along with the product, in which a pseudo-scientific rationale for its efficacy would be set out. A well-known example was 'Doctor' Samuel Solomon's *Dr Solomon's Guide to Health* which was offered alongside his *Cordial Balm of Gilead*, for an additional three shillings (Figure 4.15).

[64] *Ibid,* p.16.

Consumption, and other Decays of Nature,

WHETHER the effects of natural consequences, or proceeding from imprudencies, at an advanced stage of life, have engaged the study and attention of the best physicians of this and all other nations in vain, until Dr. SOLOMON'S CORDIAL BALM OF GILEAD was happily discovered and promulgated to the world, and which has produced such instances of its good effects, as must convince the most incredulous of its amazing restorative powers. To enumerate its truly happy, healing, balmic, and renovating efficacy, testimonies of the first authority are now extant. It is admirably calculated for bilious and other disorders of the stomach and bowels; for head-achs occasioned by indigestion; and for preventing palsies and apoplexies, so often the consequences of free living. Recourse should be had to it after every excess, and upon every slight indisposition.

In the most excruciating pains of the stomach and viscera, or windiness, it gives instant relief; and in all those diseases that have their rise from irregular living, or an enfeebled state of the digestive powers, its effects are astonishing; debility of speech, and all other the mental and corporal powers that depend on the tone of the nervous system, have so frequently and suddenly yielded to its power, as to render unquestionable its efficacy in those disorders.

This Cordial has been uncommonly successful with young people who have the appearance and air of old age; who are pale, effeminate, benumbed, stupid, and even imbecile; whose bodies are become bent, whose legs are no longer scarcely able to carry them; who have an utter distate for every thing, and are totally incapacitated. Where the stomach is frequently disordered, the body is weakened; paleness, bodily decay, and emaciation, succeed this most destructive habit, and the eyes sink into the head. The virtues of the Cordial Balm of Gilead are daily demonstrated, in eradicating the worst and most dangerous symptoms of nervous disorders; and nothing has tended so much to establish the fame of this medicine, as its certain success in those complaints which strike their roots so deep in the constitution, and are so fatal to the happiness of mankind.

*** Persons entering upon the holy state of matrimony should consider, that "where the fountain is polluted, the streams that flow from it cannot be pure."

Prepared by Dr Solomon, Gilead-House, near Liverpool, in 10*s. 6d.* and 33*s.* bottles; the latter contain four of the former, by which the purchaser saves Nine Shillings.—Every genuine bottle has a stamp, which bears the Proprietor's name and address, "*Saml. Solomon, Liverpool,*" to counterfeit which is felony.

The ANTI-IMPETIGINES, or SOLOMON'S DROPS, for purifying the blood, and restoring the system when impaired by the imprudent use of Mercury, have been found the great and only restorer of health and vigour in disorders where salivation has repeatedly failed. Price 10*s. 6d.*—Family Bottles, 33*s.*

The ABSTERGENT LOTION, for removing Eruptions from the surface of the human body. Price 4*s. 6d.* Half-Pints, 2*s. 9d.* duty included.

The DETERGENT OINTMENT, for Old Sores, &c. at 4*s. 6d.* per Box.

Double Postage of all letters to Dr. Solomon, Liverpool, must be paid, and a fee of 10*s. 6d.* inclosed for advice.

Also, just published, price 3s. a New Edition, (with Additions,) of

A GUIDE to HEALTH, in a variety of Complaints, some of which are treated on under the following heads, viz—Advice to Nervous Patients—Asthmas—Barren Women—Deficiency of Natural Strength—Female Complaints—Gouty Spasms in the Stomach—Hypochondriac Complaints—Internal Sinking—Loss or Defect of Memory—Rheumatism—Scurvy—Scrofula—Turn of Life—Venereal Disease—Weakness—Youth.

By S. SOLOMON, M.D.

Sold by D. WALKER, Printer of this Paper, Westgate-Street, Gloucester; Stevens and Watkins, Cirencester; Brisley, Stroud; Goodwyn, Tetbury; Reddell, Tewkesbury; Pritchard, Chepstow; Roberts, Ross; and all other Medicine Venders.

Figure 4.15 Advertisement for Dr Solomon's Cordial Balm of Gilead and Guide to Health, 1812

Source: *Gloucester Journal*, 27 January 1812, p.4.

Solomon, a former shoe-black, purchased his medical degree from a Scottish university and set himself up with a baronial sounding address 'Gilead House' for good measure.[65] His 300-page treatise on genitourinary and venereal complaints was claimed to have sold 'no less than One Hundred Thousand Five Hundred copies' (by 1815).[66] Thomas Holloway went one better, styling himself 'Professor,' while others adopted titles such as Baron or Count and claimed the patronage of the nobility or even royalty. An example of this genre is shown in Figure 4.16, where an advertisement for *Roper's Royal Bath Plasters* claims the product to be used by the 'Queen and the principal nobility.'[67] Ironically, these techniques designed to confer legitimacy were widely regarded as the very hallmark of quackery. That they continued for many decades, and still do so today in an albeit more regulated and restrained form, speaks of the power of the cult of celebrity in shaping both social attitudes and purchasing behaviour.

The final commonly used strategy was to claim the product as a wondrous discovery made in an exotic foreign location an explorer or gentleman of fortune, who on his return, then beneficently offers it *gratis* to the public upon written application. Typical was the following:

> A gentleman of fortune, who had suffered a martyrdom for twenty years from low spirits, melancholy, pains in the head, loss of memory, giddiness, sleeplessness, indigestion, constipation, and all the fearful symptoms of nervous and general debility; and who had spent hundreds of pounds in physicians' fees and medicines, all to no purpose, was speedily cured by a simple remedy, whilst on a tour in Germany. All sufferers are welcome to this means of cure, eight doses of which, sufficient to cure all ordinary cases, with instructions for use, diet, &c.[68]

In a similar vein was an advertisement for a 'self-cure for country patients' dating from 1857:

> …by a Physician from the Crimea. - This wonderful treatment as practised in the East, for the instant Relief and permanent Cure of all kinds of Secret Disease, Discharge, Weakness, Impotency; also invaluable Remedies for Nervous Weakness of Mind and Body - nightly draining the system of all its powers, causing trembling, and loss of all manly vigour of mind and body. By these Eastern Botanical and invaluable Remedies, persons who have been at death's door are now enjoying robust health, and may be referred to. Persons can cure themselves in any part of the world of all Diseases of the Generative Organs, or Nervous Complaints. No treatment ever known here, or remedies, can be compared to this invaluable Eastern mode of Cure. Such miseries are

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[65] 'Balm of Gilead' referenced a remedy of Babylonian origin - see W.E. Court, 'Pharmacy from the Ancient World to 1100AD' in S. Anderson (ed.), *Making Medicines: A Brief History of Pharmacy and Pharmaceuticals* (London, 2005), p.22.
[66] *Gloucester Journal,* 3 April 1815, p.4.
[67] *Gloucester Journal*, 13 January 1855, p.1.
[68] *Gloucester Mercury,* 8 May 1858, p.1.

cured there in a few days. This is offered to Sufferers only from benevolence. No consulting fee is charged. It will save the young man from a life of misery, and others from the extortions of advertising impostors. - Mode of Self-cure sent post free, on receipt of a letter, containing every symptom respecting the case. Address, - House Physician, [?]. Leicester Place, Leicester Square, London, (W.C.). At home from 11 to 4 daily, except Sundays.[69]

"What is infirm from your sound parts shall fly,
Health shall live free and sickness freely die."—*Shakspere.*

UNDER THE PATRONAGE OF THE QUEEN AND THE PRINCIPAL NOBILITY.

The only REAL CURE without Inward Medicine is

ROPER'S ROYAL BATH PLASTERS, for Coughs, Asthma, Hoarseness, Indigestion, Palpitation of the Heart, Croup, Hooping Cough, Influenza, Chronic Strains, Bruises, Lumbago or Pains in the Back, Spinal and Rheumatic Affections, Diseases of the Chest, and Local Pains.

More wonderful Cures, from many Thousands of others:—

GREAT ATTACK OF RHEUMATIC PAINS CURED.

Dear Sirs,—Having suffered many years from severe attacks of Rheumatic pains, I feel great pleasure in telling you that I have derived great benefit from your invaluable Plastrs. I shall most certainly recommend it to all my friends, all medical aid being of no use whatever. You are at leave to publish this in any way you may think proper.

I am, dear sirs, yours truly, H. MAYOR, M.A.

Leamington, Aug. 12th, 1854.

Carrickginss, Longford, Irriland, July 2d, 1854.

Gentlemen,—Herewith I send you sixteen Postage Stamps for another of your very valuable Ropers' Plasters. The one already got has given me very considerable ease.—(Signed) WM. SCANLAN.

BEWARE OF SPURIOUS IMITATIONS.

Normandy-street, Alton, Hants, May, 1854.

Gentlemen,—Having for several years been troubled with an inveterate cough, and which has hitherto defied the power of every antidote that I have tried—and that has not been a few—seeing your advertisement of Roper's Plasters, induced me to make trial of one, which afforded me great relief and had almost effected a cure. Unfortunately I caught fresh cold, the cough again became very troublesome, as the person of whom I had the first was quite out of them, and after waiting some time could not get one. I applied to another chemist here, and he sent to London for a supply, which was soon forwarded, and I had a plaster sent me—when opened, I remarked the dissimilarity from the one I first used. It appeared to be spread on linen, when I believe yourselves use some species of leather. I thought that strange, but as there were similar papers containing instructions, lists of cures, &c. I applied it, when to my great surprise, instead of affording relief, it increased the troublesome visitant, and indeed made me very unwell altogether, and from which I have not yet recovered.

In justice to yourselves I have, therefore, taken this liberty, and which I hope you will pardon, as, if any unprincipled person will, for the sake of gain, foist on the public a spurious article, and which may produce incalculable injury on individuals, they cannot be too severely punished. I shall be obliged if you will forward me here a Ropers' Plaster, also, a box of Pills, then I shall know they are genuine, for which I enclose postage stamps. (Signed) J. GILL.

To Messrs. Roper and Son, Sheffield.

HOOPING COUGH CURED.

Sirs,—I have used your Roper's Plasters for myself and children for several months with decided benefit for Hooping-cough; three of my children being comparatively well since their application.

I am, Sirs, yours respectfully, T. MAIDEN.

Ash Cottage, Stalisfield, near Faversham, Kent.

(Communicated by Mr. J. C. REINHARDT, Chemist, Hull.)

Sproatley, near Hull, Oct. 3d, 1853.

Sirs,—Having found great benefit from Ropers' Royal Bath Plasters and Pills, I wish to make my case known for the advantage of those who suffer, as I have done for a long time. I have been afflicted with spasmodic pains in the chest, and palpitation of the heart, arising from indigestion and liver complaint; I was under medical treatment many months without feeling any better, at last I tried one of Roper's Plasters and a box of Pills, which gave me relief in a few days, from which time my health has improved, and I am now quite well.—I remain, with thanks, yours respectfully, ELIZABETH THOMPSON.

Haydon Vicarage, Sleaford, April 27th, 1854.

Sirs,—The effects of Ropers' Plasters I had some short time since from you has been so marvellous among my poor parishioners that I will thank you to send me an 11s. Case as soon as convenient.

Your obedient servant, A. LEAPINGWELL.

Unprincipled Shopkeepers, for the sake of gain, have vended spurious Imitations. Purchasers are, therefore, cautioned to NOTICE!—The words, "ROPER'S ROYAL BATH PLASTER," engraved on the government stamp, and the Proprietor's Autograph on the back, thus:—

Robt Roper

Prepared only by ROBERT ROPER and SON, Chemists Sheffield, on Medico-Chemical Principles, from British Herbs and the Gums and Balsams of the Eastern Clime, where

"The trees drop balsam, and on all the boughs
Health sits and makes it sovereign as it flows."

Full-sized Plasters, 1s. 1½d.; and for Children, 9½d. each; or direct by post, on receipt of 1s. 4d. or 1s. each, in postage stamps.—For Family use, and Charitable purposes, &c.—in Tin cases, at 4s. 6d. 11s. 22s. 33s. each case.

Sold by D. M. WALKER, *Journal Office*, Gloucester, and most Patent Medicine Vendors in the United Kingdom.

BEWARE OF IMITATIONS!—Be particular to ask for ROPER'S PLASTERS.

Figure 4.16 Advertisement for Roper's Royal Bath Plasters, 1855

Source: *Gloucester Journal*, 13 January 1855, p.1. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

[69] *Gloucester Mercury,* 3 October 1857, p.1.

Such advertisements fed upon the public's appetite for tales of adventure and discovery in this golden age of empire building. It seems likely most of them were scams of one sort or another and what the applicant eventually received almost certainly disappointed them. As such, these advertisements occupied the quack end of the spectrum. Beyond these simple techniques, the most ubiquitous tool for establishing customer trust was surely the testimonial, which built upon the principle that, confronted by illness, most people 'preferred to act on personal advice received from people they knew and trusted on the social grapevine.'[70] With the dislocation caused by the Industrial Revolution and consequent mass-migration to the towns, personal recommendation was often not available and the testimonial provided the next best thing. Barker has observed how:

> Testimonials were supposedly provided by individuals who were willing to publicize their cures and have their names in print, but who – in the main – were distinguished only by their 'ordinariness.' In this way, testimonial writers appeared to stand in for those day-to-day contacts who would have provided the type of word-of-mouth reputations upon which most people might have depended previously, aping something of the 'thick' forms of trust that were more prevalent when towns were smaller and their populations less diverse and unconnected.[71]

As well as these 'ordinary' sufferers, testimonials from celebrities, or experts who had used, or analysed, the product were also common. The testimonial was, and is, an essential tool of the mail order trade; one that has undergone a renaissance with the online customer review. Like these modern reviews, they suggest a public wise to the hazards of the marketplace, who needed more than the supplier's word to be convinced of the efficacy of what they were being invited to buy. Testimonials thus suggest a discerning, vigilant and intelligent customer quite removed from the stereotype. Figure 4.17 is emblematic of many similar advertisements that deployed testimonials supposedly from 'ordinary sufferers'.

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[70] J. Browne, 'Spas and Sensibilities: Darwin at Malvern,' *Medical History*, Supplement No.10 (1990), pp.102-113.

[71] Barker, 'Medical Advertising', p.396.

SURE CURE.—LAMBERT'S ASTHMATIC BALSAM, truly efficacious and pleasant without confining the bowels or affecting the head. A few of the many thousand testimonials of cures of asthma, consumption, coughs, colds, shortness of breath, and all disorders of the chest and lungs, by taking LAMBERT'S ASTHMATIC BALSAM. Sufferers from Asthma, of however long standing, or those who are prevented from even lying down for fear of suffocation, may rely on immediate relief, and a cure will certainly follow the use of it. Those who are subject to or suffer from Bronchitis should immediately take a few doses of this wonderful medicine.

Wonderful Cure of Hoarseness and Cough.

Sir,—I cannot refrain from acknowledging the extraordinary benefit I have derived from taking your wonderful cough medicine—Lambert's Asthmatic Balsam. For three months last winter I was confined to my room with a dreadful hoarseness and wheezing at the chest, accompanied with a violent cough; the hoarseness was to that dreadful extent that no one could understand what I said unless they put their ears to my mouth, and the cough so violent that I was in daily fear of breaking a blood vessel; I had nearly the whole of that time the advice of two eminent medical men, without getting any better, and when pressed as to their ultimate success, they candidly confessed they had done all they could for me. Having read in the newspapers some extraordinary cures performed by the Asthmatic Balsam, as a last resource I was induced to try its efficacy. I am happy to inform you of the great benefit I have derived from taking it. The contents of the first bottle relieved me, and after taking it three weeks, the cough and hoarseness entirely left me, and I have been perfectly free from it ever since, and in the enjoyment of good health. I remain, Sir, your's truly,

Ilford, Essex. JOHN BENNETT.

Wonderful Cure of Asthma of many years' duration.

To Mr. W. Lambert, Chemist, 20, Jermyn-street, Haymarket, London.

SIR,—I have been upwards of 15 years afflicted with a confirmed asthma, attended with violent coughing, (so much so that I was daily in fear of breaking a blood-vessel,) shortness of breath, and occasionally spitting of blood; for the last three winters, I have scarcely been out of my bed, with the entire deprivation of both taste and smell; I have tried nearly all the advertised supposed remedies, and some hundreds of private recipes of friends, without obtaining any relief, and I gave up all hope of getting better; but providentially, when on the verge of the grave, a friend who had tried and experienced wonderful benefit by taking your Asthmatic Balsam, induced me to make trial of it; I am happy to inform you I was considerably relieved by the contents of the first bottle, and the third so much restored me as to enable me to take my daily walks with ease and comfort. Sir, yours, respectfully,

Lewisham Marsh. MARY DOWNS.

Mrs. Mary Banks, of Caroline-street, Camden-town, was cured of a violent cough by taking four doses.

Astonishing Cure of Cough and Spitting of Blood.

SIR,—About four years since, I caught a severe cold, which terminated in a violent cough with spitting of blood; I tried every remedy which my friends recommended, without perceiving any benefit; last winter the cough so much increased in violence, and the spitting of blood became so frequent, and attended with all the symptoms of a rapid consumption; I continued in this dreadful state, notwithstanding I had the advice of some of the most eminent physicians, and gave up all hope of recovering. Seeing in the newspapers, some extraordinary cures which your Asthmatic Balsam had performed, as a last resource, I was induced to try its efficacy; to my great astonishment and delight, in less than a week I perceived a wonderful benefit, and by the time I had taken two of the 2s. 3d. bottles, with gratitude I acknowledge I was perfectly well. I remain, Sir, your obedient servant,

Kennington Cross, March, 1845. ELIZ. BROWN.

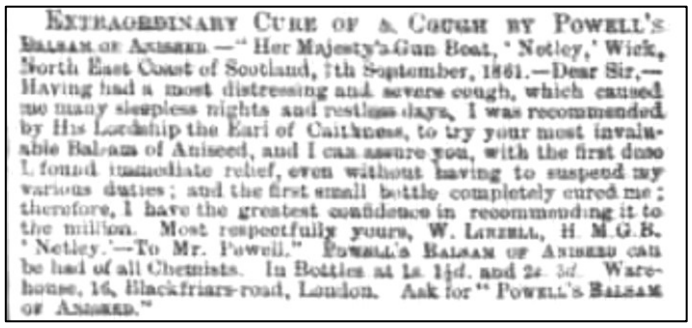
Wonderful Cure of Asthma.

Extract of a letter from Mr. Charles Mumby, Chemist and Druggist, 53, High-street, Gosport, dated December 7th, 1852.—To Mr. William Lambert, Chemist, 20, Jermyn-street, Haymarket, London.—I, John Henry Adams, am a gunner in her Majesty's Royal Artillery, and while stationed at Malta, six years ago, was suddenly seized in the middle of the night with a violent attack of asthma, and was nearly suffocated with the great difficulty in breathing, and excessive cough for two hours. This visited me, accompanied with violent pain in the side, and continued the same interval for upwards of two months, and has troubled me more or less ever since; after having been to the hospital twice, and tried every remedy that my friends could recommend, or my means command, without obtaining any permanent relief; after reading an advertisement of Lambert's Asthmatic Balsam, I resolved, as a last resource, to try it, and wonderful to relate, the cough, difficulty of breathing, pain in the side, &c. that had resisted every other remedy, yielded to this. After taking only four small bottles, I am now completely free from any of the distressing symptoms of asthma, and, in fact, my health, is re-established.

Prepared only and sold by W. Lambert, Chemist, 20, Jermyn-Street, Haymarket, London, in bottles at 1s. 6d., 2s. 3d., and 4s. 6d. Be particular and ask for "Lambert's Asthmatic Balsam," and not be persuaded to take any other medicine. Sold by D. M. Walker, at the *Journal* Office, Gloucester, and all druggists and patent medicine vendors.

Figure 4.17 Advertisement for Lambert's Asthmatic Balsam, 1855

Noticeable immediately is just how much of this advertisement the three testimonials take up and while three may seem excessive, Loeb has noted how 'by 1870 some advertisers with increasing enthusiasm employed as many as twelve to fifteen testimonials in one advertisement. Testimonials themselves became the focus, the very source of the selling message.'[72] The evidence from the sample survey suggests the practice was widespread long before 1870. In 1814, for example, an advertisement placed by 'Dr A. Lamert' included sixteen testimonials,[73] as did an 1850 one for *Du Barry's Revalenta Arabica*.[74] A total of 54 advertisements sampled contained three or more testimonials and it was not uncommon for entire advertisements taking the form of a testimonial, as illustrated by Figure 4.18.



EXTRAORDINARY CURE OF A COUGH BY POWELL'S BALSAM OF ANISEED.—"Her Majesty's Gun Boat, 'Netley,' Wick, North East Coast of Scotland, 7th September, 1861.—Dear Sir,—Having had a most distressing and severe cough, which caused me many sleepless nights and restless days, I was recommended by His Lordship the Earl of Caithness, to try your most invaluable Balsam of Aniseed, and I can assure you, with the first dose I found immediate relief, even without having to suspend my various duties; and the first small bottle completely cured me; therefore, I have the greatest confidence in recommending it to the million. Most respectfully yours, W. LANZELL, H. M.G.B. 'Netley.'—To Mr. Powell." POWELL'S BALSAM OF ANISEED can be had of all Chemists. In Bottles at 1s. 1½d. and 2s. 3d. Warehouse, 16, Blackfriars-road, London. Ask for "POWELL'S BALSAM OF ANISEED."

Figure 4.18 Advertisement for Powell's Balsam of Aniseed, 1870

Source: *Gloucester Journal,* 15 January 1870, p.2. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

How many of these testimonials were genuine is impossible to establish. There is strong evidence that the text of testimonials was frequently edited to alter both the language and form in order to conform to an underlying discourse. The words and phrases used, supposedly by different people, could be predictably similar. Barker, looking at the eighteenth century, observed 'the rhetoric and language used varied surprisingly little over time.'[75] The proprietor was usually portrayed as a saviour figure, with fawning declarations of gratitude designed to represent him in a heroic light. The obsequious tone, supposedly the authentic words of working people, panders too readily to paternalistic middle-class attitudes (the same ones that expected hospital and dispensary patients to write to thank the subscriber who had provided their ticket). It seems unlikely working people would have fallen for this and it is more suggestive of

[72] Loeb, p.75.
[73] *The Glocester Herald*, 23 July 1814, p.1.
[74] *Gloucestershire Chronicle,* 6 July 1850, p.1.
[75] Barker, 'Medical advertising,' p.391.

middle-class assumptions about working-class culture. For example, in an 1855 advertisement for *De Roos Guttae Vitae*, a working man, 'A.T. of Sheffield,' wrote ''I return you my sincere thanks for your attention to me. I assure you I am deeply thankful for the result. I am now able to earn my own livelihood, which to me is a great boon, and now hope a better time is coming. With deepest respect, believe me, dear Sir, yours truly."[76] No hint of colloquialism is apparent in the language and the deferential tone, while it could have been genuine, feels unauthentic. The 'storyline' of a testimonial was also often predictably formulaic. Typically, the correspondent, or someone they know, being ill for many years with a multitude of distressing symptoms, consults numerous doctors and/or tries numerous other remedies, all of which fail, before finally being made aware of the product by a benevolent friend. Persuaded to try it, the product effects a miraculous cure which lasts with regular use. Figure 4.19 is representative of this genre.

COMFORT FOR THE AFFLICTED.

Dr. Smith's Ploughman's Drops.

I THOMAS MINSHULL, of Prees Heath, near Whitchurch, being induced, for the benefit of my fellow creatures, to lay my Case before the Public, did authorize Dr SMITH, of Upton Magna, near Shrewsbury, to publish an account of the Cure I received by taking his PLOUGHMAN's DROPS; and do now voluntarily come forward, and make the following statement:—Being at Wellington, in the County of Salop, in July, 1809, where I followed the occupation of a shoemaker, I perceived I had contracted the Venereal Disease. I made application to a professional gentleman there, under whose care I continued for a considerable time, without experiencing any relief whatever, but, on the contrary, I found myself grow worse and worse, till at length I was reduced to a melancholy situation indeed, by the internal and external use of mercury. Hopeless of receiving any benefit, and having both my constitution and my patience nearly worn out, I gave up all hopes of being cured by the mercurial preparations, which only exhausted my frame, without in the least degree abating the virulence of the disorder, which by this time was arrived to an alarming pitch indeed, I took the resolution of returning to my home near Whitchurch, and seeking relief elsewhere. I put myself under the care of another gentleman of the profession, who gave some relief, and, as I thought, cured me; but, after some time, the disorder broke out with greater violence than ever, and my condition nearly reduced me to despondency. Having no hopes from the faculty, who had entirely failed in their efforts to eradicate the disorder, it was now that I found Dr. Smith's bills of "Comfort to the Afflicted," and determined on giving it a trial: I bought a bottle of Mr. Jones, Printer, Whitchurch. On the third day of taking it, I found a wonderful alteration for the better, and before I had finished the first bottle, I had the cheering prospect before me, of being at last cured of this afflicting disorder; and before I had finished the third bottle, I found myself in a situation far different from what I was when I left Wellington. I had now comfortable sleep at nights my spirits returned, and my health was completely re-established. Thus, by taking the inestimable Ploughman's Drops was I rescued from the grave, and a state bordering on despair.—Signed, in the presence of R. B. Jones, this 3d day of December, 1811. THOMAS MINSHULL.

Witness, R. B. JONES.

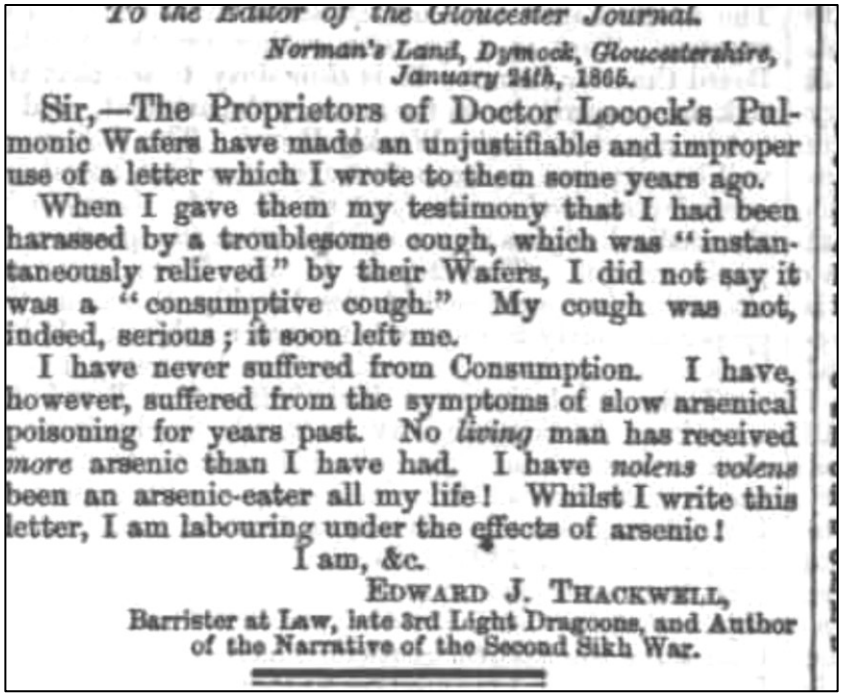
Sworn at Shrewsbury, in the County of Salop, the 4th day of December, 1811, before me, W. SMITH.

Figure 4.19 Advertisement for Dr Smith's Ploughman's Drops, 1814

Source: *Gloucester Journal*, 5 December 1814, p.1. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

[76] *Gloucestershire Chronicle,* 7 April 1855, p.1.

On balance, it is highly likely many testimonials were written, re-written, or heavily paraphrased before publication. Loeb has claimed they were 'frequently shamelessly fabricated,' [77] while Brown found 'the texts of most advertisements were not composed locally but were supplied by the central distributors of medicines' and this likely accounts for lexical similarities in testimony from different people in advertisements for different products.[78] Occasionally, this led to complaints, as was the case in Figure 4.20:



To the Editor of the Gloucester Journal.

Norman's Land, Dymock, Gloucestershire,
January 24th, 1865.

Sir,—The Proprietors of Doctor Locock's Pulmonic Wafers have made an unjustifiable and improper use of a letter which I wrote to them some years ago.

When I gave them my testimony that I had been harassed by a troublesome cough, which was "instantaneously relieved" by their Wafers, I did not say it was a "consumptive cough." My cough was not, indeed, serious; it soon left me.

I have never suffered from Consumption. I have, however, suffered from the symptoms of slow arsenical poisoning for years past. No *living* man has received *more* arsenic than I have had. I have *nolens volens* been an arsenic-eater all my life! Whilst I write this letter, I am labouring under the effects of arsenic!

I am, &c.

EDWARD J. THACKWELL,
Barrister at Law, late 3rd Light Dragoons, and Author of the Narrative of the Second Sikh War.

Figure 4.20 Notice in respect of Doctor Locock's Pulmonic Wafers, 1865

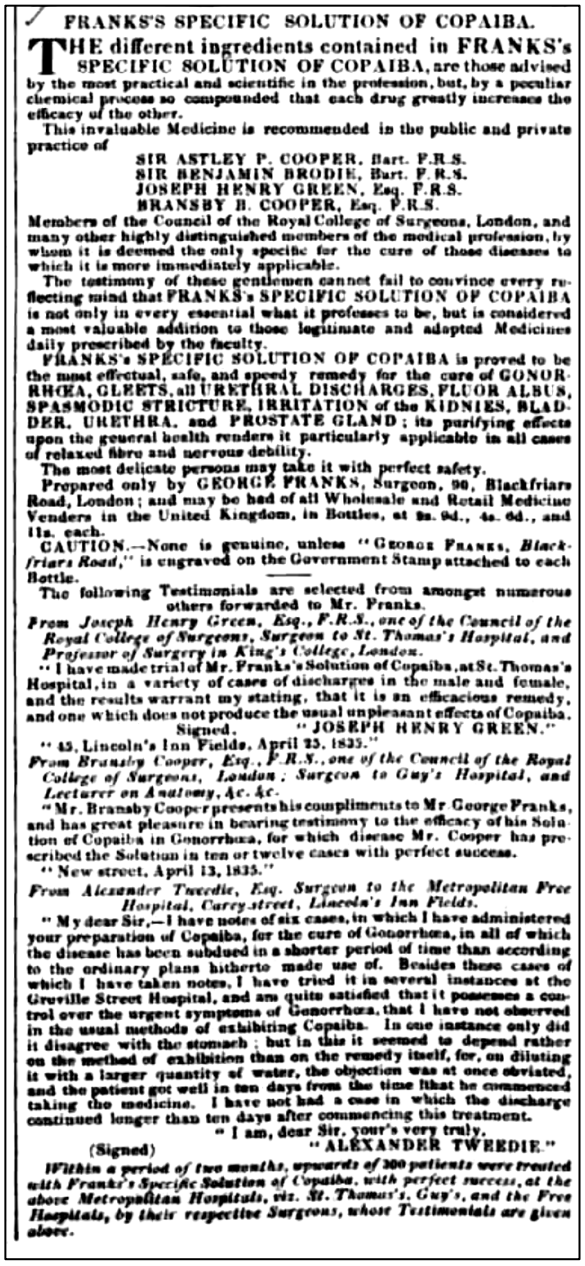
Source: *Gloucester Journal*, 28 January 1865, p.7. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

Some testimonials were anonymised (usually those of women, venereal disease, or 'secret vice' sufferers), but most usually gave a name or initials and an address, sometimes with an offer to respond to further enquiries. What would happen if anyone did write is a matter of conjecture, but it was the case that even if the individual was genuine they sometimes received a fee that could easily compromise their impartiality.[79]

Similar questions surround those testimonials purporting to be from well-known contemporary physicians and surgeons. For example, the makers of *Franks's Specific*

[77] Loeb, p.75.
[78] Brown, 'The Venders of Medicines,' p.354.
[79] C. Rance, *The Quack Doctor: Historical Remedies for all your Ills* (Stroud, 2013), pp.115-117.

Solution of Copaiba (Figure 4.21), included testimonials claiming to be from Sir Astley Cooper, Sir Benjamin Brodie, Joseph Green and Bransby Cooper. Whether these doctors knew anything of this is an intriguing question. As with the appropriation of names from the medical pantheon, this strategy points toward a customer who possessed a certain degree of education and literacy, who would be familiar with these names and the reputations attached to them. In short, not the stereotype of someone too ignorant or poor to seek regular medical advice.



FRANKS'S SPECIFIC SOLUTION OF COPAIBA.

THE different ingredients contained in FRANKS's SPECIFIC SOLUTION OF COPAIBA, are those advised by the most practical and scientific in the profession, but, by a peculiar chemical process so compounded that each drug greatly increases the efficacy of the other.

This invaluable Medicine is recommended in the public and private practice of

SIR ASTLEY P. COOPER, Bart. F.R.S.
SIR BENJAMIN BRODIE, Bart. F.R.S.
JOSEPH HENRY GREEN, Esq. F.R.S.
BRANSBY B. COOPER, Esq. F.R.S.

Members of the Council of the Royal College of Surgeons, London, and many other highly distinguished members of the medical profession, by whom it is deemed the only specific for the cure of those diseases to which it is more immediately applicable.

The testimony of these gentlemen cannot fail to convince every reflecting mind that FRANKS's SPECIFIC SOLUTION OF COPAIBA is not only in every essential what it professes to be, but is considered a most valuable addition to those legitimate and adopted Medicines daily prescribed by the faculty.

FRANKS's SPECIFIC SOLUTION OF COPAIBA is proved to be the most effectual, safe, and speedy remedy for the cure of GONORRHŒA, GLEETS, all URETHRAL DISCHARGES, FLUOR ALBUS, SPASMODIC STRICTURE, IRRITATION of the KIDNIES, BLADDER, URETHRA, and PROSTATE GLAND; its purifying effects upon the general health renders it particularly applicable in all cases of relaxed fibre and nervous debility.

The most delicate persons may take it with perfect safety.

Prepared only by GEORGE FRANKS, Surgeon, 90, Blackfriars Road, London; and may be had of all Wholesale and Retail Medicine Venders in the United Kingdom, in Bottles, at 2s. 9d., 4s. 6d., and 11s. each.

CAUTION.—None is genuine, unless "GEORGE FRANKS, *Blackfriars Road*," is engraved on the Government Stamp attached to each Bottle.

The following Testimonials are selected from amongst numerous others forwarded to Mr. Franks.

From Joseph Henry Green, Esq., F.R.S., one of the Council of the Royal College of Surgeons, Surgeon to St. Thomas's Hospital, and Professor of Surgery in King's College, London.

"I have made trial of Mr. Franks's Solution of Copaiba, at St. Thomas's Hospital, in a variety of cases of discharges in the male and female, and the results warrant my stating, that it is an efficacious remedy, and one which does not produce the usual unpleasant effects of Copaiba.

Signed, "JOSEPH HENRY GREEN."

"45, Lincoln's Inn Fields, April 25, 1835."

From Bransby Cooper, Esq., F.R.S., one of the Council of the Royal College of Surgeons, London; Surgeon to Guy's Hospital, and Lecturer on Anatomy, &c. &c.

"Mr. Bransby Cooper presents his compliments to Mr George Franks, and has great pleasure in bearing testimony to the efficacy of his Solution of Copaiba in Gonorrhœa, for which disease Mr. Cooper has prescribed the Solution in ten or twelve cases with perfect success.

"New street, April 13, 1835."

From Alexander Tweedie, Esq. Surgeon to the Metropolitan Free Hospital, Carey street, Lincoln's Inn Fields.

"My dear Sir,—I have notes of six cases, in which I have administered your preparation of Copaiba, for the cure of Gonorrhœa, in all of which the disease has been subdued in a shorter period of time than according to the ordinary plans hitherto made use of. Besides these cases of which I have taken notes, I have tried it in several instances at the Gruville Street Hospital, and am quite satisfied that it possesses a control over the urgent symptoms of Gonorrhœa, that I have not observed in the usual methods of exhibiting Copaiba. In one instance only did it disagree with the stomach; but in this it seemed to depend rather on the method of exhibition than on the remedy itself, for, on diluting it with a larger quantity of water, the objection was at once obviated, and the patient got well in ten days from the time that he commenced taking the medicine. I have not had a case in which the discharge continued longer than ten days after commencing this treatment.

"I am, dear Sir, your's very truly,

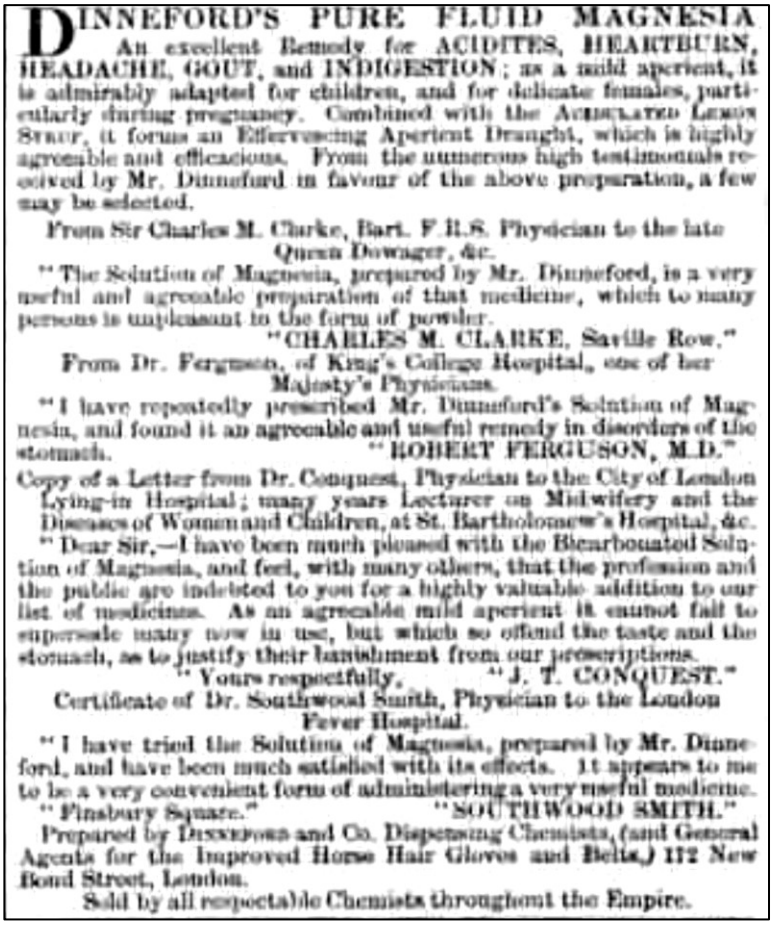
(Signed) "ALEXANDER TWEEDIE."

Within a period of two months, upwards of 300 patients were treated with Franks's Specific Solution of Copaiba, with perfect success, at the above Metropolitan Hospitals, viz. St. Thomas's, Guy's, and the Free Hospitals, by their respective Surgeons, whose Testimonials are given above.

Figure 4.21 Advertisement for Frank's Specific Solution of Copaiba, 1845

Source: *Gloucestershire Chronicle*, 4 July 1840, p.1. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

In a similar fashion, the advertisers of *Dinneford's Pure Fluid Magnesia* (Figure 4.22) quoted expert opinion from four eminent physicians, who each testified to having used the product on their patients with beneficial results.



DINNEFORD'S PURE FLUID MAGNESIA

An excellent Remedy for ACIDITES, HEARTBURN, HEADACHE, GOUT, and INDIGESTION; as a mild aperient, it is admirably adapted for children, and for delicate females, particularly during pregnancy. Combined with the Acidulated Lemon Syrup, it forms an Effervescing Aperient Draught, which is highly agreeable and efficacious. From the numerous high testimonials received by Mr. Dinneford in favour of the above preparation, a few may be selected.

From Sir Charles M. Clarke, Bart. F.R.S. Physician to the late Queen Dowager, &c.

"The Solution of Magnesia, prepared by Mr. Dinneford, is a very useful and agreeable preparation of that medicine, which to many persons is unpleasant in the form of powder.

"CHARLES M. CLARKE, Saville Row."

From Dr. Ferguson, of King's College Hospital, one of her Majesty's Physicians.

"I have repeatedly prescribed Mr. Dinneford's Solution of Magnesia, and found it an agreeable and useful remedy in disorders of the stomach. "ROBERT FERGUSON, M.D."

Copy of a Letter from Dr. Conquest, Physician to the City of London Lying-in Hospital; many years Lecturer on Midwifery and the Diseases of Women and Children, at St. Bartholomew's Hospital, &c.

"Dear Sir,—I have been much pleased with the Bicarbonated Solution of Magnesia, and feel, with many others, that the profession and the public are indebted to you for a highly valuable addition to our list of medicines. As an agreeable mild aperient it cannot fail to supersede many now in use, but which so offend the taste and the stomach, as to justify their banishment from our prescriptions.

"Yours respectfully, "J. T. CONQUEST."

Certificate of Dr. Southwood Smith, Physician to the London Fever Hospital.

"I have tried the Solution of Magnesia, prepared by Mr. Dinneford, and have been much satisfied with its effects. It appears to me to be a very convenient form of administering a very useful medicine.

"Finsbury Square." "SOUTHWOOD SMITH."

Prepared by Dinneford and Co. Dispensing Chemists, (and General Agents for the Improved Horse Hair Gloves and Belts,) 172 New Bond Street, London.

Sold by all respectable Chemists throughout the Empire.

Figure 4.22 Advertisement for Dinneford's Pure Fluid Magnesia, 1855

Source: *Gloucester Journal*, 6 January 1855, p.1 Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

The use of expert testimony more generally seems to have become increasingly common as the century progressed and was probably due to a conjunction of several factors, including medicine becoming more scientifically orientated, the professionalisation of pharmacy and expert opinion generally increasing in value as it came to be more widely employed in the judicial system and in industry. Loeb has claimed that 'more than any other model of human achievement, the advertisement relied on the expert. His was an elevating presence, a voice of calm rationality in a forum replete with exaggeration and distortion.[80] The technique was not restricted to

[80] Loeb, p.75.

medicines, but occurred in advertisements for food and beverages too, particularly tea, coffee, invalid and baby foods as illustrated by Figure 4.23.

NECESSARIES FOR CHRISTMAS.

STIVENS' ORIGINAL GREEN GINGER WINE,
STIVENS' UNIVERSAL SAUCE,
AND
COOPER'S STOMACHIC GINGER TONIC.

FOR the unprecedented quality of the first we refer the Public to the Testimonial of the celebrated Dr. Sheridan Muspratt; for the second, "Stivens' Universal Sauce," we would only say, no Beefsteak, Stew, Soup, or Fish, is complete without it.

To those suffering from Indigestion, Weakness of the Stomach or Diarrhœa, or to the Sportsman, we would say—Try "Cooper's Stomachic Ginger Tonic."

TESTIMONIAL.

The certificate of Dr. Sheridan Muspratt, F.R.S.E., Member of the Royal Irish Academy, and of the National Academy of France, &c., &c.

19th June, 1852.

Gentlemen,—Having carefully analysed (at your request) a portion of your "ORIGINAL GREEN GINGER WINE," I find it to be perfectly free from metallic astringents, so often used to adulterate British Wines.

As too much caution cannot be exercised by professional men of standing in recommending articles for general consumption, I hesitate in giving a hasty opinion until I have satisfied myself analytically and physiologically of its truth.

The Green Ginger, in your Wine, renders it an excellent antispasmodic, and an agreeable antiflatulative; in cases of leucophlegmacy it will prove serviceable; it is a very good stomachic, and its taste is most palatable.

One of its greatest recommendations, however, is its *purity and the excellence of its manufacture*. In conclusion, I can confidently say, that I consider your "ORIGINAL GREEN GINGER WINE" a valuable and most agreeable beverage, the moderate use of which cannot fail to prove beneficial, as well to the robust as to the invalid.

Yours respectfully,
SHERIDAN MUSPRATT, F.R.S.E.,
Membre de la Societe, D'Encouragement,
College of Chemistry, Duke Street.

The Public are requested to see also the Testimonials of the following eminent Medical Men:—William Herapath, Philosophical Chemist and Lecturer to the Bristol Medical School; Henry Ryley, M.D. Physician to the Bristol Infirmary; J. C. Prichard, M.D. Bristol; Henry Hawes Fox, M.D., Bristol; Henry Sully, M.D. Physician to his Majesty the King of Hanover, Taunton; J. A. Symonds, M.D. Bristol; James Heygate, M.D., F.R.S. Physician to the Derbyshire General Infirmary, Derby; Jonas Malden, M.D. Physician to the Worcester Infirmary, Worcester; Henry Johnson, M.D. Senior Physician to the Salop Infirmary, Shrewsbury; M. S. Kenny, M.D. Halifax.

Observe the signature—

John Stivens & Co

Over the neck of each Bottle.

Sold wholesale by the Manufacturers, W. and E. COOPER, Wine, Pickle, and Sauce Manufacturers, Sugar House, Wilder Street, Bristol; and all respectable Grocers, Druggists, and Confectioners.

Figure 4.23 Advertisement for Stivens' Original Green Ginger Wine, Universal Sauce and Stomachic Ginger Tonic, 1855

Source: *Gloucester Journal*, 6 January 1855, p.1.

It became increasingly common to provide testimonials purporting to be from chemists who had either analysed the product scientifically and found it to be pure and efficacious, or who had received positive feedback from their customers and felt compelled to share it. The increase in the use of this type of testimonial occurred concurrently with rising public concern about adulteration and food and drug quality,

fuelled by press reports of accidental and deliberate poisonings. The value placed on testimony from pharmaceutical or analytical chemists partly reflected these 'attempts to control adulteration [which] provided pharmacy with an important role in nineteenth-century science.'[81]

Overall, these techniques tell us several things about this trade. Most obviously, competition was intense enough to necessitate their use. Equally however, they suggest that manufacturers sought to distinguish themselves not by undercutting rivals on price but by establishing a trusted brand reputation. This challenges the notion that these products were all cheap rubbish and suggests many manufacturers were serious about the medicinal properties of their goods. At once, this segments the proprietary medicines trade from fair-ground quackery and suggests a different clientele. The fact that different approaches were used for different groups points further toward customer segmentation. Advertising was sophisticated enough to tailor messages to discrete groups of customers, be they embarrassed V.D. sufferers, those with chronic long-term conditions, men or women concerned about their personal appearance, or anxious mothers. As mentioned earlier, the omnipresence of testimonials indicates consumers were both sceptical and discerning and needed persuading through the deployment of an impressive array of references and recommendations. None of this suggests these products were designed to appeal to those who could not afford medical advice; rather their appeal was to those compelled to order by post through embarrassment or desperation and who would respond to printed endorsements from ordinary people, medical celebrities or trained experts. Proprietary medicine manufacturers competed primarily with each other on reputation and for the custom of those groups who were least well served by the regular medical offering. Further evidence to support such an interpretation can be found by looking at the endemic problem of counterfeiting.

4.4.2 Imitations and counterfeits.

In 1846, the *Gloucestershire Chronicle* reproduced a review of *The Health and Sickness of Town Populations* claiming 'more than half the drugs now sold to the public are adulterated or counterfeit.'[82] If the frequency with which advertisers warned their

[81] J. K. Crellin, 'Pharmaceutical History and its Sources in the Wellcome Collection: 1. The Growth of Professionalism in Nineteenth-Century British Pharmacy,' *Medical History,* Vol. 11, No.3 (July 1967), p.221.
[82] *Gloucestershire Chronicle,* 21 March 1846, p.3.

customers to beware of fakes is any measure, this claim may well be correct. However, Barker believed the prevalence of these warnings was also partly born of 'a dubious understanding of the workings of capitalism: that the medical marketplace could itself act as a regulator in some ways, as medicines that worked, and were known to work, were liable to be copied by others, and that this was itself a proof of their efficacy.'[83] Of the 302 advertisements for proprietary medicines included in the sample survey, 146 (48 per cent) contained some form of warning against imitations. Occasionally, the warning comprised the entire advertisement. Customers were entreated to ask for products by name, not to accept any generic substitute and to check for distinctive identifying marks before purchasing. This speaks not only of intense competition but as with testimonials it suggests the battleground was not price but brand reputation in an unregulated market largely devoid of intellectual property and copyright protections.

Prosecution for counterfeiting was only possible if it could be proven that the imitator had faked the government's stamp (confirming that Stamp Duty had been paid on the product) – to do so amounted to tax evasion. However, as Richards pointed out, 'over the years the government had, in effect, been pandering to the very patent medicine trade it was supposed to be regulating. Stamping the products was tantamount to giving them the government's seal of approval, and the quacks responded by using the stamps as an advertising gimmick.'[84] Whatever the legalities, 'for most consumers the stamp served to guarantee the product's authenticity and legitimacy';[85] hence the frequent reference in advertisements to the product being 'Protected by Royal Letters Patent of England.'[86] This situation encouraged imitation and in the absence of a clear legal route to redress, disputes over ownership of the "original" recipe were played out through the medium of the press. Warnings were frequently accompanied by an account of legitimate means by which this proprietor had obtained the 'original' recipe. To avoid being mis-sold an imitation, customers were encouraged to purchase directly from the proprietor by mail order, or from one of their trusted local agents. It was not unknown for rival manufacturers *of the same product* to advertise in the same newspaper and on the same page, as the two advertisements for *Widow Welch's Pills* shown in Figure 4.24 demonstrate. In this case, the two advertisements appeared one

[83]Barker, 'Medical advertising,' p.388.
[84] Richards, p.175.
[85] Morrison, p.16.
[86] *Gloucestershire Chronicle,* 7 April 1855, p.1. In this case the products being *Triesemar No.'s I, II and III*.

directly below the other, one from 'Mrs Smithers' and one from Kearsley's. Both claimed to be in possession of the 'real,' 'original and genuine' recipe and denounced the other as fake.

TWO LADIES.—THE ONLY GENUINE WIDOW WELCH'S PILLS are those prepared by Mrs. Sarrman, Greenland, late to the Widow Welch, from the real Family Recipe, without the least variation whatever.

This Medicine is justly celebrated for all Female Complaints, Nervousness & Headaches, Weakness of the Stomach, Loss of Appetite, Sick Headache, Lowness of Spirits, and particularly for Irregularities in the First & System. Mrs. Sarrman recommends Mothers, Guardians, Milliners of Schools, and all those who have the care of Females, at already a, to never be without this Real Medicine.

IMPORTANT CAUTION.—The ONLY REAL PREPARATION and Powder of the Recipe, Granddaughter of the late Widow Welch, feels it her duty, not only in defence of her own and most great, but as a protection to the Public, to declare HERSELF the ONLY PERSON entitled to the Original Recipe, or at all authorised to make or prepare the said Medicine.

Observe that the genuine are wrapped in blue paper, and signed on the label by Mrs. Smithers.

Sold in Bottles, at 1s. 3d., 2s. 9d., 4s. 6d., and 11s. each, by Wingate, Stafford; Tucker, Charrington, Millington, Lea, Gloucester; Jones, Wilton, Tewkesbury; Nelmes, Stroud; White, Painley; and most respectable Chemists and Booksellers.

FEMALE COMPLAINTS.

KEARSLEY'S ORIGINAL WIDOW WELCH'S FEMALE PILLS, so long and justly celebrated for their peculiar virtues are strongly recommended to the notice of every lady, having obtained the approbation of most gentlemen of the Medical Profession, as a safe and valuable Medicine to effectually remove obstructions, and relieving all other inconveniences to which the female frame is liable, especially those which, at an early period of life, frequently arise from want of exercise and general debility of the system; they create an appetite, correct indigestion, remove giddiness and nervous headache, and are eminently useful in windy disorders, pains in the stomach, shortness of breath, and palpitation of the heart; being perfectly innocent, they may be used in safety in all seasons and climates.

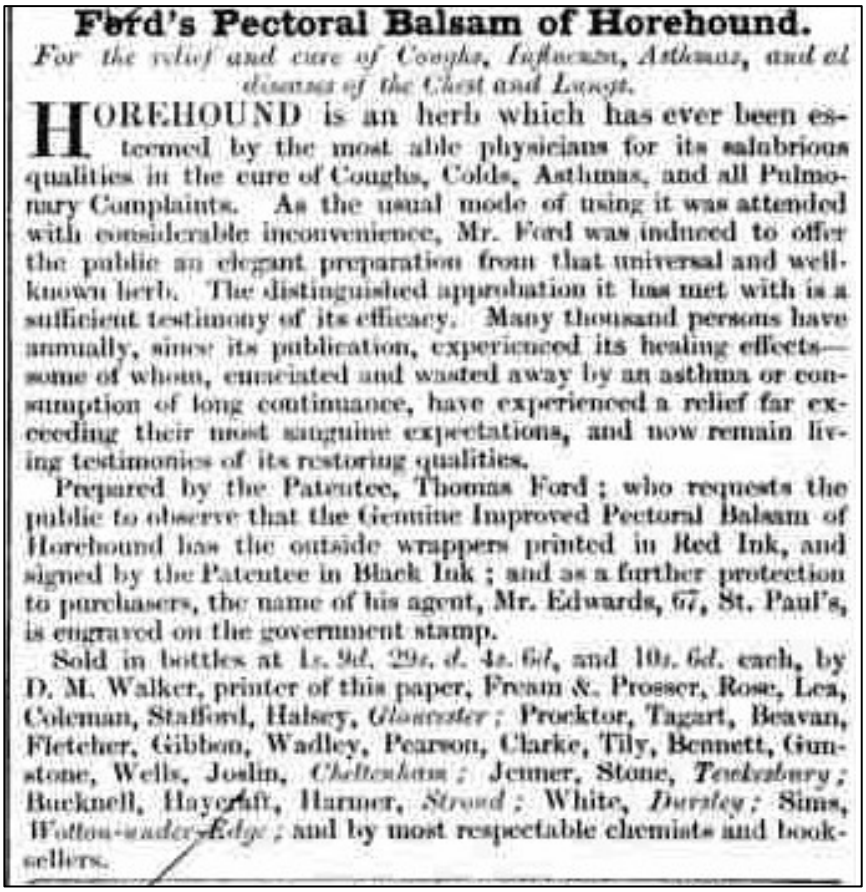
N.B. It is necessary, owing to the numerous imitations, to inform the Public that KEARSLEY'S is the only ORIGINAL and GENUINE MEDICINE of this description ever made, and has been prepared by them for more than seventy years.—Purchasers are particularly requested to remark, that as a testimony of authenticity, each bill of direction contains an affidavit, and bears the signature of "E. KEARSLEY" in writing, also engraved on the Government stamp, and each box is wrapped in white paper.

Sold, Wholesale and Retail, by J. Seager, 150, Oxford Street, London; in Boxes, price 2s. 9d. each, or by post for 36 Postage Stamps; and all respectable Medicine Vendors throughout the Country.

Figure 4.24 Advertisements placed by two rival manufacturers of Widow Welch's Pills, 1860

Source: *Gloucester Journal,* 7 January 1860, p.1. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

Often highly detailed information was provided on how to differentiate the genuine product from an imitation or describing what exactly the customer should say when asking for it in a shop so as to ensure they received the genuine article. The makers of *Ford's Pectoral Balsam of Horehound*, for example, drew the public's attention to the colour and wording of the stamp (Figure 4.25).



Ford's Pectoral Balsam of Horehound.

For the relief and cure of Coughs, Influenza, Asthmas, and all diseases of the Chest and Lungs.

HOREHOUND is an herb which has ever been esteemed by the most able physicians for its salubrious qualities in the cure of Coughs, Colds, Asthmas, and all Pulmonary Complaints. As the usual mode of using it was attended with considerable inconvenience, Mr. Ford was induced to offer the public an elegant preparation from that universal and well-known herb. The distinguished approbation it has met with is a sufficient testimony of its efficacy. Many thousand persons have annually, since its publication, experienced its healing effects—some of whom, emaciated and wasted away by an asthma or consumption of long continuance, have experienced a relief far exceeding their most sanguine expectations, and now remain living testimonies of its restoring qualities.

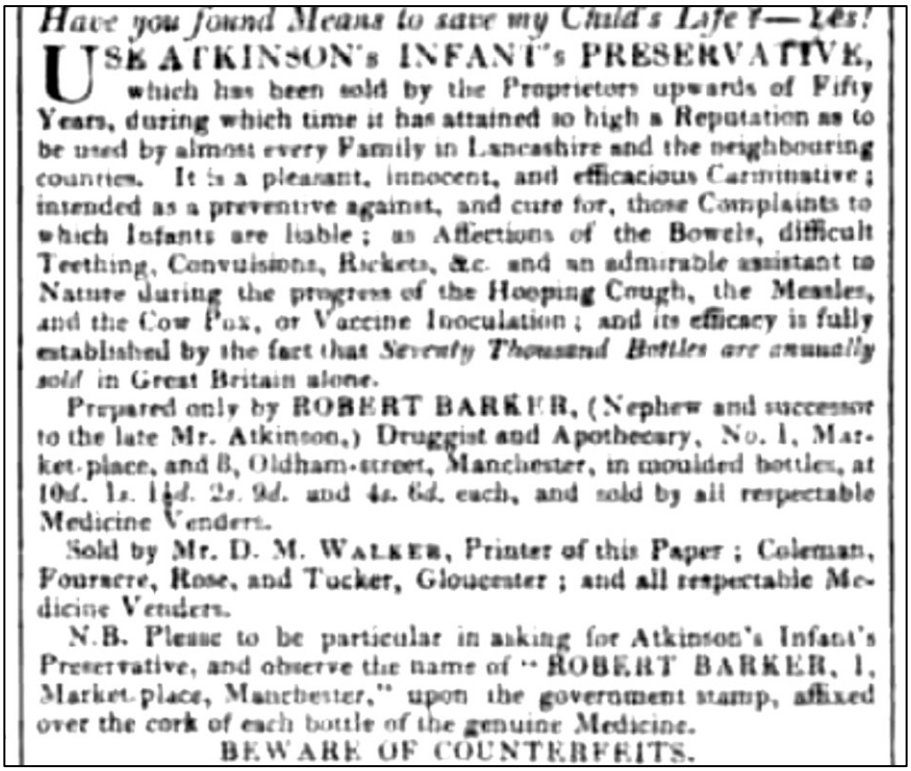
Prepared by the Patentee, Thomas Ford; who requests the public to observe that the Genuine Improved Pectoral Balsam of Horehound has the outside wrappers printed in Red Ink, and signed by the Patentee in Black Ink; and as a further protection to purchasers, the name of his agent, Mr. Edwards, 67, St. Paul's, is engraved on the government stamp.

Sold in bottles at 1*s.* 9*d.* 2*s.* *d.* 4*s.* 6*d.*, and 10*s.* 6*d.* each, by D. M. Walker, printer of this paper, Fream &. Prosser, Rose, Lea, Coleman, Stafford, Halsey, *Gloucester*; Procktor, Tagart, Beavan, Fletcher, Gibbon, Wadley, Pearson, Clarke, Tily, Bennett, Gunstone, Wells, Joslin, *Cheltenham*; Jenner, Stone, *Tewkesbury*; Bucknell, Haycraft, Harmer, *Stroud*; White, *Dursley*; Sims, *Wotton-under-Edge*; and by most respectable chemists and booksellers.

Figure 4.25 Advertisement for Ford's Pectoral Balsam of Horehound, 1845

Source: *Gloucester Journal,* 25 January 1845, p.1. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

Similarly, in Figure 4.26 the manufacturers of *Atkinson's Infant's Preservative* implored the purchaser to 'observe the name of "ROBERT BARKER, 1 Market-place, Manchester," upon the government stamp, affixed over the cork of each bottle of the genuine Medicine.'



Have you found Means to save my Child's Life?—Yes!

USE ATKINSON's INFANT's PRESERVATIVE, which has been sold by the Proprietors upwards of Fifty Years, during which time it has attained so high a Reputation as to be used by almost every Family in Lancashire and the neighbouring counties. It is a pleasant, innocent, and efficacious Carminative; intended as a preventive against, and cure for, those Complaints to which Infants are liable; as Affections of the Bowels, difficult Teething, Convulsions, Rickets, &c. and an admirable assistant to Nature during the progress of the Hooping Cough, the Measles, and the Cow Pox, or Vaccine Inoculation; and its efficacy is fully established by the fact that *Seventy Thousand Bottles are annually sold* in Great Britain alone.

Prepared only by ROBERT BARKER, (Nephew and successor to the late Mr. Atkinson,) Druggist and Apothecary, No. 1, Market-place, and 8, Oldham-street, Manchester, in moulded bottles, at 10*d*. 1*s*. 1½*d*. 2*s*. 9*d*. and 4*s*. 6*d*. each, and sold by all respectable Medicine Venders.

Sold by Mr. D. M. WALKER, Printer of this Paper; Coleman, Fouracre, Rose, and Tucker, Gloucester; and all respectable Medicine Venders.

N.B. Please to be particular in asking for Atkinson's Infant's Preservative, and observe the name of "ROBERT BARKER, 1, Market-place, Manchester," upon the government stamp, affixed over the cork of each bottle of the genuine Medicine.

BEWARE OF COUNTERFEITS.

Figure 4.26 Advertisement for Atkinson's Infant's Preservative, 1840

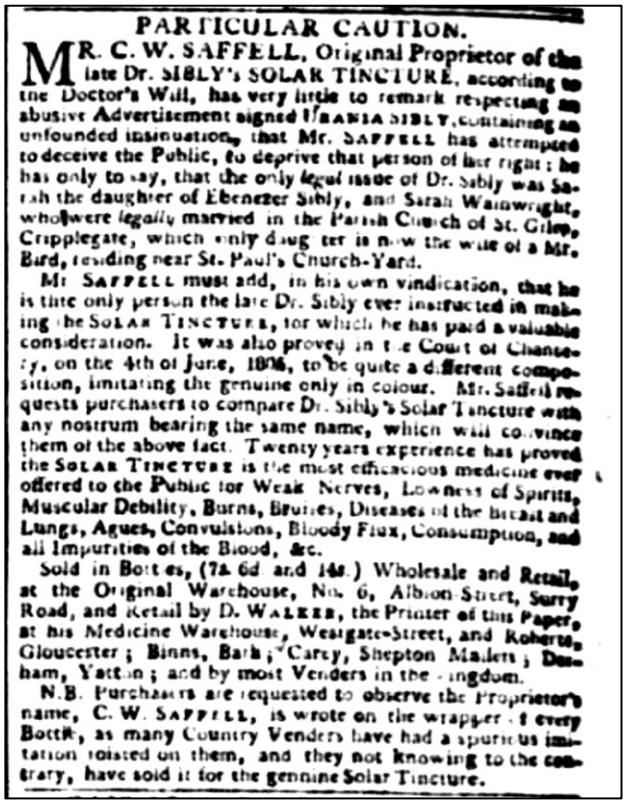
Source: *Gloucester Journal*, 25 June 1840, p.1. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

Just how expansive such warnings could be is illustrated in a further example; an advertisement for *Prince's Russia Oil*, which appeared in 1822:

> Proved by affidavit, the 24th November, 1814, before the Lord Mayor of London, that A. Prince is the Original Proprietor in the universe of the Russia Oil; and therefore if any Perfumer, Medicine Vender, Hair Dresser, or any one else, sell Russia Oil, that is not Prince's, they are impostors, as they sell counterfeits to their customers.
>
> It is no wonder that Ladies and Gentlemen have complained of late of the Russia Oil not being of service to the hair, as they have found out that unprincipled persons have sold them counterfeits.
>
> Ladies and Gentlemen will be particular as imposters in Great Britain, France, and other different parts of the Continent, have made the covers of counterfeit Russia Oil so much like the Genuine, and some more to deceive, falsely have printed on their counterfeit covers "the original" or "Genuine Russia Oil," and some even are so daring, although they know it punishable, to put the Original Proprietor's Name and pretend they are sent by the Proprietor, and also copied the Affidavit of the Original Proprietor, made before the Lord Mayor; therefore purchasers should be cautious, and have it of the Proprietor, or of respectable and principal Perfumers, Medicine Venders, and Hair Dressers; which they may rely on their not selling them spurious.
>
> Ask for Prince's Improved Russia Oil and observe "Prince" on the wrapper and seals; and his address "A. Prince, 9, Poland-street, Oxford-street, London," is on the cover of each bottle; without, it is not genuine, and cannot answer the purpose....
>
> Observe - There are trash Counterfeits selling in petty shops for any small price, which are injurious to the Hair, but the Genuine is only sold in two sizes, 5s and 20s bottles.

> Ladies and Gentlemen residing in the country, be certain of having the genuine Russia Oil, by sending a remittance to the Proprietor, it will be forwarded immediately by coach. Observe, there are persons who, finding they cannot now impose by selling counterfeit Russia Oil, it being now well known that Prince's is the original and genuine, so they pretend to sell Bear's Grease, but it is well known that Bear's Grease, or any other hard grease alone, is too harsh for the hair, and makes the hair fall off.[87]

The amount of attention this advertisement devotes to instructing customers in how to identify counterfeits and differentiate them from genuine article left little room even to explain the benefits of the product. In this case, its attributes are barely mentioned. It is difficult to know whether this advertisement reflected a genuine grievance that sales were being lost to impostors or whether it was a strategy to persuade customers the product was special enough to warrant widespread imitation. Numerous other examples adopt a similar refrain, such as that for *Dr Sibly's Solar Tincture* shown in Figure 4.27, which dates from a little earlier (1815). In this 37-line advert, only six lines related to the properties of the product, with the remainder devoted to denouncing an 'abusive advertisement' placed by a rival.



PARTICULAR CAUTION.

MR. C. W. SAFFELL, Original Proprietor of the late Dr. SIBLY'S SOLAR TINCTURE, according to the Doctor's Will, has very little to remark respecting an abusive Advertisement signed HANNA SIBLY, containing an unfounded insinuation, that Mr. SAFFELL has attempted to deceive the Public, to deprive that person of her right; he has only to say, that the only *legal* issue of Dr. Sibly was Sarah the daughter of Ebenezer Sibly, and Sarah Wainwright, who were *legally* married in the Parish Church of St. Giles, Cripplegate, which only daughter is now the wife of a Mr. Bird, residing near St. Paul's Church-Yard.

Mr SAFFELL must add, in his own vindication, that he is the only person the late Dr. Sibly ever instructed in making the SOLAR TINCTURE, for which he has paid a valuable consideration. It was also proved in the Court of Chancery, on the 4th of June, 1806, to be quite a different composition, imitating the genuine only in colour. Mr. Saffell requests purchasers to compare Dr. Sibly's Solar Tincture with any nostrum bearing the same name, which will convince them of the above fact. Twenty years experience has proved the SOLAR TINCTURE is the most efficacious medicine ever offered to the Public for Weak Nerves, Lowness of Spirits, Muscular Debility, Burns, Bruises, Diseases of the Breast and Lungs, Agues, Convulsions, Bloody Flux, Consumption, and all Impurities of the Blood, &c.

Sold in Bottles, (7s 6d and 14s.) Wholesale and Retail, at the Original Warehouse, No. 6, Albion-Street, Surry Road, and Retail by D. WALKER, the Printer of this Paper, at his Medicine Warehouse, Westgate-Street, and Roberts, Gloucester; Binns, Bath; Carey, Shepton Mallett; Dunham, Yatton; and by most Venders in the Kingdom.

N.B. Purchasers are requested to observe the Proprietor's name, C. W. SAFFELL, is wrote on the wrapper of every Bottle, as many Country Venders have had a spurious imitation foisted on them, and they not knowing to the contrary, have sold it for the genuine Solar Tincture.

Figure 4.27 Advertisement for Dr Sibly's Solar Tincture, 1815

Source: *Gloucester Journal,* 18 September 1815, p.4. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

[87] *The Glocester Herald,* 28 December 1822, p.2.

Evidence from the Gloucester press suggests the problem of counterfeiting was endemic, with advertisements containing warnings about imitations just as frequent in 1870 as they were in 1815. Their presence in such high numbers points not only to the fact that there were inadequate protections afforded to manufacturers, but that preserving brand reputation was of paramount importance; something that speaks of discerning customers capable of assessing the efficacy of a product and purchasing it on its merits as a medicine, rather than on its cost alone. By the nineteenth century, the concepts of brand loyalty and the unique selling point were already important in advertising and marketing strategy. The fierce competition for ownership of 'genuine' recipes and formulae tells us that what went into these products mattered to manufacturers and customers. Proprietary medicines need to be taken seriously as a legitimate part of the nineteenth century healthcare economy: one that rather than occupying a place amongst the medical fringe was positioned between prescribed medicines and traditional domestic remedies. Like doctors, manufacturers competed with each other more than with other types of supplier and represented a discrete stratum of healthcare. It is difficult to assess what customers thought of these products, but given the longevity of many of them, they clearly offered something the public wanted. This conclusion conflicts with some elements of the literature surrounding the medical marketplace, which, as we have seen, insists that their cheapness compared to medical prescriptions was their main selling point. To see if there is any merit in this widely held belief it is now necessary to look at pricing.

4.4.3 Pricing

That the success of proprietary medicines lay primarily in their cheapness *vis-à-vis* medical prescriptions and that 'the cost element was most attractive' is an entrenched assumption.[88] If this was the case, some doctors certainly had reason to fear this trade, for 'in cheap [medical] practices profits from the sale of medicine formed the largest single item of income'[89] However, whether proprietary medicines stole patients from doctors is at least questionable and we should not assume people bought the former simply because they were cheaper. As we have just seen, manufacturers focussed heavily on brand reputation and the cost difference between these products and

[88] P. Branca, *The Silent Sisterhood: Middle-Class Women in the Victorian Home* (London, 1975), p.67.
[89] F.B. Smith, *The People's Health 1830-1910* (London, 1990), p.371.

prescription medicines was not as great as might be imagined. Bearing in mind that it was common for doctors to operate sliding scale of charges based on the patient's ability to pay with and many doctors treating poor patients *gratis*, as the next chapter will show, there is robust evidence to suggest that most people sought regular medical advice when they *considered it was necessary*. Factoring in the role of the Dispensary, sick clubs and friendly societies we cannot assume that medical advice was unavailable to working people simply on grounds of cost – the picture is more complex. Even when a fee was involved the cost of medicines might not be vastly different from that of a proprietary medicine. Taking one example to illustrate this point, a surviving bill from a Gloucestershire surgeon, Mr Franklin of Saintbury, dating from the 1830s, charged the patient, one J.H. Beadles 3s 6d per journey, 2s for castor oil, 1s 6d for pills, 2s for an electuary, 1s for ointment, 6s for leeches.[90] Not including £1 1s for surgery to correct a hare lip, the bill for approximately four months of treatment, was £3 15s. Although the overall bill was substantial, the cost of the medicines was not much more than the entry level price of a proprietary medicine (usually 1s 1 $^1/_2$d), the premium was on the doctor's attendance and the surgery undertaken – neither of which could be substituted with an off-the-shelf remedy.

Most importantly, many proprietary medicines were not cheap, and the prices charged for them do not suggest a customer too poor to afford medical advice. Although boxes of pills and bottles of liquid usually started at 1s 1 1/2d for the smallest quantity or size (which according to one advertisement was offered 'for the convenience of the poor')[91] even this was not a token amount and in the patient's mind would be balanced against the likelihood of effecting a cure when compared to what could be obtained from a doctor. Beyond this entry-level price, most products were available in larger quantities/sizes on a scale that normally went 2s 9d, 4s 6d, 11s, 22s and 33s. Referring back to Mr Franklin's bill above, these prices do not compare all that favourably. Even *Holloway's Pills,* a market leader with scope for economies of scale did not deviate from the convention of offering sizes with prices ranging from 1s 1 $^1/_2$d a box through to 33s, the latter well beyond the means of most working-class families. Solomon's *Cordial Balm of Gilead* was only advertised in bottles priced 11 shillings or

[90] Doctor's bill, 1834, Gloucestershire, GA, Gloucestershire Archives, Franklin family of Saintbridge; family papers, MS, D/2029/2/5.
[91] From an advertisement for *Ching's Patent Worm Lozenges*, *Gloucester Journal,* 5 June 1820, p.4.

33 shillings, suggesting this product was not aimed at working-class customers at all. Table 4.3 provides a sample of prices over the period from 1815 through to 1870. Surprisingly, pricing remained remarkably consistent over time, with little or no differentiation between rival products throughout this fifty-five-year period. This seems extraordinary in a 'marketplace' supposedly characterised intense by competition between rival types of supplier.

Table 4.3 Examples of pricing of proprietary medicines 1815-1870

YEAR	PRODUCT	PRICES
1815	Dr. Radcliffe's Elixir Hallam's Antibilious Pills Tower's Tonic Pills	1s 1 1/2d [bottle] 2s 9d. And 4s. 6d [box] 2s. 9d. 4s. 6d. and 11s [box]
1820	Dr. Sydenham's Family Pills of Health Ching's Patent Worm Lozenges Mrs. Johnson's American Soothing Syrup	1s 1 1/2d, 2s 9d, and family boxes at 4s 6d "by which there is a considerable saving" 2s. 9d. "(and for the convenience of the poor, in Papers at 1s 1 1/d)" [box] 2s. 9d [bottle]
1825	Powell's Pectoral Balsamic Pills Cordial Balm of Rakasiri Dr. James's Powder	1s 1/2d and 2s 9d [box] 11s each, "or two quantities in each one, for 20s or four quantities in one family bottle for 33s, duty included, by which one 11s bottle is saved." [bottle] 2s 9d; Bottles 24s and 33s [packet]
1830	Dixon's Antibilious Pills Manning's Malta Exotic Dr. Glass's Magnesia	2s 9d, 4s 6d, 11s, and 22s [box] 2s 9d and 4s 6d [box] 2s 9d [box]
1835	Woodhouse's Balsam of Spermaceti, or Pectoral Cough Drops Wrey's Balsamic Pills Thorp's Horehound and Aniseed Pills	1s 1 1/2d, 2s 9d each, 4s 6d, and 10s 6d [bottle] 2s 9d, 4s 6d, and 11s [box] 1s 1 1/2d; "three in one at 2s 9d; or five in one at 4s 6d" [box]
1840	Franks's Specific Solution of Copaiba Dr. John Armstrong's Liver and Antibilious Pills Harvey's Bark Pills with Sarsaparilla	2s 9d, 4s 6d, and 11s [bottle] 1s 1 1/2d [box] 1s 1 1/2d and 2s 9d [box]

YEAR	PRODUCT	PRICES
1845	Dr. Grandison's Charity Pills Ford's Pectoral Balsam of Horehound Simco's Gout and Rheumatic Pills	1s 1 1/2d, 2s 9d and 4s 6d [box] 1s 9d, 2s 9d, 4s 6d, and 10s 6d [bottle] 1s 1 1/2d or 2s 9d [box]
1850	Eden's Ointment Bewley Fisher and Co.'s Concentrated Essence of Jamaica Ginger Parr's Life Pills	1s 1 1/2d, 2s 9d and 4s 6d [pot] 2s 6d and 4s [bottle] 1s 1 1/2d, 2s 9d, and family packets at 11s [box]
1855	Ford's Pectoral Balsam of Horehound Dr. Bateman's Pectoral Drops Dr. Locock's Pulmonic Wafers	1s 9d, 2s 9d, 4s 6d, and 10s 6d [bottle] 1s 1 1/2d [bottle] 1s 1 1/2d, 2s 9d, and 11s. "The 2s 9d boxes contain nearly three of the small size, and the 11s Boxes five of those at 2s 9d." [box]
1860	Lambert's Asthmatic Balsam Dr. Kiesow's Elixir of Life Snook's Family Pills	1s 1 1/2d, 2s 3d, and 4s 6d. [bottle] 2s and 4s [bottle] 1s 1 1/2d and 2s 9d [box]
1865	Frampton's Pill of Health Blair's Gout and Rheumatic Pills Kaye's Worsdell's Pills	1 1/2d and 2s 9d [box] 1s 1 1/2d and 2s 9d [box] 1s 1 1/2d, 2s 9d, and 4s 6d [box]
1870	Dr. King's Dandelion and Quinine Liver Pills Mrs. Winslow's Soothing Syrup Norton's Camomile Pills	1s 1 1/2d, 2s 9d, 4s 6d, and 11s [box] 1s 1 1/2d [bottle] 1s 1 1/2d, 2s 9d, and 11s [bottle]

The degree of uniformity in this table would be startling if this was a price-driven industry. Although it is conceivable local agents were given discretion over the prices they charged in store and those advertised were only indicative, no evidence has been found to support this and clearly rival producers did not attempt to compete with each other on advertised prices. This supports the conclusions of the previous section that brand reputation rather than price was the primary selling point for these medicines; something that speaks of a discerning customer capable of making a considered purchase.

Something else that points toward customers having spending power is the prevalence of bulk-buy deals. Larger quantities were commonly advertised at a reduced unit price which suggests that one potential market could have been the

stocking and re-stocking of medicine chests, something particularly popular in middle-class households for the use of family and servants. This trade was also a lucrative sideline for medical practitioners.[92] Marland has noted how 'those who could afford them kept well-stocked family medicine chests containing well-tried remedies for common complaints.'[93] Griggs meanwhile observed how "Ladies" who had once so confidently consulted their Gerard and Markham now left them to gather dust on the shelf while they tried their hand at a rather more potent medicine.'[94] Mrs Beeton recommended that a chest should contain the following:

> Antimonial Wine. Antimonial Powder. Blister Compound. Blue Pill. Calomel. Carbonate of Potash. Compound Iron Pills. Compound Extract of Colocynth. Compound Tincture of Camphor. Epsom Salts. Goulard's Extract. Jalap in Powder. Linseed Oil. Myrrh and Aloe Pills. Nitre. Oil of Turpentine. Opium, powdered, and Laudanum. Sal Ammoniac. Senna Leaves. Soap Liniment. Opodeldoc. Sweet Spirits of Nitre. Turner's Cerate. – To which should be added: Common Adhesive Plaster, Isinglass Plaster. Lint. A pair of small Scales with Weights. An ounce and a drachm Measure-glass. A Lancet. A Probe. A pair of Forceps, and some curved Needles.[95]

Such a comprehensive array of drugs and equipment would have been expensive and beyond the means of an average working-class household. Beeton does not recommend any proprietary medicines, but the prevalence of bulk-buy deals strongly suggests this was a market that manufacturers were interested in. Those who kept medicine chests were concerned with prudence and preparedness; just the sort of people likely to make considered and discerning choices, and to value efficacy over cost. Combined with the absence of price differentiation, it suggests a middle-class customer. If consumers were not, for the most part, people unable to afford medical assistance, this could be more evidence of a stratified healthcare economy. To explore this hypothesis further it is necessary to now look in detail at what advertisements disclose about the groups of customers manufacturers were most interested in.

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[92] M. M. Hendriksen, 'Consumer Culture, Self-Prescription, and Status: Nineteenth-Century Medicine Chests in the Royal Navy,' *Journal of Victorian Culture,* Vol.20, No.2 (2015), p.148.

[93] H. Marland, ''The Doctor's Shop': The Rise of the Chemist and Druggist in Nineteenth-Century Manufacturing Districts' in L.H. Curth (ed.), *From Physic to Pharmacology: Five Hundred Years of British Drug Retailing* (Aldershot, 2006), p.93.

[94] B. Griggs, *Green Pharmacy: The History and Evolution of Western Herbal Medicine* (Rochester, VE, 1981), p.184.

[95] I. Beeton, *Beeton's Book of Household Management.* Facsimile edition. (London, 1982 [1861], p.1061.

4.4.4 Customers

A useful starting point in discerning who the customers for proprietary medicines might be is to look at the parallel trade in advice literature, which blossomed in this age of self-reliance where, in an emergent urban-industrial society, traditional sources of healing knowledge were disrupted. Given what we have seen so far it is likely the customers for both were often the same people. Certainly, the vibrant trade in advice literature suggests a large cohort of consumers who were quite happy to self-medicate. Advice literature had a long history; its roots lay in the medical recipes handed down within families through generations and throughout the early modern period, 'interest in maintaining one's health was a fairly universal concern, and that making medicines at home was a common pastime – or, for many early modern housewives, even a duty.'[96] The advent of affordable printed text helped to commercialise this activity and according to Porter and Porter, 'a great quantity of advice was disseminated about health promotion and disease prevention.'[97] A market existed for this material as long as 'healing without any view to reward, but rather out of neighbourliness, paternalism, good housekeeping, religion, or simple self-help' remained important.[98] Bynum similarly found 'a vigorous market in medical advice' providing 'laymen instructions for drug remedies for a wide variety of disorders;'[99] something Holloway thought meant 'a substantial area of health care escaped control by the medical profession.'[100]

Evidence of the continued vitality of lay-healing traditions into the nineteenth century is widespread, as these examples from the village of Mickleton in Gloucestershire and dating from the 1830s, illustrate:

> ***For a bowel complaint***
>
> *Two ounces of tincture of rhubarb*
>
> *One of tincture of Aloe*

---

[96] E. Leong, 'Making Medicines in the Early Modern Household,' *Bulletin of the History of Medicine*, Vol.82, No.1 (2008), p.146.
[97] Porter and Porter, *Patient's Progress*, p.6.
[98] R. Porter, 'The Patient in England, c.1660-c.1880' in A. Wear (ed.), *Medicine in Society* (Cambridge, 1992), p.94.
[99] W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge, 1994), p.164.
[100] S.W.F. Holloway, *Royal Pharmaceutical Society of Great Britain, 1841-1991: A Political and Social History* (London, 1991), p.57.

For a person of strong habit of body take a table spoonful and if that is not sufficient to remove the pain repeat in the course of an hour.

For a Cancer under the Eye

Drink daily a quart of tar water washing the part with it apply a plaister of mutton suet and tar meted together.

For Corns

Powdered chalk mixed with your fasting spittle or the juicegrains of Rhubarb of the [illegible] *every morning and evening well wetted with a pitch plaster of Venice turpentine spread on white leather.*

For a bowel complaint

60 grains of Rhubarb

60 grains of prepar'd ginger

Mixed well in 12 Table Spoonfuls of Brandy

One or two Tablespoonfuls to be taken in a wine glass of Water.

Pills

1 ¼ oz of Rhubarb

1 oz of Julap

6 pennyworth of [illegible]

A little soap mix all together with a little Ether roll'd in Magnesia

Fever mixture

1 Teaspoonful & a half of Magnesia

1 Do of Spirits of Nitre

To be taken in a glass of water.[101]

Porter and Porter found 'the more lethal (or "incurable") the condition, the greater the number of recipes in the family recipe books and on the grapevine,'[102] while also cautioning 'a recipe book is not in itself a proof of use.'[103] By the nineteenth century, these hand-written recipes and word-of-mouth advice were being superseded by mass printed books and pamphlets. Most of this material was not directed toward those who renounced orthodox medicine or were too poor to afford it – the market mostly comprised those who were interested in medical science but wanted for a variety of reasons to take charge of their own treatment; i.e. a very similar clientele to that of the proprietary medicines industry. Porter and Porter found that 'all the signs are that the

[101] Accounts of payments, 1831-35 (few entries) and (at end) recipes for food and medicine, n.d., 1831-1846, Gloucestershire, GA, Mickleton village records, MSS, D5290/2.
[102] Porter and Porter, *Patient's Progress*, p.261.
[103] *Ibid*, p.268.

educated eagerly assimilated those bodies of orthodox medical knowledge that were increasingly in circulation in a print-dominated market society.'[104]

Doctors themselves frequently published collections of letters, advice books and pamphlets, research findings, or accounts of particularly complex or unusual surgical procedures, for public consumption. These were considered acceptable forms of self-promotion. Doctors also authored home doctoring books aimed at a mass readership and Porter believed that although 'doctors doubtless had mixed motives for writing home-care books, reward and reputation being amongst them…one should not underestimate how far a sector at least of the regular medical profession positively advocated enlightened self-care and educated auto-medication.'[105] One of those drawn to enter this market, Samuel Thompson, addressed potential criticism from colleagues in his preface to *A Dictionary of Domestic Medicine and Household Surgery* (1852):

> I know well what is said by a few, about injuring the medical profession, by making the public their own doctors. Nothing will be so likely to make "long cases" as for the public to attempt any such folly; but people of moderate means – who, as far as medical attendance is concerned, are worse off than the pauper – will not call in and fee their medical adviser for every slight matter, and in the absence of a little knowledge, will have recourse to the prescribing druggist, or to the patent quackery which flourishes upon ignorance, and upon the mystery with which some would invest their calling. And not patent quackery alone, but professional quackery also, is less likely to find footing under the roof of the intelligent man who, to common sense and judgement, adds a little knowledge of the whys and wherefores of the treatment of himself and his family. Against this knowledge which might aid a suffer from accident, or in the emergency of sudden illness, no humane man could offer or receive an objection.[106]

Here Thompson hit upon one of the groups identified in this chapter as most likely to buy proprietary medicines when he refers to those who 'will not call in and fee their medical adviser for every slight matter'; in other words, those with minor ailments that did not warrant medical attention.[107] We have seen already how these people comprised one of the largest groups of potential customers and a wide array of products catered for them. *Rowland's Kalydor,* for example, claimed to be "the auxiliary of beauty and preserver of the Complexion for the chilling blast". It was advertised as a treatment that

> …thoroughly exterminates Eruptions, Tan, Pimples, Freckles, Redness, and all cutaneous Imperfections whatsoever - arrays the Neck, Hands, and Arms, in matchless whiteness -

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[104] R. Porter and D. Porter, *In Sickness and in Health: The British Experience 1650-1850* (London, 1988), p.274.
[105] Porter, 'The Patient in England,' p.107.
[106] S. Thompson, *A Dictionary of Domestic Medicine and Household Surgery* (London, 1852), p.2.
[107] *Ibid.*

> bestows on the Complexion a juvenile bloom - renovates beauty when on the decline, realises it where before absent, and sustains it in pristine splendour to the latest periods of life, diffusing a pleasing coolness truly refreshing.[108]

As well as dealing with minor or cosmetic problems not deserving of medical attention, the more dubious fringes of the trade in advice literature provided opportunities for quackery. Typical of these was an advertisement placed by one G. Thomas of Newcastle-upon-Tyne under the headline 'AN ACT OF GRATITUDE. 5,000 copies of a Medical book for gratuitous circulation,' which went on:

> GEORGE THOMAS. Esq. having been effectually cured of a nervous debility, loss of memory, and dimness of sight, resulting from the early errors of youth, by following the instructions given in a Medical Work by a Physician, he considers it his duty, in gratitude to the author, and for the benefit of nervous sufferers, to publish the means used. He will therefore send free, to any address, in a sealed envelope, on receipt of a directed envelope enclosing two stamps, to pre-pay postage, a copy of the medical work.[109]

As with proprietary medicines, we should be cautious in assuming those taken in by such material comprised solely the gullible poor. It is more likely the desperate who would resort to such offerings and Young's remark that 'since people hope for the impossible, the quack always has a potential clientele' goes some way to explaining the appeal of these advertisements.[110] Some customers undoubtedly came in hope rather than expectation and with a sense of needing to feel everything had been tried.

As in the advice literature market, there was plenty of demand for proprietary medicines without the need to compete with doctors for business. If minor and cosmetic ailments accounted for a significant part of the market, there was also a plentiful reservoir of potential customers whom the doctors could do nothing to help, or who had had quite enough of their unpalatable and ineffective remedies. In addition, some people were probably willing to buy products for others that they might not be prepared to use themselves. Yet another important group comprised those too embarrassed or with too great a sense of shame to seek medical attention, most commonly venereal disease sufferers and those with various sexual problems. Davenport-Hines has described how in the nineteenth century 'sexual diseases… were

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[108] *The Gloucester and Cheltenham Herald,* 13 November 1826, p.1.
[109] *Gloucester Mercury,* 2 May 1857.
[110] Young, 'Patent Medicines,' p.652.

invested with additional anxieties'[111] and venereal disease cures were, as might be expected, couched in euphemism, attributing symptoms to unlikely causes such as being 'too long residence in hot climates' and thereby exploiting the sufferer's capacity for self-deceit.[112] Advertisers made much of the unpleasant side-effects of the mercurial treatments favoured by the medical profession, as for example in Figure 4.28, which claims the product to be 'devoid of taste and smell and of all nauseating qualities' associated with mercury.[113]

TRIESEMAR, protected by Royal Letters Patent of England and secured by the Seals of the Ecole de Pharmacie de Paris, and the Imperial College of Medicine, Vienna.

TRIESEMAR No. 1.

Is a remedy for Relaxation, Spermatorrhœa, and Exhaustion of the System, whether arising from excesses, accident, or climate.

TRIESEMAR No. 2

Effectually, in the short space of three days, completely and entirely eradicates all traces of those disorders which Capaivi and Cubebs have so long been thought an antidote for, to the ruin of the health of a vast portion of the population.

TRIESEMAR No. 3.

Is the great continual remedy for that class of Disorders which, unfortunately the English Physician treats with Mercury, to the inevitable destruction of the patient's constitution, and which all the Sarsaparilla in the world cannot remove.

TRIESEMAR, Nos. 1, 2, and 3, are alike devoid of taste or smell, and of all nauseating qualities. They may lay on the toilet table without their use being suspected.

Sold in tin cases at 11s each; free of post, 2s extra; divided into separate doses, as administered by Valpeau, Lallemand, Roux, &c., &c. To be had wholesale and retail in London, of Johnson, 68, Cornhill; Hannay and Co. 63, Oxford-street; and Sanger, 150, Oxford-street; R. H. Ingham, druggist, 46, Market-street, Manchester; H. Bradbury, bookseller, Deansgate, Bolton; J. Priestly, chemist, 12, Lord-street, Liverpool; Powell, bookseller, 18, Westmorland-street, Dublin; Winnall, bookseller, High-street, Birmingham.

Figure 4.28 Advertisement for Triesemar Nos.1. 2 and 3, 1855

Source: *Gloucester Journal*, 13 January 1855, p.1. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

Nicholls has identified how the heroic dosing with toxic chemicals and blood-letting favoured by early-nineteenth-century medical practitioners, 'particularly when treating venereal disease, begun to appear increasingly objectionable to the public.'[114] In total, 27 of the products in the sample survey advertised the absence of mercury, calomel, blue pill, or antimony as a selling point. *Dr King's Dandelion and Quinine Liver Pills*, shown in Figure 4.29, for example, were advertised as 'Liver Pills without Mercury' and claimed that 'Thousands of Constitutions have been destroyed by Mercury, Blue Pill, or Calomel.'[115]

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[111] R. Davenport-Hines, *Sex, Death and Punishment: Attitudes to Sex and Sexuality in Britain since the Renaissance* (London, 1991), p.156.
[112] *Gloucester Mercury,* 26 September 1857, p.1.
[113] *Gloucester Journal*, 13 January 1855, p.1.
[114] P. A. Nicholls, *Homeopathy and the Medical Profession,* (London, 1988), p.96.
[115] *Gloucestershire Chronicle,* 2 April 1870, p.7.

LIVER PILLS WITHOUT MERCURY

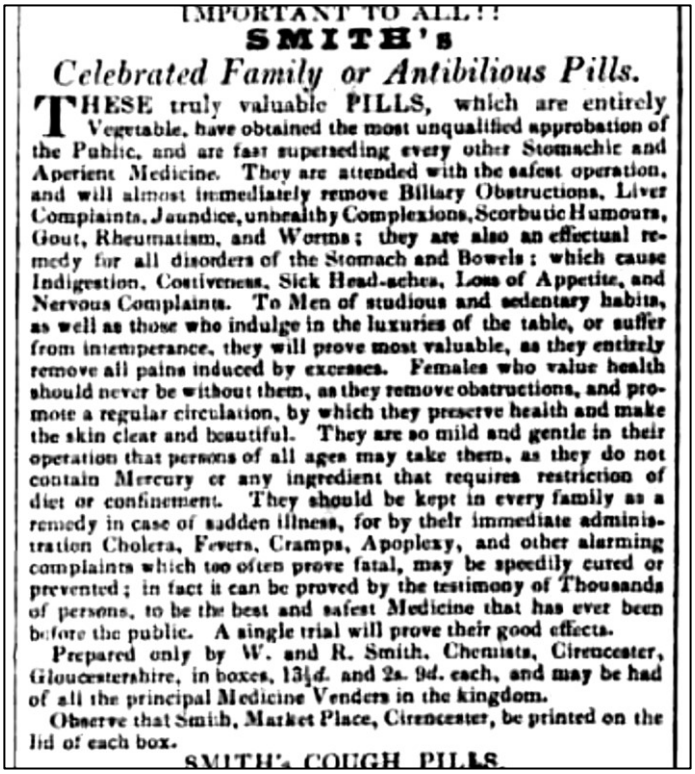
ONLY two Medicines really act upon the Liver - one is Mercury or Blue Pill, the other Dandelion. Thousands of Constitutions have been destroyed by Mercury, Blue Pill, or Calomel The only safe remedy is

DR. KING'S DANDELION and QUININE LIVER PILLS. Which act very gently on the Liver, giving immediate relief in all cases of Bile, Indigestion, Sick Headache, Loss of Appetite, Giddiness, Spasms, Heartburn, Flatulency, Nervousness, Gout, and all disorders of the stomach and bowels. Manufactured by J. Rorke, 47, Mortimer Street, London, W. and sold all over the world by every respectable Chemist and Medicine Vendor, in boxes, at 1s. 1½d., 2s. 9d., 4s. 6d., and 11s. each.

Figure 4.29 Advertisement for Dr King's Dandelion and Quinine Liver Pills. 1870

Source: *Gloucester Journal*, 1 January 1870, p.7. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

This theme of safety appears also in an advertisement for *Smith's Pills,* shown in Figure 4.30, which were marketed as 'entirely vegetable,' 'mild and gentle':



IMPORTANT TO ALL!!

SMITH'S

Celebrated Family or Antibilious Pills.

THESE truly valuable PILLS, which are entirely Vegetable, have obtained the most unqualified approbation of the Public, and are fast superseding every other Stomachic and Aperient Medicine. They are attended with the safest operation, and will almost immediately remove Biliary Obstructions, Liver Complaints, Jaundice, unhealthy Complexions, Scorbutic Humours, Gout, Rheumatism, and Worms; they are also an effectual remedy for all disorders of the Stomach and Bowels: which cause Indigestion, Costiveness, Sick Head-aches, Loss of Appetite, and Nervous Complaints. To Men of studious and sedentary habits, as well as those who indulge in the luxuries of the table, or suffer from intemperance, they will prove most valuable, as they entirely remove all pains induced by excesses. Females who value health should never be without them, as they remove obstructions, and promote a regular circulation, by which they preserve health and make the skin clear and beautiful. They are so mild and gentle in their operation that persons of all ages may take them, as they do not contain Mercury or any ingredient that requires restriction of diet or confinement. They should be kept in every family as a remedy in case of sudden illness, for by their immediate administration Cholera, Fevers, Cramps, Apoplexy, and other alarming complaints which too often prove fatal, may be speedily cured or prevented; in fact it can be proved by the testimony of Thousands of persons, to be the best and safest Medicine that has ever been before the public. A single trial will prove their good effects.

Prepared only by W. and R. Smith, Chemists, Cirencester, Gloucestershire, in boxes, 13½*d.* and 2s. 9*d.* each, and may be had of all the principal Medicine Venders in the kingdom.

Observe that Smith, Market Place, Cirencester, be printed on the lid of each box.

SMITH'S COUGH PILLS.

Figure 4.30 Advertisement for Smith's Celebrated Family or Antibilious Pills, 1845

Source: *Gloucester Journal*, 4 January 1845, p.1. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

These examples show how the unpleasantness of the medical remedies on offer fuelled the market for alternatives among those who could afford medical treatment but did not want it or had had enough of it. The stigma associated with venereal disease

and a range of other 'conditions,' including masturbation ('secret vice'), mental health problems and unwanted pregnancies also made the anonymity offered by medicines that could be obtained discretely by mail order without any face-to-face contact, attractive. These customers were likely to try a proprietary medicine before, or instead of, facing the humiliation of a consultation with a doctor that might know, or know of them or their acquaintances; a risk that in a small city like Gloucester was particularly acute. Advertisers were well-aware of the opportunities such thinking accorded for charging high prices as we saw with Solomon's *Cordial Balm of Gilead*. In 1860 an advertisement by Walter De Roos for his book *The Medical Adviser* played upon the fears of desperate people:

> To those who contemplate marriage its perusal is especially recommended - The knowledge it imparts must come some time, and happy they who do not possess it too late. - Cure is certain in every curable case, and few indeed are they which are not so. - It is calculated to effect a complete revolution in the treatment of these complaints. - Simple and inexpensive, every sufferer may cure himself, speedily, privately, and at the least possible cost.[116]

Invoking the spectre of an impediment to marriage, this advertisement stresses the importance of prompt action with the promise of a certain cure. The tone in this case is beguilingly empathetic, but others chose to emphasise the extent of the sufferer's moral failure. Dr Solomon, advertising his *Cordial Balm of Gilead* (1815), referred to masturbation as 'a Delusive Habit generally learnt at Great Schools, [that] weakens and destroys the whole nervous system, and in the very flower of youth brings on all the infirmities of the most languid old age; rendering its votaries indifferent to all amusements, absent in company, dull and lifeless everywhere.'[117] Adopting an earnest and moralising tone, it casts the customer as a deviant, corrupted by others at an impressionable age: someone whom only the ministrations of Dr Solomon could restore to physical and moral health. Again, the target customer, a former pupil of 'Great Schools' was middle or upper-class, not working-class.

Adverts aimed at vulnerable women bore a similar hallmark, using euphemism and exploiting the customer's desire for discretion. Abortion was illegal in Britain and advertisers hid the abortifacient properties of their products in references to 'obstructions' or 'regulating the cycle,' which were ambiguous but understood by all.

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[116] *Gloucester Mercury,* 4 August 1860, p.1.
[117] *The Glocester Herald,* 5 August 1815, p.1.

Hooper's Female Pills, for example, were 'not equalled by any other Medicine in the relief of the Obstructions of Nature in the young or aged.'[118] Similarly, *Dr Fothergill's Tonic Female Pills* were 'recommended in general Debility of the Constitution, also as a safe and excellent remedy in those periodical irregularities which Females, of delicate and languid circulation, more especially the younger part, are liable to.'[119] Advertisers commonly invoked prevailing notions of female delicacy and fragility, something some potential customers may even have found attractive by validating their self-affirmed status as invalids in an age when invalidism itself offered a sometimes welcome opportunity to be excused from the stifling and tedious expectations and duties of a middle-class woman's life.[120] As Digby pointed out 'an invalid state had attractions for a woman who wished to create a private space to escape from the pressures of bourgeois society, with incessant demands of family life.'[121] Other advertisements targeted women because wives commonly managed the household budget. As the next chapter will show they largely undertook the purchase and collection of medicines and other healthcare items.[122] In addition, unmarried women often had caring responsibility for invalid siblings or ageing parents. As Folbre noted, 'the "cult of domesticity" contributed to the emergence of a distinctively female culture.'[123] And, according to Loeb, 'in the periodical press women, the clear audience of most nineteenth-century advertisements, encountered all the puffery and paraphernalia that Victorian consumer society could supply.'[124] A gender-specific discourse emerged emphasising notions of hygiene, cleanliness, beauty and purity appealed particularly to *middle-class* women, both affirming and resonating with prevailing gender stereotypes.[125]

Women were also targeted in their role as mothers by advertisements for medicines for children and infants. As chapter six will explore in more detail, this was

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[118] *Gloucester Journal*, 25 November 1837, p.1.
[119] *The Gloucester and Cheltenham Herald,* 23 July 1827, p.2.
[120] See A. Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine 1720–1911* (Cambridge, 1994), p.27; M. Bailin, *The Sickroom in Victorian Fiction: The Art of Being Ill* (Cambridge, 1994); M.H. Frawley, *Invalidism and Identity in the Nineteenth Century* (Chicago, ILL., 2004).
[121] Digby, *Making a Medical Living,* p.278.
[122] J. Robin, 'Family Care of the Elderly in a Nineteenth-Century Devonshire Parish,' *Ageing and Society*, Vol.4, No.4 (1984), p.515.
[123] N. Folbre, 'The Unproductive Housewife: Her Evolution in Nineteenth-Century Economic Thought,' *Signs*, Vol.16, No.3 (Spring 1991), p.465.
[124] Loeb, *Consuming Angels*, p.5.
[125] *Ibid.*

an area where resort to proprietary medicines was more common and might be preferred to regular medical advice. Here advertisers traded upon the fear and guilt of parents, exemplified by this advertisement for *Holloway's Pills* (1859), which warned:

> COMPLAINTS INCIDENT TO CHILDREN. In no country in the world are more children carried to an early grave than this. Cough, measles, scarletina, fevers, and similar diseases attack the little sufferers, and death but too often follows at a rapid pace; yet if at the first stage of the complaints parents were to have recourse to Holloway's Pills, all danger would be avoided; for the stomach and the bowels being gently cleansed by this mild aperient, the depraved humours corrected, and the secretions duly regulated, a perfect cure is soon effected, and the little patient is restored to sound health.[126]

In this case the product was recommended to be used before seeking medical advice, an approach also found in adverts for infant soothing syrups, which similarly stressed the need to start using the product quickly before any malady became established. Diseases of children were notoriously fast-acting, and advertisers exploited parents' fear that timely action was essential. If they could be persuaded to buy first and think later, or better still, stock up in preparation, so much the better. An example of this approach was *Dr Locock's Powders*, where an 1865 advertisement warned 'no family should be without these valuable Powders, ready to hand in all cases of sudden illness at night or day. In the 20 years that have elapsed since they were first used, the lives of many hundreds of children have been saved by their prompt administration.'[127]

Having looked at those people for whom regular medical advice was not considered the appropriate course of action, either because the ailment was too minor, the patient was a child, or the person was too embarrassed to contemplate medical assistance, at the other end of the spectrum were those beyond the curative powers of doctors, or who were too terrified by the prospect of surgery to face this as an option. As Davenport-Hines recognised, 'people who are in pain or in fear of death yearn for reassurance, grasp at any hope or power, and will gladly surrender their private judgement for the chance of relief.'[128] Barker too noted how 'in the case of medicines, we should not overlook the possibility that individual actions could be driven largely by desperation, and as such, do not lend themselves easily to analysis in terms of rational decision-making.'[129] Unsurprisingly, these people, who might best be collectively described as the desperate, formed one of the principal markets for proprietary

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[126] *The City of Gloucester Guardian,* 29 October 1859, p.1.
[127] *Gloucester Mercury,* 5 August 1865, p.1.
[128] Davenport-Hines, p.159.
[129] Barker, 'Medical Advertising,' p.380.

medicines. Among them were those afflicted by fast-acting infectious diseases, who were, as discussed in chapter three, often ineligible for treatment at an infirmary and for whom the medical profession could in any case do very little. Furthermore, these patients did not have time and were too ill to negotiate access to a doctor and likely sought whatever they could get hold quickly in the way of medication. Proprietary medicines were an obvious choice and some manufacturers responded by adding cholera, typhoid or dysentery to the lists of ailments their products could supposedly treat.

Of all the epidemic diseases, after smallpox cholera was arguably the most feared and wherever it appeared it highlighted both the impotence of the medical profession and the iatrogenic effects of its remedies. Here proprietary medicines filled an obvious void. For example, in 1849 (around the time of the second great cholera epidemic) *Twinberrow's Dandelion, Camomile and Rhubarb Pills* (1849) claimed to be effective against the disease, while also reassuring customers that 'in most cases mercurial may be avoided' (Figure 4.31).

IT is universally acknowledged that the only preventive of Cholera is to keep the secretions in a perfectly healthy state; for producing so desirable an object no Medicine has ever been so extensively patronised and found so efficacious as TWINBERROW'S DANDELION, CAMOMILE, AND RHUBARB PILLS, an effectual cure of Indigestion and all Stomach Complaints and Liver Affections. In cases of Constipation, these Pills never fail in producing a healthy and permanent action of the Bowels, so that in a short period aperients may be discontinued. Indigestion is a weakness, or want of power of the Stomach to convert what we take into healthy matter for the proper nourishment of the whole system; from it proceed nearly all the diseases to which we are liable—pain after eating a meal, distension of the stomach, heart-burn, eructations, acidity, unpleasant taste in the mouth; these are some of the consequences. It is impossible to enumerate all the symptoms; but whatever they may be, they are all occasioned by the food becoming a burden rather than support to the stomach, and in all stages the medicine most wanted is that which will afford speedy and effectual assistance to the digestive organs: to effect so desirable an object, the Dandelion, Camomile and Rhubarb Pills can with the greatest confidence be recommended. The peculiar preparation of Dandelion has an efficient effect on the liver, so that in most cases mercurials may be avoided.

Prepared by TWINBERROW, Pharmaceutical Chemist, 2, Edwards Street, London; and may be had of Prosser and Trenfield, late Fream and Prosser, Chemists, Gloucester; Mr. Taplin, Chemist, Bristol; Giles and Son, Clifton; Smith and Prockter, Cheltenham; Bennet and King, Chemists, Bath; Barclays and Edwards, London; Scott, Thomson, and Co. Calcutta; and all Patent Medicine Venders.

Figure 4.31 Advertisement for Twinberrow's Dandelion, Camomile. And Rhubarb Pills, 1849

Source: *Gloucester Journal,* 29 December 1849, p.1. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

Medical practitioners responded by warning of the threat posed by the 'cholera quacks,' the following example being emblematic:

> CHOLERA MORBUS & CHOLERA QUACKS
>
> We earnestly caution the public against the seductive bills of itinerant quacks, who placard the walls of this city with papers announcing the discovery of specifics for the *infallible* cure of Cholera. One will effect a miraculous discovery with a *pitch plaster*! – another recommends pills, as possessing magic powers of purification. Voltaire had a happy saying, which is not now obsolete for want of adaptation – *Notre credulité fait toute votre science – Our credulity constitutes your knowledge.* So it is with a great portion of gullible John Bulls, on whose credulity Quacks and Mountebanks drive a flourishing trade. An eminent physician of Bath once asked a notorious quack – "How is it you have so many patients?" The reply had more merit than the respondent's medicine had virtue – "You see" said he, "ten persons have just passed; now nine at least of them are fools – nine will visit me, and one call on you!"
>
> A certain "doctor's" magic balm, or mixture of some sort, won its way into the favour of old women in petticoats and pantaloons from its *exciting* quality – the brandy, mixed up with this wonder-working beverage, set old ladies' tongues in motion – those little "instruments of loquacity" echoes the praises of the *cordial* that raised their spirits. AS depression generally follows excitement, the brandy beverage was oft resorted to, particularly when those infallible attendants on languor – "the blue devils" – made their appearance. Thus the guinea bottles that cost the knowing "doctor" only a few shillings each, were exchanged in rapid succession for gold – the "doctor" transmuted, by his magic *dilution*, every half-pint of brandy into a sovereign charm at least *for himself!* Oh! when are the credulous to be saved from those who "pour drugs of which they know little into a body of which they know less." Alas, alas, for public credulity![130]

The plight of the cholera victim confronted by an array of ineffectual remedies was famously satirized in the second of Robert Cruikshank's *Random shots* (1832)[131], which depicts an impoverished patient experimenting with a selection of useless remedies, including a box of Blue Pills and a bottle of emetic, while sitting on a stall labelled 'starvation' – likely a reference to the equally ineffective Day of Fasting and Humiliation held on 21 March 1832.[132] In Gloucester, the hygeist, Mr C. Chubb of 7 Worcester Street, was claiming in August 1832 (shortly after cholera first appeared in the city) that the *Morison's Vegetable Universal Medicines* he stocked 'may be relied on as the most certain preventative and cure for CHOLERA MORBUS.'[133] A similar advertisement in June 1832 had made no mention of cholera.[134] Others quick to react

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[130] *The Gloucester and Cheltenham Standard*, 1 September 1832.
[131] 'A Cholera Patient Experimenting with Remedies'. Coloured etching by R.I. Cruikshank, [1832?]. [London] (24 Great Newport Street): Tomlinson, [1832?]. Wellcome Library, London. https://wellcomeimages.org/ [Date accessed: 28 June 2017].
[132] M.P. Park and R.H.R. Park, 'Fear and Humour in the Art of Cholera', *Journal of the Royal Society of Medicine,* Vol.103, No.12 (December 2010), p.p.481-483.
[133] *Gloucester Journal,* 4 August 1832.
[134] *Gloucester Journal,* 30 June 1832.

included the makers of *Daffy's Elixir* and *Smith's Antibilious Pills,* both of whom were claiming their products were effective against the disease as early as August 1832.[135] Similarly, *Eden's Pills*, if taken regularly, were also advertised as preventing cholera. Interestingly however, relatively few proprietary medicine manufacturers were prepared to risk the reputation of their product by entering this market, again suggesting that trust mattered. Safer ground was to be found offering treatments for chronic conditions, particularly those where the only alternative might be painful surgery, or where there was a prospect of spontaneous remission. Examples of this genre included *Squire's Original Grand Elixir*, which 'gives speedy and lasting Ease in the most violent fits of the Gout, Stone, or Gravel, and has frequently brought away Gravel and sometimes Stones of a large Size'[136] and *Mr Aranson's Tincture, for the Tooth Ache*, 'which gives immediate relief to the most extreme pain.'[137]

Perseverance was recommended, both to maximise the chances of a spontaneous recovery, for which the product could claim credit, and to encourage repeat purchases. Some remedies were also recommended to be used in combination with a prescribed regime of care, exercise, or diet, the therapeutic effects of which, if felt, might also be attributed to the product (a strategy also used by regular doctors). The range of ailments targeted by proprietary medicine manufacturers is illustrated in Appendix IV, which lists a sample of products on sale in 1850. Although by no means comprehensive, it provides a good sense of the spectrum on offer and illustrates well the point made earlier that proprietary medicines were targeted toward those least well-served by the regular medical offering, who were desperate to try anything or might otherwise do nothing. Importantly, these people were not defined by social class, gender, or the place in which they lived. Most of the ailments listed in Appendix IV were trivial, incurable with the extent of medical knowledge at the time, carried the burden of stigma and humiliation for the sufferer, or were digestive complaints where the emetic or laxative effect of the medicine might have an obvious effect. Within this milieu, another discrete group to be targeted were those travelling to places where access to Western medicine might be difficult or impossible. The Age of Reform was also an age of exploration and empire, with a burgeoning market to be found amongst overseas travellers, mariners, imperial officials, members of the armed forces, and explorers

[135] *Gloucester Journal,* 11 August 1832.
[136] *The Glocester Herald,* 14 October 1815, p.1.
[137] *The Glocester Herald,* 4 February 1815, p.3.

wishing to go prepared into climates where disease represented a mortal hazard. References to products being suitable for 'hot climates' or 'sea voyages' were aimed squarely at this market. Examples included *Spyring and Marsden's Essence of Anchovies* (1815), advertised for 'the attention of Merchants and Captains to these articles, as they are well adapted for exportation, and will keep in any climate.'[138] As we saw with venereal disease cures, hot climates were referenced not only as a source of disease, but in this case as a cause of deterioration in inferior products. Similarly, the makers of *Grimstone's Eye Snuff* (1845) claimed 'this celebrated snuff is shipped to all quarters of the globe, and retains its benign qualities in every climate.'[139] Others focussed solely on the health dangers. An advertisement for *Perry's Cordial Balm of Syriacum* (1840), for example, referred to its suitability in treating 'the bilious complaints contracted in hot climates'[140] and one for *Dr. King's Dandelion and Quinine Pills* (1860) claimed the product to be 'admitted by officers from India and other hot climates where Liver complaints abound to be the best Pill ever made.'[141] Advertisers encouraged travellers to stock up with medicines before departing as a prudent precautionary measure, with an advertisement for *Kaye's Worsdell's Vegetable Restorative Pills* (1867) addressed directly:

> To Emigrants and Persons residing in the Colonies these Pills are invaluable as they are admirably adapted to supply a great want that of a remedy always at hand, easy of application, and certain in its results…[142]

The final group of customers identified comprised those who can be broadly described as the disenchanted. This was a more disparate and nebulous group than the others, consisting of those who, for whatever reason, rejected, or had lost faith, in regular medicine. People might drift in and out of this group and/or simultaneously belong to others and they were probably less reliable as regular customers than the others. The infamous cure-alls were well-suited to appeal to these people, as they were not linked by any common ailments, but by their disillusionment with regular medicine. Cure-alls relied on whole-system aetiologies that provided customers with a cogent explanation of why a single product could treat seemingly unrelated conditions. Their

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[138] *Gloucester Journal,* 3 April 1815, p.4.
[139] *Gloucestershire Chronicle,* 5 July 1845, p.1.
[140] *Gloucestershire Chronicle,* 4 July 1840, p.1.
[141] *Gloucester Journal,* 7 January 1860, p.1.
[142] [unknown], *Gloucester Directory* ([unknown], 1867), p.83.

explanations differed little from those the medical profession had once favoured in the age of humoral theory. Such advertisements commonly held that 'disease resulted from one underlying state of the body,' tracing diverse symptoms to a common cause, often some disorder of the blood or nerves, or an imbalance in the humours.[143]

These theories were becoming increasingly outmoded as the nineteenth century progressed, but they retained widespread currency amongst the public, especially those sceptical of modern practices and drawn to the orthodoxies of their younger years. One example is emblematic of many; the infamous quack remedy *Dr Jordan's Cordial Balm of Raskiri* (advertisements for which claimed it to be made from the resin of an American tree species, but in fact it consisted of spirit of wine flavoured with rosemary oil and sugar) was sold as a cure for 'consumption and the decays of nature' and claimed it also had 'astonishing properties…in all cases of inveterate Scurvy, King's Evil, Rheumatic Gout, Palsy, Nervous Affections, Asthma, Consumption, Dropsy, and all disorders arising from an impure or impaired state of the blood.'[144] The advertisement explained, using pseudo-scientific language, that such impurities were the root of all disease:

> "In the Blood is Life;"
>
> and no longer is this vital stream kept in due circulation, pure and uncontaminated can the body be preserved in health and vigour. Hence the infinite variety of complaints an affected state of the blood produces, which brings on Diarrhoea, Dysentery, Dropsy, Consumption, Palsy, Contractions, Melancholy, and all the long direful strain of Nervous Disorders. The object is to reduce the virulence of the infection, and to eradicate its seeds from the blood and lymph, to which end the mildest and most simple medicines are recommended; but when those fail, mercury or a mercurial course is looked upon as the only cure, which. in fact, is to give the human frame its last [illegible] shock, and send the wretched patient in agonies to the grave.
>
> The peculiar property of the BALM OF RASAKIRI is, that it corrects, warms, purifies, animates, and impels through the whole system; it cleanses all the viscera and glandular parts, particularly the lungs and kidnies, [sic] stimulates the fibres, whereby the gastric juice and digestion are promoted; it exerts very considerable effects on the whole nervous system, sensibly rises the pulse, strengthens the solids, and invigorates the whole animal spirits, it penetrates into the most internate parts, restores the natural perspiration, and promotes all the fluid secretions.[145]

Adverts for *Holloway's Pills* (sold from 1837 onwards) similarly emphasised the importance of 'renewal of the blood' to recovery from all manner of unrelated conditions (Figure 4.32). This advertisement dates from 1865 and shows that even then,

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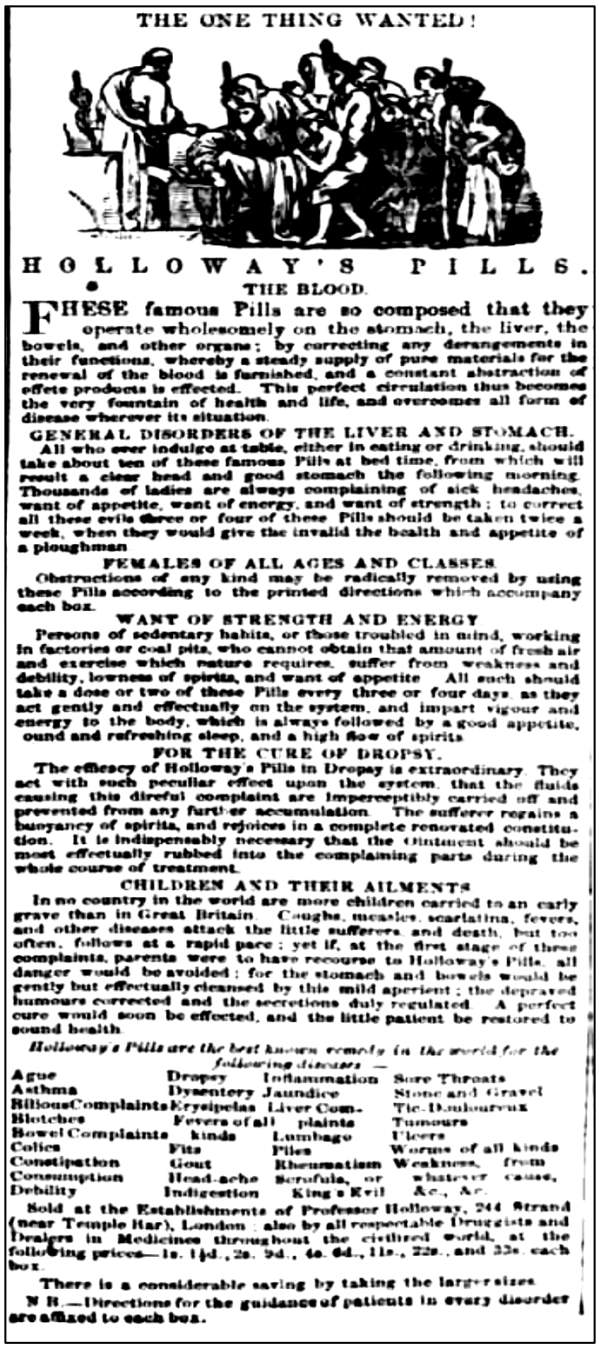
[143] N.D. Jewson, 'Medical Knowledge and the Patronage System in 18th century England,' *Sociology,* Vol. 8, No.3 (September 1974), p.372.
[144] *Gloucester Journal,* 5 June 1820, p.4.
[145] *Ibid.*

the notion that a single pill could 'operate wholesomely on the stomach, the liver, the bowels, and other organs; by correcting any derangements in their functions, whereby a steady supply of pure materials for the renewal of the blood is furnished, and a constant abstraction of effete products is effected,' was still seemingly tenable.[146]



THE ONE THING WANTED!

HOLLOWAY'S PILLS.

THE BLOOD.

THESE famous Pills are so composed that they operate wholesomely on the stomach, the liver, the bowels, and other organs; by correcting any derangements in their functions, whereby a steady supply of pure materials for the renewal of the blood is furnished, and a constant abstraction of effete products is effected. This perfect circulation thus becomes the very fountain of health and life, and overcomes all form of disease wherever its situation.

GENERAL DISORDERS OF THE LIVER AND STOMACH.

All who ever indulge at table, either in eating or drinking, should take about ten of these famous Pills at bed time, from which will result a clear head and good stomach the following morning. Thousands of ladies are always complaining of sick headaches, want of appetite, want of energy, and want of strength; to correct all these evils three or four of these Pills should be taken twice a week, when they would give the invalid the health and appetite of a ploughman

FEMALES OF ALL AGES AND CLASSES.

Obstructions of any kind may be radically removed by using these Pills according to the printed directions which accompany each box.

WANT OF STRENGTH AND ENERGY

Persons of sedentary habits, or those troubled in mind, working in factories or coal pits, who cannot obtain that amount of fresh air and exercise which nature requires, suffer from weakness and debility, lowness of spirits, and want of appetite. All such should take a dose or two of these Pills every three or four days, as they act gently and effectually on the system, and impart vigour and energy to the body, which is always followed by a good appetite, sound and refreshing sleep, and a high flow of spirits.

FOR THE CURE OF DROPSY.

The efficacy of Holloway's Pills in Dropsy is extraordinary. They act with such peculiar effect upon the system, that the fluids causing this direful complaint are imperceptibly carried off and prevented from any further accumulation. The sufferer regains a buoyancy of spirits, and rejoices in a complete renovated constitution. It is indispensably necessary that the Ointment should be most effectually rubbed into the complaining parts during the whole course of treatment.

CHILDREN AND THEIR AILMENTS

In no country in the world are more children carried to an early grave than in Great Britain. Coughs, measles, scarlatina, fevers, and other diseases attack the little sufferers, and death, but too often, follows at a rapid pace; yet if, at the first stage of these complaints, parents were to have recourse to Holloway's Pills, all danger would be avoided; for the stomach and bowels would be gently but effectually cleansed by this mild aperient; the depraved humours corrected and the secretions duly regulated. A perfect cure would soon be effected, and the little patient be restored to sound health.

Holloway's Pills are the best known remedy in the world for the following diseases —

Ague	Dropsy	Inflammation	Sore Throats
Asthma	Dysentery	Jaundice	Stone and Gravel
Bilious Complaints	Erysipelas	Liver Complaints	Tic-Douloureux
Blotches	Fevers of all kinds		Tumours
Bowel Complaints		Lumbago	Ulcers
Colics	Fits	Piles	Worms of all kinds
Constipation	Gout	Rheumatism	Weakness, from whatever cause, &c., &c.
Consumption	Head-ache	Scrofula, or King's Evil	
Debility	Indigestion		

Sold at the Establishments of Professor Holloway, 244 Strand (near Temple Bar), London; also by all respectable Druggists and Dealers in Medicines throughout the civilized world, at the following prices—1s. 1½d., 2s. 9d., 4s. 6d., 11s., 22s., and 33s. each box.

There is a considerable saving by taking the larger sizes.

N.B.—Directions for the guidance of patients in every disorder are affixed to each box.

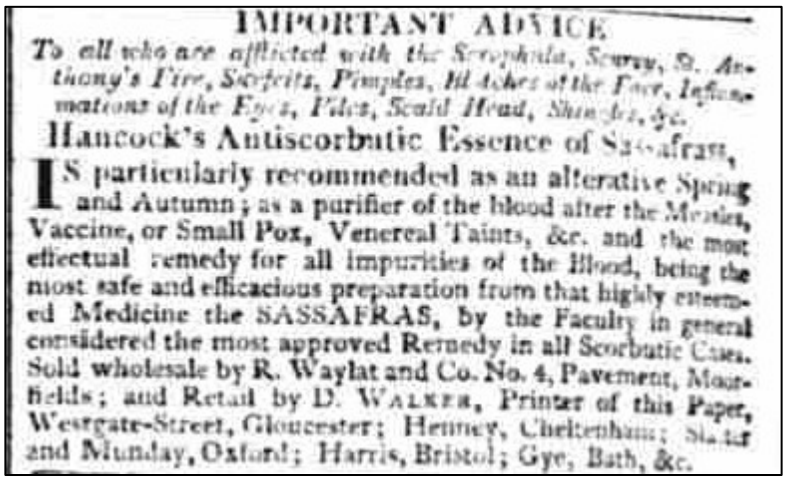
Figure 4.32 Advertisement for Holloway's Pills, 1865

Source: *Gloucestershire Chronicle,* 1 April 1865, p.7, www.BritishNewspaperArchive.co.uk [Date accessed: 31 March 2017] Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

[146] *Gloucestershire Chronicle,* 1 April 1865, p.7.

Any explanation that emphasised the necessity of ridding the body of toxins and restoring humoral balance was useful when, as discussed earlier, the active ingredient of these medicines, if there was one, usually comprised an emetic or laxative. This perhaps accounts for why, despite ground-breaking discoveries being made in the science of medicine, these explanations scarcely evolved over more than half a century: a point illustrated by comparing Figure 4.33 from 1814 with Figure 4.34 from 1870. This rationale was not confined to proprietary medicines: in his 1854 treatise on hydropathy, the Malvern water-cure doctor James Wilson advocated a similar whole system approach to disease, which he also linked to impurities in the blood:

> The *blood* is a vital fluid. Moses declared it to be *the life.* The vitality, however, is only retained so long as it is in the living vessels, and under the influence of the *nerves of organic life*, which preside over the vessels…The precise degree of its *vitality* also is regulated by the amount of vitality existing in the organic nervous system and vessels. In the state of these nerves and vessels is to be sought and found the explanation of the *phenomena of disease.*[147]



IMPORTANT ADVICE

To all who are afflicted with the Scrophula, Scurvy, St. Anthony's Fire, Scorbutic Pimples, Head-aches at the Face, Inflammations of the Eyes, Piles, Scald Head, Shingles, &c.

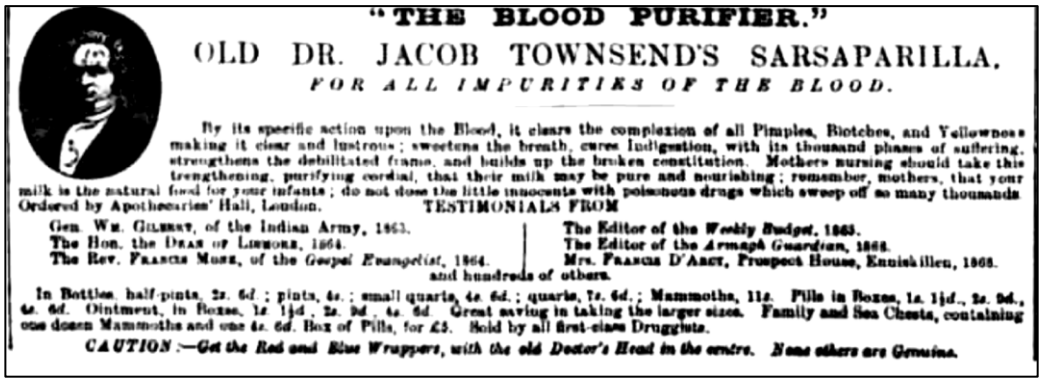
Hancock's Antiscorbutic Essence of Sassafras,

IS particularly recommended as an alterative Spring and Autumn; as a purifier of the blood after the Measles, Vaccine, or Small Pox, Venereal Taints, &c. and the most effectual remedy for all impurities of the Blood, being the most safe and efficacious preparation from that highly esteemed Medicine the SASSAFRAS, by the Faculty in general considered the most approved Remedy in all Scorbutic Cases. Sold wholesale by R. Waylat and Co. No. 4, Pavement, Moorfields; and Retail by D. WALKER, Printer of this Paper, Westgate-Street, Gloucester; Henney, Cheltenham; Slatter and Munday, Oxford; Harris, Bristol; Gye, Bath, &c.

Figure 4.33 Advertisement for Hancock's Antiscorbutic Essence of Sassafrass, 1814

Source: *Gloucester Journal*, 5 September 1814, p.4. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

[147] J. Wilson, *The Principles and Practice of the Water Cure: and Household Medical Science*, 2nd edition (London, 1854), p.xxi.


"THE BLOOD PURIFIER."

OLD DR. JACOB TOWNSEND'S SARSAPARILLA.

FOR ALL IMPURITIES OF THE BLOOD.

By its specific action upon the Blood, it clears the complexion of all Pimples, Blotches, and Yellowness making it clear and lustrous; sweetens the breath, cures Indigestion, with its thousand phases of suffering, strengthens the debilitated frame, and builds up the broken constitution. Mothers nursing should take this treengthening, purifying cordial, that their milk may be pure and nourishing; remember, mothers, that your milk is the natural food for your infants; do not dose the little innocents with poisonous drugs which sweep off so many thousands. Ordered by Apothecaries' Hall, London.

TESTIMONIALS FROM

Gen. Wm. Gilbert, of the Indian Army, 1863.
The Hon. the Dean of Lismore, 1864.
The Rev. Francis Muse, of the *Gospel Evangelist*, 1864.
The Editor of the *Weekly Budget*, 1865.
The Editor of the *Armagh Guardian*, 1868.
Mrs. Francis D'Arcy, Prospect House, Enniskillen, 1868.
and hundreds of others.

In Bottles, half-pints, 2s. 6d.; pints, 4s.; small quarts, 4s. 6d.; quarts, 7s. 6d.; Mammoths, 11s. Pills in Boxes, 1s. 1½d., 2s. 9d., 4s. 6d. Ointment, in Boxes, 1s 1½d., 2s. 9d., 4s. 6d. Great saving in taking the larger sizes. Family and Sea Chests, containing one dozen Mammoths and one 4s. 6d. Box of Pills, for £5. Sold by all first-class Druggists.

CAUTION:—Get the Red and Blue Wrappers, with the old Doctor's Head in the centre. None others are Genuine.

Figure 4.34 Advertisement for Old Dr Jacob Townsend's Sarsaparilla, 1870

Source: *Gloucester Journal*, 12 March 1870, p.7. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

The fact that advertisers went to the bother of concocting detailed explanations of how their products worked suggests they believed the public were interested in this information; something that again speaks of a discerning and educated customer. More interestingly, the fact that these explanations owed much to eighteenth-century understandings of disease suggests customers valued familiarity rather than completely alternative theories. If advertising is to be believed, proprietary medicine customers were not, for the most part, those people who were drawn to medical heresies like hygeism and homeopathy, which renounced conventional medical thought completely. In the harking back to medical theories of the previous century, proprietary medicine advertising highlights how tenacious these theories were in the public consciousness, but it also perhaps reflects the same middle-class *zeitgeist* that was contemporaneously embracing Medievalism, Romanticism and the Arts and Crafts movement. Clearly, the appeal of proprietary medicines was complex, with different groups of customers having quite different reasons for buying them but each of whom was, for various reasons, poorly served by regular medicine. Thus, rather than competing with doctors, the manufacturers of these remedies served those strata of the healthcare economy that doctors would not, or could not, treat.

4.5 Conclusion

The advertising of healthcare was described in the introduction to this chapter as the area in which evidence of a medical marketplace, characterised by diversity, plurality, choice and competition should be easiest to find. Superficially at least, this appears to have been the case, with a wide and diverse range of healthcare products and providers,

multitudinous choice available to buyers, and intense competition between rival manufacturers, each claiming authenticity and attacking their competitors as imitators and counterfeiters. Healthcare advertisers were found to be innovators and early-adopters of advertising techniques such as eye-catching banner headlines, memorable catch-phrases, and illustrations. They occupied a significant proportion of the advertising space in the Gloucester local press throughout the Age of Reform. The trade was dominated by large London manufacturers and distributors, who exploited the lack of regulation to make inflated claims for products of little therapeutic value.

Yet important questions have been raised over how this sector functioned and its relationship to the rest of the healthcare economy. Most importantly, the case that these products represented serious competition to regular medical practitioners has been contested. While many products advertised bore all the hallmarks of quackery, with their exaggerated claims, and bogus associations with great medical figures past and present, others were quite sophisticated in their appeal, carefully targeting discrete groups of customers. Overall, the findings of this chapter support King and Weaver's conclusion that 'the density of advertising…could not have been aimed at the labouring classes alone' and strong evidence exists that the principal market for proprietary medicines lay amongst the educated classes.[148] Interestingly, manufacturers did not compete on price, which remained fixed over many years. In fact, building reputation and 'proving' efficacy through testimonials seems to have been more important to advertisers than under-cutting rivals, and some of these products cannot, by any criteria, be described as cheap. Surprisingly, from being pioneers of advertising in the early years of the nineteenth century, proprietary medicine manufacturers did not keep pace with change, at least in provincial newspaper advertising and by 1870 their adverts appear stale, outdated, and unimaginative, compared to those for some other products and services. Although this loss of momentum was temporary and appears to have been confined to newspapers, it too raises questions as to the exact nature of competition.

Overall, the evidence presented here challenges conventional wisdom regarding the customers for proprietary medicines and the nature of competition between suppliers. The many contradictions and mixed messages found in healthcare

[148] S. King and A. Weaver, 'Lives in Many Hands: The Medical Landscape in Lancashire, 1700-1820,' *Medical History*, Vol.44, No.2 (April 2000), p.192.

advertising from this period reflect the extent to which this was a segmented market, in which manufacturers attempted to appeal simultaneously to quite different groups of consumers with markedly different expectations. Despite this, the proprietary medicines industry proved remarkably resilient to change and maintained its share of advertising space in the face of increasing competition from other groups. The most successful proprietors became household names. The industry adapted and evolved, albeit slowly, and its direct descendants in today's alternative or complimentary supplements industry continue to thrive on a not dissimilar discourse of distrust and disillusionment with orthodox medicine.

Importantly, the findings do not support the assumption that proprietary medicines were primarily aimed at and bought by those easily duped or too poor to afford regular medical advice. What customers had in common was not poverty or ignorance, but that they did not need, did not want, or could not get, medical advice and had the means to try alternatives. Advertisers were interested in those groups of people least well-served by the medical profession, who might otherwise have done nothing, but were literate and discerning. Five groups feature most prominently, six if one includes mothers of infants and young children, the other five being:

- Those with minor or cosmetic ailments not worthy of medical attention.
- Those whose condition was a source of stigma or embarrassment, precluding them from seeking medical advice.
- Those whom medical science of the time could do nothing to help and were thus desperate enough to try anything that might work.
- Travellers and mariners, who could not easily access Western medical practitioners.
- Those either disillusioned with regular medicine or terrified of surgery.

Many products were advertised for their mild and gentle effects compared to the heroic dosing with toxic chemicals favoured by the medical profession. Early-nineteenth-century proprietary medicine manufacturers could claim, with some justification, that their products were no more unpleasant, or dangerous, than a medical prescription. As Holloway noted, 'the proprietors of patent medicines used elementary consumer psychology. The real secret of their remedies was the promise to meet the

needs which orthodox medicine failed to supply'[149] and 'nostrum makers opposed…heroism and appealed to man's cowardice by stressing the mildness of their remedies in contrast with the doctor's lancet and harsh mercurials.'[150] Thus, these remedies met a real and legitimate need and, importantly, the fact that they were advertised in this way suggests a customer who could afford, but had had enough of, medical attention.

The findings of this chapter raise important questions about the validity of the medical marketplace paradigm and the nature of competition in the healthcare economy. Rather than posing a threat to doctors, proprietary medicine manufacturers and other advertisers of healthcare products *competed with each other* for the custom of those people least well-served by the regular medical offering. Interestingly, the battleground was not in pricing, but in reputation, suggesting customers did not buy these products because they were cheap, but because they believed, or hoped, they might work. These people were thus far removed from the stereotype we are familiar with. The next chapter will now develop these findings further by looking in detail at the role of chemists and druggists as dispensers of medical prescriptions; the meeting point of orthodox and 'irregular' practice.

[149] Holloway, *Royal Pharmaceutical Society*, p.57.
[150] Young, 'Patent Medicines,' p.653.

Chapter Five: Dispensers

5.1 Introduction

Through a systematic deconstruction of the supply of healthcare in Gloucester between 1815 and 1870, and a detailed examination of healthcare advertising, evidence has been presented that casts doubt on some key tenets of the medical marketplace paradigm. The extent of competition, particularly between qualified general practitioners and 'irregular' providers appears to have been exaggerated by some of the literature of the medical marketplace. Chapter three showed how the supply of healthcare in Gloucester was, by the early decades of the nineteenth century, dominated by regular doctors and chemists and druggists. In terms of their growth, they followed a similar trajectory, numbers stabilising from the 1840s onwards and reaching parity by 1870, with no obvious inverse correlation between the size of the two groups. Compelling evidence of diversity, plurality, choice and competition has not been found. Instead, this was a stable, stratified and hierarchical healthcare economy. Surprisingly, in the most commercialized and competitive area of healthcare – medical advertising - what emerged was not the 'free-for-all' of a medical marketplace, but a highly segmented market where product reputation was more important than price. Advertisements were not untargeted, nor directed principally toward the supposedly gullible poor. On the contrary, advertisers were interested in those specific groups of customers who possessed purchasing power, but were, for a variety of reasons, least well-served by the regular medical offering and who might otherwise have done nothing or relied on home remedies.

The current chapter builds on this cumulative picture by focussing on the dispensing activity of Gloucester's chemists and druggists. Curiously, this important part of their trade has been relatively neglected by the historiography, yet it gives an invaluable insight into the place of these businesses in their communities and in the overall healthcare economy. A contextual discussion of the role of chemists and druggists in Gloucester is followed by a description of sources and methods, and then the detailed analysis of the four sets surviving prescription books.

5.2 Gloucester's chemists and druggists

Well into the second half of the nineteenth century, pharmacy remained first and foremost a retail trade with only limited professional structure and accountability. However, as Marland has pointed out, 'the chemists and druggists were one of the few fringe or para-medical groups to emerge during this period who could lay claim to some form of professional standing.'[1] Furthermore, as shopkeepers, reputation and trust were the foundation of a successful business model and even more so for the small but growing number of pharmaceutical chemists. As was seen in chapter three, chemists and druggists were often local people, who traded from the same premises for many years and for whom reputation and trust had been built upon the quality of their goods and customer service. Thus, it was not in their interest to sell rubbish when the shop was a source of pride and the showcase for their knowledge and skills. A typical chemist and druggist's shop of the mid-nineteenth century featured:

> carboys of coloured water, which were sometimes provided with oil lamps or gas jets to illuminate them at night and cast an attractive multi-coloured glow into the street. There was usually an outside lamp in coloured glass. The exterior, often of mahogany or teak was frequently painted in a solid dark colour, usually black or green with a simple name in gold letters above mosaic-floored entrances, marble steps, and red granite footings. The interior was treated in a similar fashion, with mahogany fittings and sometimes false enamelled iron ceilings decorated with raised patterns.'[2]

Status and reputation were built upon the customer experience and as the description above shows considerable thought, effort and expense went into furnishing the shop and it is reasonable to argue that equal care went into the choice of merchandise it stocked.

The counter was the focal point of the chemists and druggists store. Here prescriptions would be prepared and dispensed, and the scales, mortar and prescription book, all consciously impressive articles, were designed to convey a sense of professional *gravitas*, exemplified by the mortar belonging to the Gloucester chemist Joseph Lovett now on display in the Museum of Gloucester (Figure 5.1).[3]

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[1] H. Marland, 'The Medical Activities of Mid-Nineteenth Century Chemists and Druggists, with Special Reference to Wakefield and Huddersfield,' *Medical History,* Vol.31, No.4 (1987), p.416.
[2] N. Tallis and K. Arnold-Forster, *Pharmacy History: Photographs from the Museum of the Royal Pharmaceutical Society of Great Britain* (London, 1991), p.46.
[3] P.G. Homan, 'The Development of Community Pharmacy' in S. Anderson (ed.), *Making Medicines: A Brief History of Pharmacy and Pharmaceuticals* (London, 2005), p.118.

Figure 5.1 Mortar for mixing drugs belonging to the Gloucester chemist and druggist John Lovett
Source: Collections of The Museum of Gloucester, part of Gloucester City Council. Photographed by the author.

Lovett's mortar embodies the sense of pride some, and perhaps most, chemists and druggists had in their trade. The way in which they sought to differentiate themselves from rivals through their customer service is also exemplified in the way in which new chemists moving into Gloucester announced their arrival in the press not by undercutting rivals on price, but with guarantees of their personal attention to the dispensing of medical prescriptions. Diligent dispensing was regarded as a hallmark of quality and respectability, as a notice placed by T. Bosley, a 'former assistant to Mr H. Kimber', who opened his own shop in 1826, makes clear:

> T.B. having resided for more than Ten Years in Houses of the first respectability, and been favoured with the decided approbation of the Principals for his Chemical and Pharmaceutical knowledge, in dispensing the Prescriptions of the most eminent Physician and Surgeons, (in which engagement he was principally employed), hopes to merit and retain a share of public patronage and support.
>
> The utmost reliance may be placed on his endeavours to execute all commissions confided to his care with every possible attention to accuracy, neatness, and despatch.[4]

Similarly, qualifications were also used as a way of signalling competence and trustworthiness to the public. When James Coleman took over the business of John Bonnor of Westgate Street in 1828, he not only emphasised that his personal attention

[4] *The Gloucester & Cheltenham Herald*, 16 October 1826.

would be given to 'every department of the business,' but that he was a qualified apothecary:[5]

> **JAMES COLEMAN**
>
> LICENTIATE OF THE SOCIETY OF APOTHECARIES OF THE CITY OF LONDON,
>
> RESPECTFULLY informs the Gentry and Inhabitants in general of Gloucester and its Neighbourhood, that he has taken to, and intends personally conducting, the
>
> **Chemical and Drug Business,**
>
> Lately carried on by Mr. JOHN BONNOR, at the Corner of the College Court, WESTGATE-STREET.
>
> The favours of Mr. BONNOR'S Friends and the Public in general will be thankfully received; J. COLEMAN pledging himself that his goods shall be of the best quality, and moderate in price; that unremitting personal attention shall be paid to every department of the business; that his retail shall be conducted with the greatest care and neatness; that the physicians' and surgeons' prescriptions and family recipes, entrusted to him to dispense, shall be prepared with extreme accuracy; and that his pharmaceuticals and chemicals shall be made according to the directions of the latest editions of the London and Edinburgh Pharmacopoeia, and the most approved methods of the present day.
>
> N.B. J. COLEMAN, having been regularly educated as a Surgeon-Apothecary, passed the usual examination at Apothecaries' Hall, and seen much medical and surgical practice since, considers himself particularly well versed in the dispensing and prescribing part of the drug business.[6]

Although Holloway claimed that most chemists and druggists 'had no pretensions to become professional men,' this does not mean they lacked aspirations to respectability and status. Arguably, reputation was of no less importance to them than it was to doctors.[7] Furthermore, doctors were not alone in wanting to achieve prominence in civic life and one chemist, William Stafford, even become a Mayor of the city.

The aspirations of ambitious chemists and druggists are probably best exemplified by the career of Thomas Washbourn, who, as we saw in chapter three, was an apothecary turned druggist who rose to sit amongst Gloucester's leading families and used his reputation and accumulated capital to successfully diversify into banking and to launch a medical dynasty.[8] In 1818, Washbourn entered into a partnership with T.

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[5] I have not been able to establish whether he was related to Edmund Coleman, but he is recorded as giving up the business a year later in 'Mr Done's index of Gloucester Retail Businesses 1722-1839,' Gloucestershire, Gloucestershire Archives -hand list.

[6] *Gloucester Mercury,* 24 September 1828.

[7] S. Holloway, 'The Regulation of the Supply of Drugs in Britain before 1868' in R. Porter and M. Teich (eds), *Drugs and Narcotics in History* (Cambridge, 1995), p.88.

[8] In addition to Buchanan Washbourn, the son of one of the other partners, Fortescue Morgan, also pursued a career in medicine.

Morgan and shortly afterwards Charles Rose (one of his former apprentices), to form the firm of Washbourn, Morgan & Rose with premises in Eastgate Street.[9] Washbourn was described as 'an enterprising man…an apothecary or surgeon, a chemist and druggist, an extensive agriculturalist, and a banker…the original founder of the bank in Eastgate-street, which eventually evolved or developed in[to] the Gloucestershire Banking Company.'[10] According to an 1892 obituary for Morgan's son, George Washbourn Morgan, 'Washbourn, as an apothecary or surgeon, did the diagnosis and prescribing business for *bipeds.* Morgan did the agricultural business; he prescribed and compounded for the *quadrupeds;* and Rose dispensed the prescriptions of the head of the firm and the other medicals of the city.'[11] In 1830 the partnership was dissolved and Rose set up on his own at 25 Southgate Street. Washbourn's son Thomas Bullock Washbourn entered into a partnership with Edmund Coleman, who took over the business in 1835[12], married Washbourn's widow, and was still trading in 1856. By 1847 Charles had died[13] and the firm was trading as 'A. Rose & Sons,' Ann being his widow, becoming 'Rose & Whinfield' in 1856. His son James Dudfield Rose (1830-1905) 'worked sporadically in the family pharmacy at 30, Southgate Street, Gloucester, and in 1865, he took the oath of a Freeman of that city, by reason of his Great-Grandfather's taking the first family oath in 1816.'[14] James D. Rose…

> described himself as "Surgeon's Assistant"' on his son's birth certificate, but 'was already a qualified Veterinary Surgeon, but rules relating to professional qualifications being more elastic, and having acquired a hatred of "horse trading" in the Argentine, he would have become a Medical Practitioner had not reinforcement in 1860 of the Medical Act of 1858, forced him to use the Pharmaceutical qualifications, already part of his Veterinary Course, to open a Chemist's shop in Jarrow, where he had gone originally to be a Surgeon's Assistant to a Doctor Bradley, and for whom he wrote the theses, accepted by Glasgow University, toward Dr Bradley's first medical qualifications.[15]

This example shows how respectable chemists and druggists were able to build upon the standing and prosperity the trade could provide to diversify and finance expensive medical training for upwardly mobile sons. Holloway has suggested that

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[9] Extract from a short memoir of James Dudfield Rose (1868-1947) written by his son, also named James Dudfield Rose, referring to the family's Gloucester connections, undated, Gloucestershire, GA, Rose family of Gloucester, pharmacists, MS, D5529/2.
[10] *Gloucester Citizen,* 6 August 1892, p.3.
[11] *Ibid.*
[12] 'Mr Done's index.'
[13] E. Hunt & Co., *Hunt & Co.'s Commercial Directory; for the Cities of Gloucester, Hereford, and Worcester, etc.* (London, 1847).
[14] Extract from a short memoir of James Dudfield Rose
[15] Memoir of James Dudfield Rose.

'before 1858 chemists and druggists were as much a part of the medical profession as apothecaries' and some former apothecaries, like Washbourn, who stayed behind their counters and metamorphosed into chemists and druggists, could enjoy successful and lucrative careers, remaining as close to the medical profession as they were to any 'medical fringe'.[16]

The professional ambitions of Gloucester's chemists and druggists can also be traced through the censuses. As discussed in chapter two, the 1852 Pharmacy Act gave separate legal definition to pharmaceutical chemists, who could register with the British Pharmaceutical Society upon qualification through examination. In 1868, the Pharmacy Act created a separate register of chemists and druggists, who took a lower level qualification. The impact of these changes can be seen in the censuses. In 1841, every chemist and druggist recorded in Gloucester self-identified as either simply 'chemist' or 'druggist,' whereas by 1871 a range of titles were recorded, including three of the higher-tier pharmaceutical chemists (Joseph Medd, William Stafford and Joseph Ward), as shown in Table 5.1. With growing professional ambitions amongst the higher echelons of the trade the gulf between the pharmaceutical chemists and the medical profession narrowed.

Table 5.1 Descriptions of Gloucester chemists and druggists in the 1871 census

Name	Occupation
Henry Burton	Chemist
Henry Meadows	Chemist
Richard Brook[e]s	Chemist
James Dancey	Chemist
Stephen Wingate	Chemist
Henry Maine Jenkins	Chemist
Thomas Millard	Chemist
Alice Maria Millington	Chemist
James Franklin	Chemist
Thomas Pearce	Chemist & Druggist
Francis J. Pearce	Chemist & Druggist
Charles H. Trigg	Chemist & Druggist
William E. Willis	Chemist & Druggist
John Sadler	Chymist

[16] S.W.F. Holloway, *Royal Pharmaceutical Society of Great Britain, 1841-1991: A Political and Social History* (London, 1991), p.51.

Name	Occupation
Thomas Edward Jones	Chymist
Francis C. Mumford	Dispenser of Medicine
George W. Palden	Dispensing Chemist
Joseph Medd	Pharmaceutical Chemist
William Stafford	Pharmaceutical Chemist
Joseph Ward	Pharmaceutical Chemist
Thomas Cook	Registered Chemist & Druggist
John Vick	Vet. Sur. M.R.C.V.S.L. & Chemist
Edward S. Morris	Wholesale Chemist

Source: Ancestry.com, *1871 Census* [database on-line]. Provo, UT, USA: Ancestry.com Operations Inc, 2005. Original data: Kew, The National Archives, *Census Returns of England and Wales, 1871*, HO 107.

The standing of some chemists and druggists in their community can be evidenced too by looking at their prescription books. As mentioned earlier, these books offer a unique insight into the role of chemists and druggists as healthcare providers and their relations with the medical profession, and they are important beyond the confines of Gloucester. Prescription books have barely featured in the literature and when they have it has been in relation to the evolution of pharmaceutical practice, where the focus has been on the formulation and dosage of medicines.[17] This chapter will take a new approach, looking at the volumes of prescriptions dispensed over time, day of collection, gender of the collector, prescribing doctors, and uniquely will cross-reference the names and addresses in one set of books to the 1851 census. Finally, it will reflect on what this evidence says about the place of chemists and druggists in the healthcare economy, the local community and their relationship to the medical profession.

5.3 Sources and methods

By the mid-nineteenth century, most respectable chemists and druggists were keeping records of the medicines they dispensed. According to Matthews 'the practice, begun in the early 19th century, was for the pharmacist to copy into his prescription book the prescription handed to him by the patient and to return it in a special envelope usually

[17] S.C. Anderson and C. Homan, 'Prescription Books as Historical Sources,' *Pharmaceutical Historian,* Vol.29, No.4, (1999), pp.51-54; S. Anderson, 'Researching and Writing the History of Pharmacy' in S. Anderson, *Making Medicines: A Brief History of Pharmacy and Pharmaceuticals* (London, 2005), p.8.

tied round the bottle, if it were a mixture, the whole package being secured with pink string and neatly sealed with wax.'[18] The prescription book was an impressive article – a large, heavy volume located on the counter, in which the name of the customer, sometimes their address, the date of the prescription, whether it was for a third party, the drug(s), form, quantity and dosage instructions, and the name or initials of the prescribing doctor was recorded. Each prescription was given a number that was then transcribed to an index of customers at the front of the book. In practice, none of Gloucester' chemists recorded all of this information all of the time. Mistakes and omissions were common, and what was recorded varied over time and according to who was completing the entry. Furthermore, errors in the numbering sequence were frequent and the spelling of names inconsistent. None of the surviving sets of books recorded the amount charged for the prescription. Despite these shortcomings, the information recorded in these books provides a unique and invaluable window upon the complexion of Gloucester's healthcare economy. The surviving books held at Gloucestershire Archives are shown in Table 5.2 below.

Table 5.2 Collections containing pre-1870 prescription books held by Gloucestershire Archives

GA Finding Ref:	Collection name	Year(s)
D2752	Walwin's of Gloucester [James Tucker and William Stafford]	1835-1871
D2914	Hampton's of Gloucester [unidentified]	1834-1846
D3096	Ward and Woodman of Gloucester [Edmund Coleman]	1835-1865
D5529*	Rose's Pharmacy, Gloucester	c.1853

*This item contains a list of medical recipes and not a record of prescriptions dispensed.

Between them, the four series of surviving books cover a period from 1835 through to 1870 and beyond into the twentieth century, and thus provide a valuable opportunity to observe both differences between the businesses and temporal changes.[19] The records were analysed primarily with a view to quantifying the volume of prescriptions being dispensed, establishing the socio-economic profile of customers, and comparing the numbers emanating from each doctor. In accordance with the key aims described in chapter one, the principal objectives of this chapter were twofold: to find

[18] L.G. Matthews, *History of Pharmacy in Britain* (Edinburgh, 1962), p.296.
[19] Coleman's books end in 1865, those of James Tucker continue after 1870.

evidence of co-operation between doctors and chemists, and to establish the extent to which the public could access qualified medical advice. Logistical practicalities meant entries in the books could not be transcribed in full and only information relevant to these objectives was extracted. There is thus considerable scope for further future analysis. In the case of three of the collections, the inconsistency and brevity of information captured allowed only a basic count of prescriptions dispensed. This still permitted longitudinal analysis of the volume of dispensing activity. Stafford's books were the only ones to consistently record the address of the customer and thus the year 1850 was selected for detailed attention because it was close in time to the 1851 census, allowing some cross-referencing of customers, and because this was a year also covered by Tucker and Coleman's books.[20]

The aim originally was to undertake a comprehensive cross-referencing of all Stafford's customers in 1850 to the 1851 census returns. Logistically, due to the volume of prescription being dispensed by Stafford this unfortunately proved impossible. In addition, as only the title, surname, and street of the customer were recorded, customers could not be identified in the census with one-hundred percent certainty and a large proportion of the surnames could not be found in the street recorded in the prescription book. The reasons for this are not known. It is possible the customer had moved in the intervening months, or, less likely, that the address was incorrectly recorded. A few may have died. None of these potential explanations however can be verified. The poor match rate, combined with the time that would be needed to attempt to match every customer, meant a much more limited exercise was undertaken, focussing on a few streets. This was combined with looking at the overall socio-economic complexion of some of the streets where customers were recorded as living. Nevertheless, the analysis provides an important and unique 'snapshot' of dispensing activity in Gloucester at the mid-point of the nineteenth-century. It must however be stressed that there is a very strong case for further research that broadens the scope of this exercise to encompass more streets and additional years.

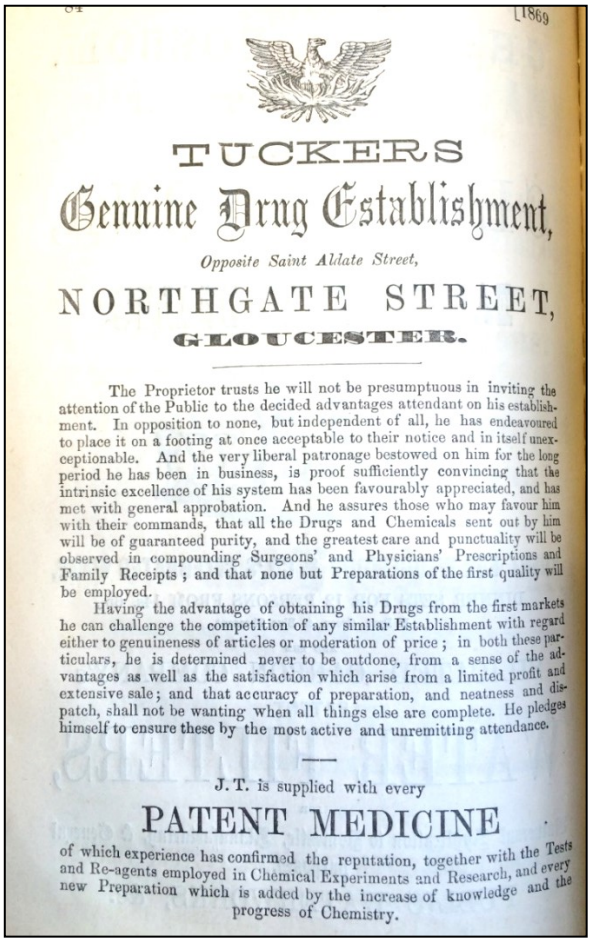
At this point, it is useful to briefly explore the genealogy of the businesses that produced these books, as it reveals more evidence of the relationship between chemists

[20] Unfortunately, toward the end of 1850, the recording of address details in Stafford's book became erratic and thus that year rather than 1851 was selected for this exercise.

and druggists, and with the medical profession. The largest collection of books was deposited in the 1960s by E.G. Davis & Co., heirs to the firm of Walwin's, a chemist's and photographic shop that first appeared in *Kelly's Directory* in 1906, and which continued trading under family ownership until 1968.[21] Through mergers and acquisitions, the firm could trace its origins back to at least the mid-eighteenth century. The business inherited two discrete series of books: those of James Tucker, who had a shop at 86 Northgate Street, and those of William Stafford of 10 Northgate Street.

James Tucker started trading in 1826, originally as a chemist and tea and coffee seller in partnership with Robert Roberts Tucker. The partnership was dissolved in 1833 and James continued the business alone.[22] By 1835, he was advertising for 'a well-educated Youth' to be his apprentice[23] and the 1841 census recorded him as employing a shopman, Henry Perry, and one female domestic servant. By 1851, his staff had increased to three servants and an assistant, Robert Stubbs. Ten years' later he was sharing his house with his son and two daughters, one of whom was married to Charles Cook, also a chemist, their two children and three servants.[24] James Tucker registered as a Pharmaceutical Chemist in 1853. In 1869, Tucker placed the advertisement shown in Figure 5.2 'inviting the attention of Public to the decided advantages attendant on his establishment.'

[21] Kelly and Co., *Kelly's Directory of the County of Gloucester* (London, 1906).
[22] *Gloucestershire Chronicle,* 16 November 1833, p.2. 'Mr Done's index' records a sale of cut-glass in 1835 occasioned by one of the Tuckers (presumably Robert) having 'now left.'
[23] *Gloucestershire Chronicle*, 10 October 1835, p.3.
[24] Charles Cook may have been related to Thomas Cook, a chemist and druggist who had owned a shop in Newnham, but who had sold the business to an R.J. Roper and moved to Northgate Street, Gloucester by 1861 and was recorded again in Northgate Street in 1871. Thomas Cook did have a son named Charles, but this Charles was too young to have been the same person.



[1869

TUCKERS

Genuine Drug Establishment,

Opposite Saint Aldate Street,

NORTHGATE STREET,

GLOUCESTER.

The Proprietor trusts he will not be presumptuous in inviting the attention of the Public to the decided advantages attendant on his establishment. In opposition to none, but independent of all, he has endeavoured to place it on a footing at once acceptable to their notice and in itself unexceptionable. And the very liberal patronage bestowed on him for the long period he has been in business, is proof sufficiently convincing that the intrinsic excellence of his system has been favourably appreciated, and has met with general approbation. And he assures those who may favour him with their commands, that all the Drugs and Chemicals sent out by him will be of guaranteed purity, and the greatest care and punctuality will be observed in compounding Surgeons' and Physicians' Prescriptions and Family Receipts; and that none but Preparations of the first quality will be employed.

Having the advantage of obtaining his Drugs from the first markets he can challenge the competition of any similar Establishment with regard either to genuineness of articles or moderation of price; in both these particulars, he is determined never to be outdone, from a sense of the advantages as well as the satisfaction which arise from a limited profit and extensive sale; and that accuracy of preparation, and neatness and dispatch, shall not be wanting when all things else are complete. He pledges himself to ensure these by the most active and unremitting attendance.

J. T. is supplied with every

PATENT MEDICINE

of which experience has confirmed the reputation, together with the Tests and Re-agents employed in Chemical Experiments and Research, and every new Preparation which is added by the increase of knowledge and the progress of Chemistry.

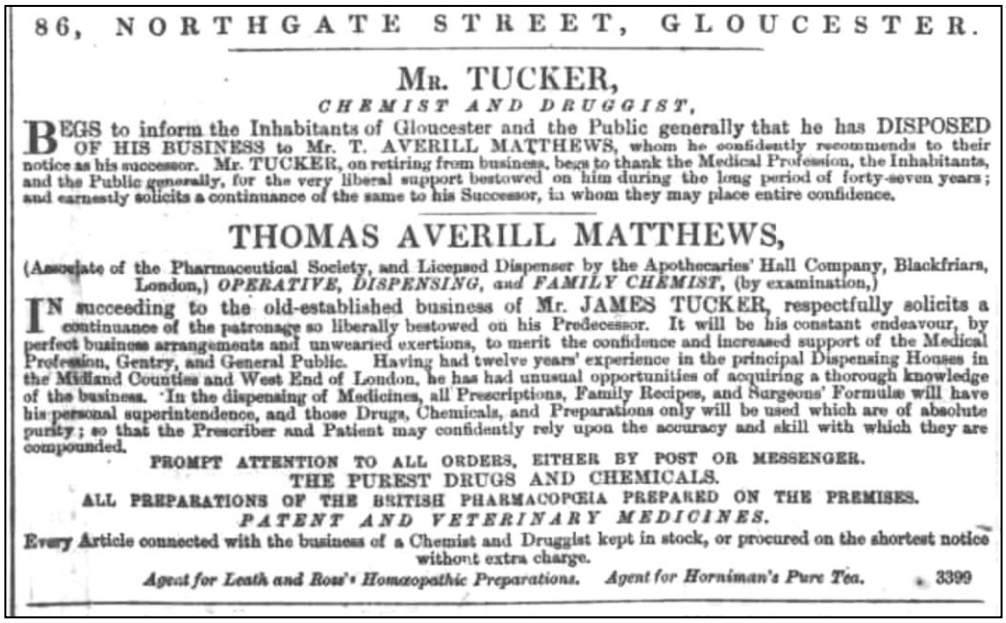
Figure 5.2 Advertisement for Tucker's Genuine Drug Establishment

Source: Bretherton, *Bretherton's Almanac and Gloucester Directory* (Gloucester, 1869), p.84.

Although two trade directories dating from 1867 and 1869 list Tucker at 95 Northgate Street, on balance it seems more likely he remained at 86 Northgate Street until the business was sold in 1874. Tucker did not appear in the 1871 census, but his daughter Jane was listed as a "chemist's daughter" living in Northgate Street with one servant and a "chemist's assistant", John Greaves. Charles Cook meanwhile appears to have given up pharmacy and moved his family to Newent, where he was recorded as a farmer of 190 acres employing three men and two boys. In 1874, Tucker disposed of the business to Thomas Averill Matthews as shown in Figure 5.3.[25] Matthews does not appear to have stayed long, as shortly afterwards the shop was in the hands of Evan G.

[25] It is possible that Tucker did move, as newspaper advertisements from 1862 record "J.W.C. Brewer, Auctioneer, Valuer, Estate & House Agent" trading from 86 Northgate Street. However, 95 Northgate Street seems to have been occupied by Charles Bossom, a china and glass dealer at the time.

Hughes (from Corbyn and Company, London).[26] Tucker died on 1 August 1883 at Gravelly Hill near Birmingham.[27]



86, NORTHGATE STREET, GLOUCESTER.

MR. TUCKER,

CHEMIST AND DRUGGIST,

BEGS to inform the Inhabitants of Gloucester and the Public generally that he has DISPOSED OF HIS BUSINESS to Mr. T. AVERILL MATTHEWS, whom he confidently recommends to their notice as his successor. Mr. TUCKER, on retiring from business, begs to thank the Medical Profession, the Inhabitants, and the Public generally, for the very liberal support bestowed on him during the long period of forty-seven years; and earnestly solicits a continuance of the same to his Successor, in whom they may place entire confidence.

THOMAS AVERILL MATTHEWS,

(Associate of the Pharmaceutical Society, and Licensed Dispenser by the Apothecaries' Hall Company, Blackfriars, London,) *OPERATIVE, DISPENSING, and FAMILY CHEMIST,* (by examination,)

IN succeeding to the old-established business of Mr. JAMES TUCKER, respectfully solicits a continuance of the patronage so liberally bestowed on his Predecessor. It will be his constant endeavour, by perfect business arrangements and unwearied exertions, to merit the confidence and increased support of the Medical Profession, Gentry, and General Public. Having had twelve years' experience in the principal Dispensing Houses in the Midland Counties and West End of London, he has had unusual opportunities of acquiring a thorough knowledge of the business. In the dispensing of Medicines, all Prescriptions, Family Recipes, and Surgeons' Formulæ will have his personal superintendence, and those Drugs, Chemicals, and Preparations only will be used which are of absolute purity; so that the Prescriber and Patient may confidently rely upon the accuracy and skill with which they are compounded.

PROMPT ATTENTION TO ALL ORDERS, EITHER BY POST OR MESSENGER.

THE PUREST DRUGS AND CHEMICALS.

ALL PREPARATIONS OF THE BRITISH PHARMACOPŒIA PREPARED ON THE PREMISES.

PATENT AND VETERINARY MEDICINES.

Every Article connected with the business of a Chemist and Druggist kept in stock, or procured on the shortest notice without extra charge.

Agent for Leath and Rose's Homœopathic Preparations. *Agent for Horniman's Pure Tea.* 3399

Figure 5.3 Notice of disposal of business of James Tucker to Thomas Matthews, 1874
Source: *Gloucester Journal*, 24 January 1874, p.1. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

At the time of the 1881 census, Hughes was recorded next door at number 87 and Tucker's former premises at 86 Northgate Street was recorded as being in the hands of Edward Harris, a boot and shoe dealer.[28] This seems to have been a temporary arrangement, or was perhaps an error, as Hughes was again recorded trading from number 86 in the 1890s. By 1902, Hampton, another chemist, had taken over the shop.[29]

A second series of books covering the period from July 1847 to August 1936 (D2752/4/56-79) are also ascribed to Tucker in the Gloucestershire Archives catalogue, but in fact belonged to the firm of William Stafford. They, like Tucker's books, came into the Walwin collection by means of mergers and acquisitions. William Stafford was born in 1810 in Claines, near Worcester. He was the son of Reverend William Stafford,

[26] Day book, 1876-1877, Gloucestershire, GA, Walwins of Gloucester, chemists; Fulljames and Waller of Gloucester, architects (later Waller and Son; then Waller, Son and Ashwell; now ASTAM Design), MS, D2752/1/1.
[27] *Gloucester Journal,* 11 August 1883, p.9.
[28] Conceivably, this may also be a mix up in the street numbers by the Census enumerator.
[29] A day book in the Walwin's collection (MS D2752/1/1 above) dating from 1876-7 contains a loose billhead of 'Evan G Hughes, dispensing and family chemist, 86 Northgate Street.'

a Canon of Worcester Cathedral.[30] Originally destined for the church, Stafford was instead apprenticed to a chemist in Bromsgrove. He came to Gloucester in 1833, taking over the business of Arkell at 10 Northgate Street, from where he traded for about sixty years. In 1838, Stafford took over the oil and colour stock of Sessions, a coal and ale agency.[31] Thereafter, he forged an 'extended and lucrative business' which he eventually passed on to his son-in-law, Joseph Ward.[32] Stafford became active in local politics and when the surgeon Charles Clutterbuck, a Liberal councillor for East Ward and former Mayor (see chapter three), died in November 1854, Stafford won the by-election to succeed him, representing the Conservative interest. He became a Sheriff in 1877 and was himself elected as Mayor of Gloucester in 1889 (Figure 5.4).

Figure 5.4 William Stafford as Mayor of Gloucester, 1889-1890

Source: Portraits of Mayors of Gloucester, Gloucestershire, GA, MS, GBR L6/30/41.

The 1851 census recorded Stafford as a chemist and druggist, residing in Theresa Place with his wife, three children, a governess and one female servant. By 1861, he was

[30] His maternal grandmother had tutored two future kings; George IV and William IV.
[31] 'Mr Done's index.'
[32] *Gloucestershire Chronicle*, 9 April 1898, p.5.

living in Hillfield Parade with his wife, two daughters and one servant. In the 1871 census, Stafford appeared for the first time as a pharmaceutical chemist and had moved again, this time to Park Parade where he was living with his daughter, son-in-law (Joseph Ward, also a pharmaceutical chemist) and grandson, a cook and a nursery maid. His last census appearance was in 1881, when he was described as a 'pharmaceutical chemist employing one assistant, one apprentice and a boy.' He was still living in Park Road with his daughter and son-in-law, but now with six grandchildren and two servants. Stafford died at Park Road in 1898 at the age of 89.[33]

Another series of books, dating from 1834 to 1846, were deposited by the firm of W.H. Hampton, who first registered as a pharmacist in 1897 and at that time resided at Upper Cross, Ledbury.[34] From 1907, Hampton was registered at 86 Northgate Street, Gloucester (i.e. James Tucker's old premises). These books cannot have belonged to Hampton originally and must have been inherited from an antecedent, but as they overlap chronologically with Tucker's books they cannot have belonged to him. An extensive search through the books and newspaper notices failed to produce any evidence as to their original ownership.[35]

The final set of books were positively identified as belonging to Edmund Coleman, who traded from premises in Eastgate Street.[36] As mentioned earlier, Coleman had originally been partnership with Thomas Bullock Washbourn. Figure 5.5 shows that through this connection, Coleman claimed a pedigree back to 1762.

[33] *Gloucestershire Chronicle,* 9 April 1898, p.5.
[34] Prescription books, 1834-1846, Gloucestershire, GA, Hamptons of Gloucester, chemists, MSS, D2914.
[35] Interestingly, in 1850 the Gloucester Journal reported that Hampton's had been awarded the contract to dispense medicines for the Gloucester Dispensary. This was the George Hampton, who appeared in the 1851 Census as a general practitioner resident at 9 Eastgate Street (and employing an apprentice, Joseph Jakeman). George Hampton was also listed as a surgeon at this address. There is however no evidence to suggest a familial relationship between George Hampton and W.H. Hampton.
[36] Prescription books, 1835-1865, Gloucestershire, GA, Ward and Woodman of Gloucester, chemists, MSS, D3096.

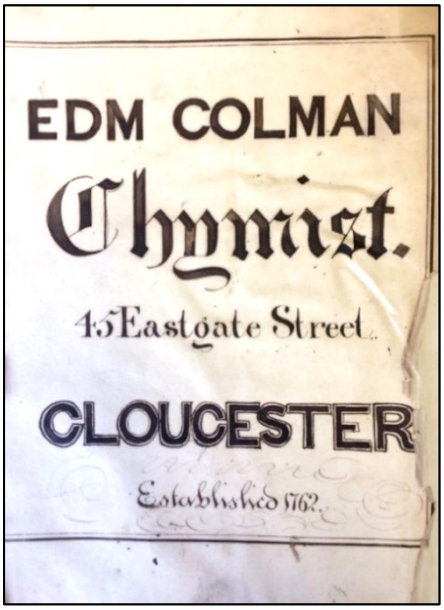


Figure 5.5 Front piece to one of Edmund Coleman's prescription books

Source: Edmund Coleman, Prescription book, July 1849 – July 1853, Gloucester, GA, Ward and Woodman of Gloucester, chemists, MS, D3096/1/3.

However, in 1835, this partnership was dissolved 'by mutual consent' and Coleman continued in business alone.[37] In January 1838 he married Eliza, the widow of his former business partner.[38] Coleman was elected as an Overseer for the parish of St Michael's in 1837[39] and was also a Churchwarden of St Michael's Church in the city centre.[40] The 1841 census recorded him living in Theresa Terrace and employing two female servants. By 1851 the family had moved to Palace Yard, still with two female servants. The last record of him was in 1856 when 'valuable furniture and effects…the property of Edmund Coleman, Esq, who is leaving' were sold by auction.[41] By 1861, there was no record of the family in Gloucester other than Edmund W. Coleman, Thomas's son, described the census as a 'Member of the Royal College of Surgeons – not practising' aged 22, a visitor to Thomas Washbourn, aged 31, then physician to the Gloucester Infirmary (his half-brother). In 1856, the business was sold to William Charrington and Coleman's books passed eventually to another occupant of the shop, Joseph Ward who first appeared trading from 45 Eastgate Street in 1869 (Ward was the

[37] *Gloucestershire Chronicle,* 28 March 1835, p.3.
[38] *Gloucester Journal,* 20 January 1838, p.2.
[39] *Gloucestershire Chronicle,* 1 April 1837, p.3.
[40] *Gloucester Journal,* 25 November 1848, p.2.
[41] *Gloucester Journal,* 12 July 1856, p.2.

son-in-law of William Stafford and a partner in the firm Ward and Woodman, who eventually deposited the collection),

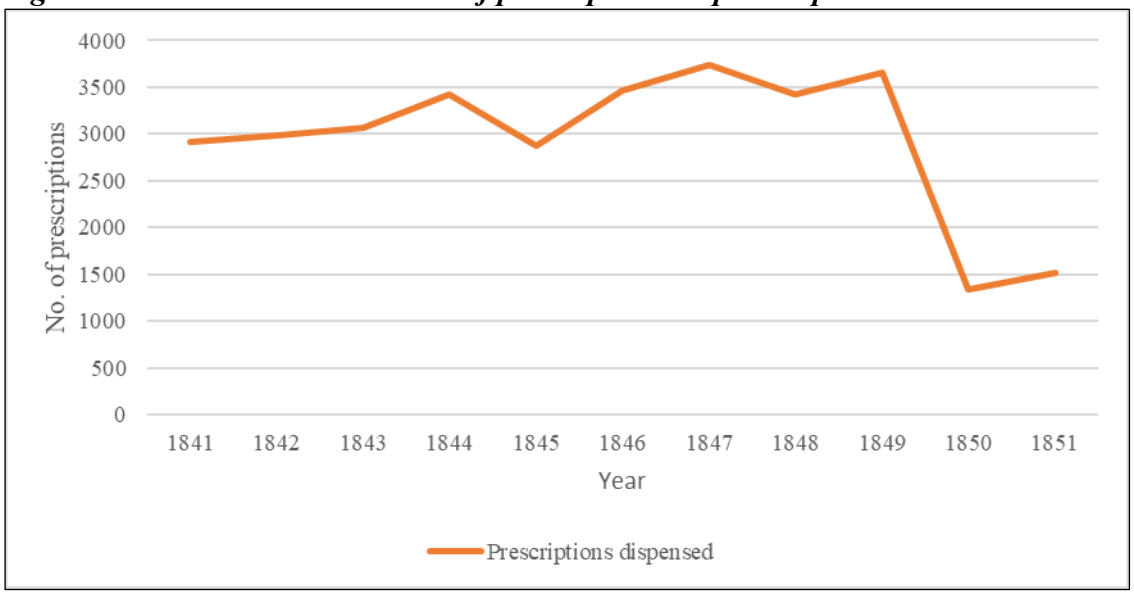
The trading pedigree of each of these firms illustrates their established position in the retail community of Gloucester and points toward their importance as a community resource. Each occupied prime retail space at the heart of the city centre. It was clearly advantageous for newcomers to take over an existing business and family ties were important too. The prescription books they left to posterity are an exciting resource through which to examine the activity of chemists and druggists and pharmaceutical chemists in Gloucester and offer a fascinating new perspective on the mid-nineteenth century 'medical marketplace.'

5.4 Analysis of the prescription books

Analysis of the four sets of surviving books reveals the high volume of dispensing these pharmacists were undertaking, raising important questions as to the nature of their relationship with the medical profession and the supposed competition between the two groups. Combined, the books cover seventy-five complete years, during which time the record 121,283 prescriptions being dispensed; an average of 1,617 per annum.[42] Looking first at James Tucker, Figure 5.6 shows that the period 1841 to 1851 saw a 144 per cent increase in Tucker's dispensing activity, from 620 prescriptions in 1841 to 1,513 in 1851.[43] In the same period, Gloucester's population increased by only 19.5 per cent from 26,815 to 32,045. Over this period the greatest number were dispensed in March (978), followed by June (960) and December (942). The highest number dispensed in any one month was 176 (June 1847) and the lowest was 26 (July 1845). In the years 1841 to 1851, an average of 970 prescriptions was dispensed per year, averaging 81 per month.

[42] Includes repeat prescriptions and repeat customers.
[43] GA D2752/4/2-4. It is important to note that the figures were derived by subtracting the prescription number on the first of each month from that on the last day of each month. Mistakes in the original recording resulting in either duplicated or omitted numbers were corrected for when identified but it is possible some errors remain.

Figure 5.6 James Tucker: Volume of prescriptions dispensed per annum 1841-1851

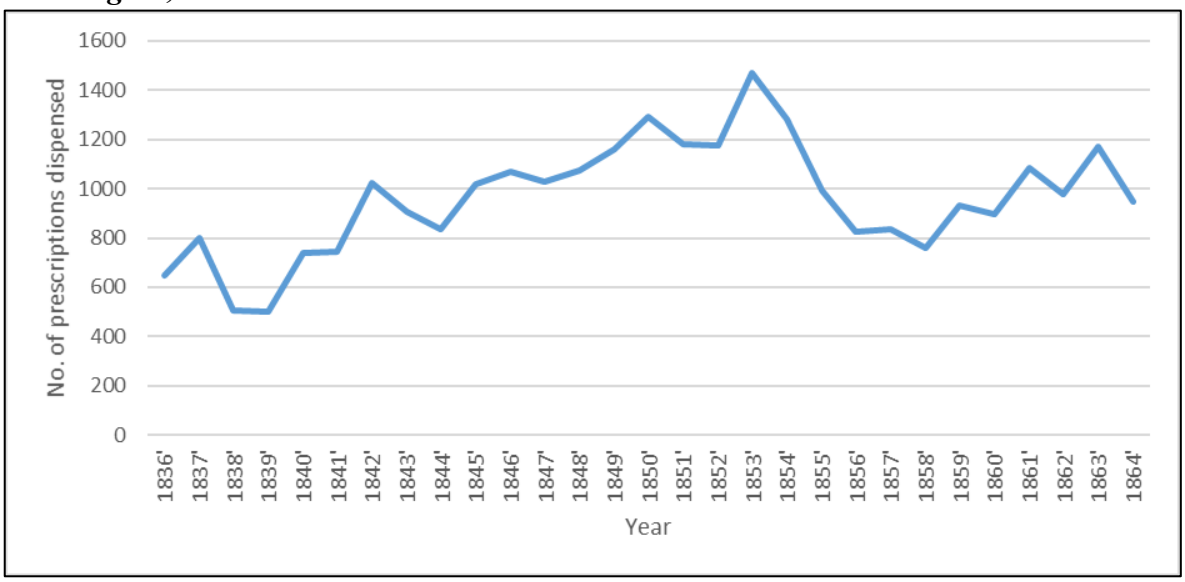


Source: James Tucker, Prescription books 1841 – 1851, Gloucestershire, GA, Walwins of Gloucester collection, MSS, D2752/4/1 – D2752/4/4.

Figure 5.7 shows the results for Edmund Coleman, whose books cover a longer period from 1836 and 1864 (after the business had passed to Charrington). A similar increase in volume over time can be observed, at least until 1853. In the ten years between 1840 and 1849, Coleman dispensed an average of 960 prescriptions per year or 80 per month. March and January were Coleman's busiest months. His dispensing activity rose from 649 prescriptions in 1836 to a high point of 1,471 in 1853, an increase of 127 per cent. Thereafter, a significant fall occurred with only a gradual and partial recovery and volumes had still not regained their 1853 level by 1864, the last complete year for which records survive. The fall-off in volumes that occurred in 1854 amounted to a 13 per cent drop, down to 1,281 prescriptions and happened shortly before the business was sold to William Charrington in 1856.[44]

[44] *Gloucester Journal,* 22 March 1856, p.2.

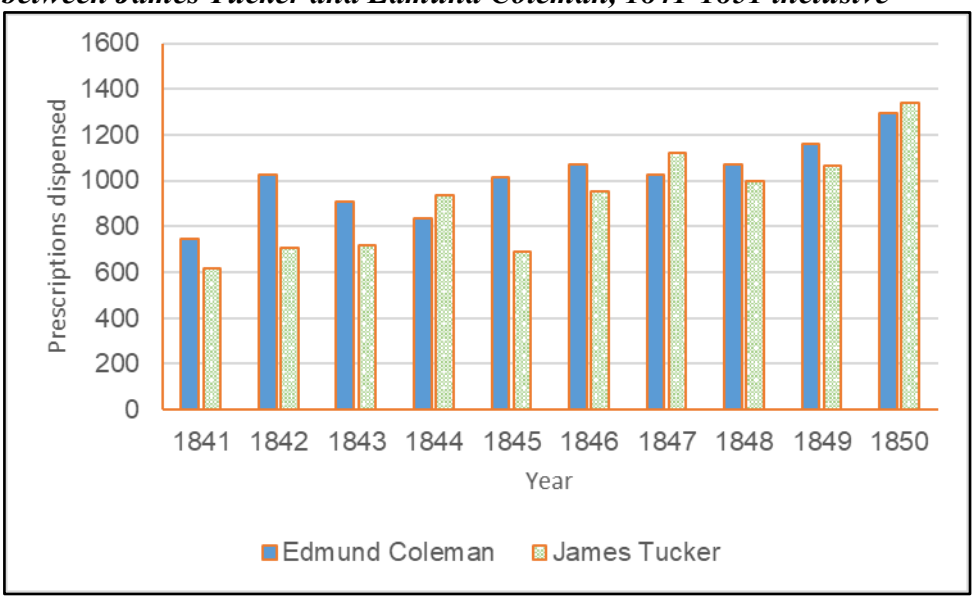
Figure 5.7 Total prescriptions dispensed each year by Edmund Coleman / William Charrington, 1836-1864



Source: Edmund Coleman/William Charrington, Prescription books, 1835 – 1865, Gloucestershire, GA, Ward and Woodman collection, MSS D3096/1/1 – D3096/1/5.

Comparing the month by month average for the period 1841-1850 inclusive, a remarkably similar trend can be observed between Tucker and Coleman, as shown in Figure 5.8. This suggests that dispensing activity was responsive to factors that affected the trade across the city.

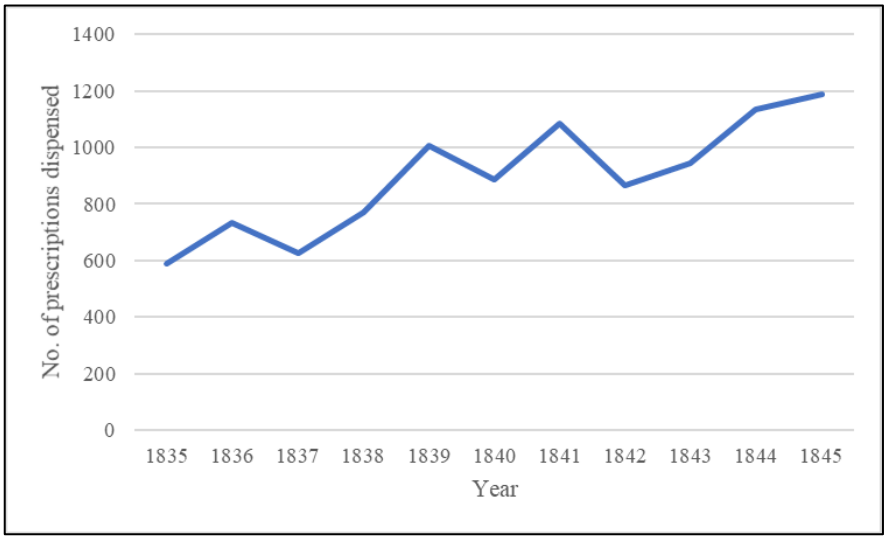
Figure 5.8 Comparison of average monthly volume of prescriptions dispensed between James Tucker and Edmund Coleman, 1841-1851 inclusive



Source: James. Tucker, Prescription books, 1841 – 1851, Edmund Coleman, Prescription books, 1835 – 1865.

The books belonging to the unknown chemist later acquired by Hampton are of much less value because the recording of dates was so erratic, making a reliable monthly count impossible. As was the case with Coleman, these books appear to record the date the prescription was written, not presented, as there were numerous examples dated several years earlier than the preceding entries. The year-on-year volume between 1835 and 1845 is shown in Figure 5.9.

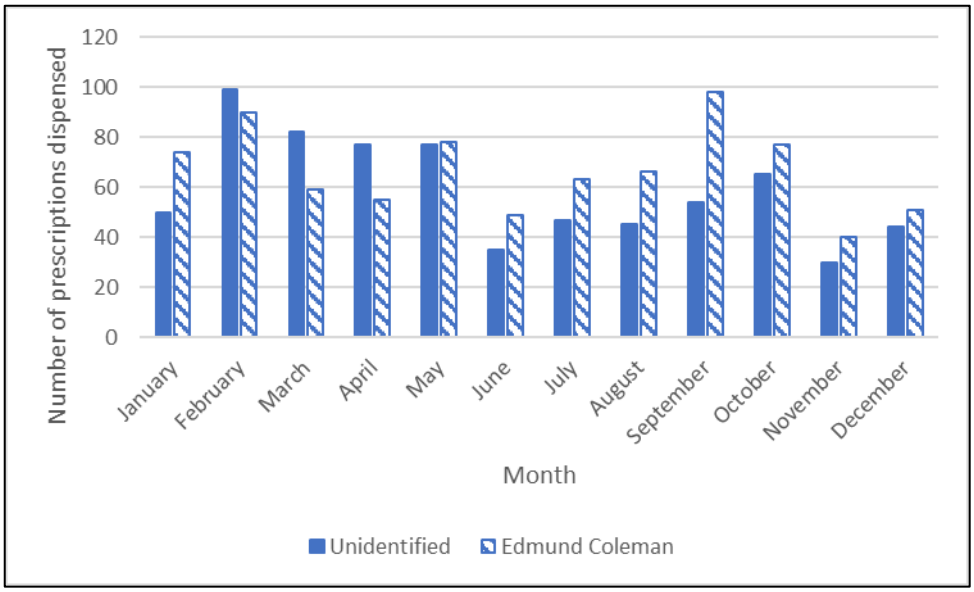
Figure 5.9 Prescriptions dispensed by an unknown Gloucester chemist 1835-1845



Source: [Unidentified]. Prescription books, 1835 – 1845, Gloucestershire, GA, Hamptons of Gloucester, chemists, MSS, D2914/2/1-D2014/2/4.

Again, the trend appears remarkably like that for Tucker. Due to the erratic dating, it was only possible to produce a month by month analysis for 1837. The results are shown in Figure 5.10, where they are compared to those of Edmund Coleman. The volume dispensed was somewhat less than that of Coleman (705 compared to 800 by Coleman), but the month-on-month trend was also quite similar. This consistency suggests that dispensing was an important and reliable source of income for Gloucester's chemists and druggists.

Figure 5.10 Prescriptions dispensed by an unidentified chemist and by Edmund Coleman in 1837



Source: [Unidentified]. Prescription books, 1836 – 1841, and Edmund Coleman, Prescription books, September 1835 – June 1844.

William Stafford's books begin in 1847 and between 1848 and 1870 Stafford dispensed 72,312 prescriptions, averaging 3,144 per annum. Stafford was thus dispensing significantly higher volumes than the other three businesses. Table 5.3 shows the monthly averages for the period from 1848 to 1870.

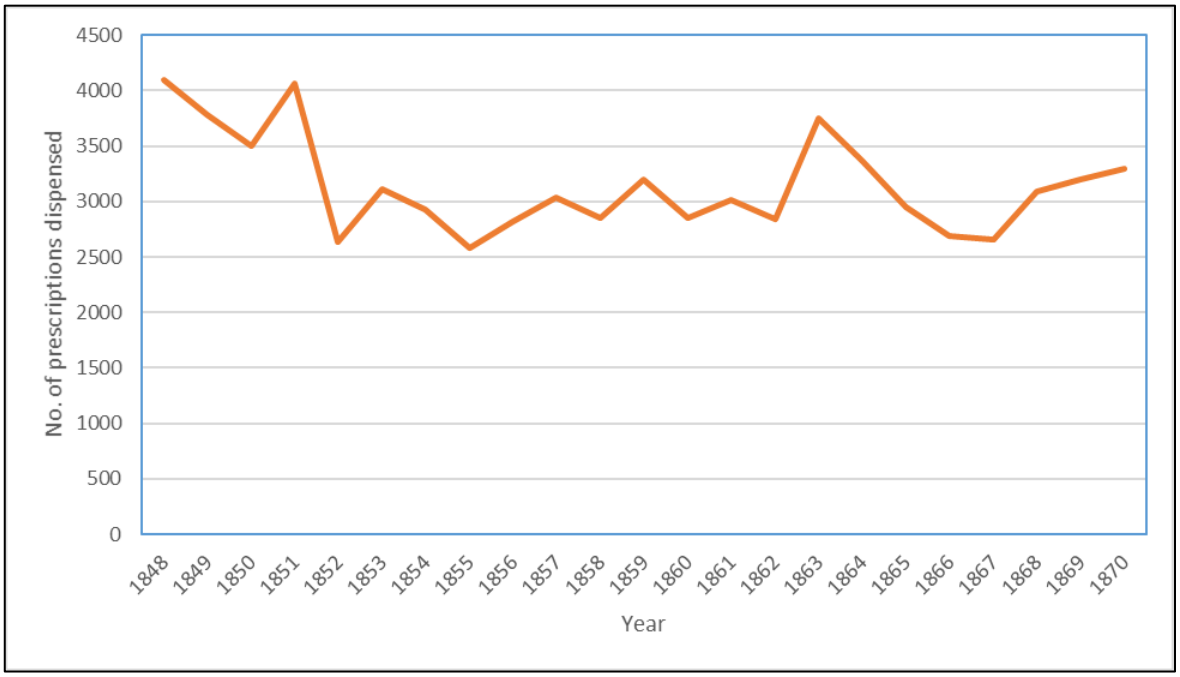
Table 5.3 William Stafford: Average number of prescriptions dispensed by month 1848 to 1870 inclusive

	Monthly average 1848-1870
January	252
February	248
March	286
April	273
May	274
June	258
July	256
August	266
September	251
October	258
November	244
December	279

Source: William. Stafford, Prescription books, 1849 – 1851, Gloucestershire, GA, Walwins of Gloucester collection, MSS, D2752/4/56 – D2752/4/57.

On average, Stafford busiest month was March, followed by December and May. Indeed, March was the busiest month for three out of the four firms. In the period 1848 to 1870, 1848 was the busiest year for Stafford (4,096 prescriptions). Thereafter, the next highest peak was in 1851 (4,060). In 1870 the number had fallen to 3,296. This is significant because the city's ever-increasing population did not translate into continuing growth in Stafford's dispensing trade and this was also the case for Coleman/Charrington. This could in part have been due to competition, as the number of chemists and druggists increased from 13 in 1847[45] to 16 in 1870, but this may not have been the only factor.[46]

Figure 5.11 Prescriptions dispensed by William Stafford 1848–1870



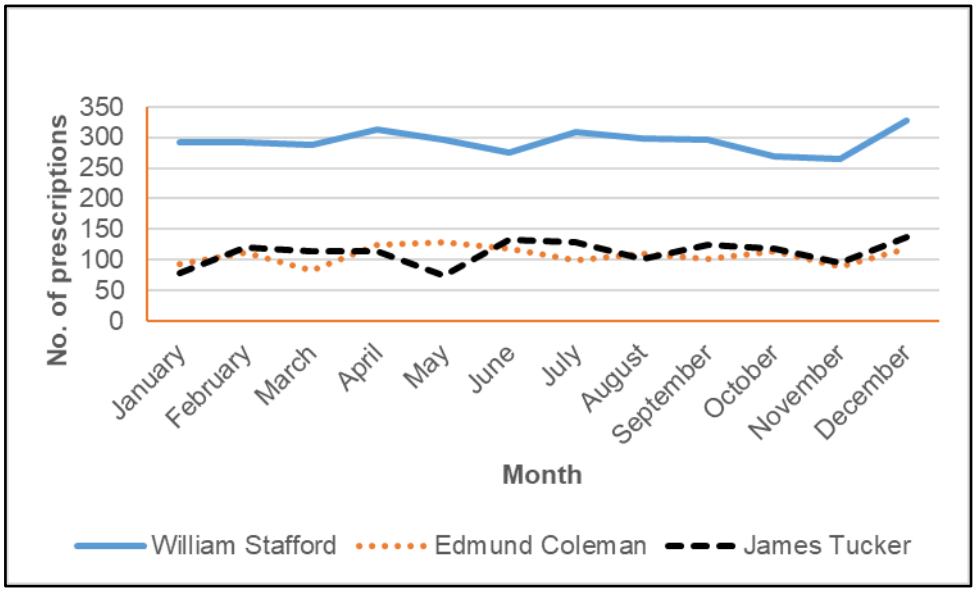
Source: William Stafford, Prescription books, 1847 – 1870, Gloucestershire, GA, Walwins of Gloucester collection, MSS, D2752/4/56 – D2752/4/66.

Analysis of the year 1850 shows that Stafford dispensed 3,498[47] prescriptions, averaging 292 per month. The index to the book covering the period November 1849 to December 1851, which ostensibly recorded individual customers, contains 3,467 entries.[48] In the same year, Edmund Coleman dispensed 1,293 prescriptions, an average

[45] Hunt & Co., *Commercial Directory,* 1847.
[46] Kelly and Co., *Kelly's Directory of the County of Gloucester* (London, 1870).
[47] This number represents the number of discrete entries in the prescription book, thus it includes repeat prescriptions for the same customer, but multiple items on the same prescription were recorded as one prescription.
[48] Due to the number of name duplications this figure must be regarded more in terms of the number of discrete courses of treatment than discrete customers.

of 108 per month, and James Tucker dispensed 1,343, averaging 112 per month. Once again, as Figure 5.12 shows, although the volume dispensed by each chemist differed significantly, the month-on-month trend in volumes was remarkably similar between the three. All show a counter-intuitive dip in November - the onset of winter. For Tucker and Coleman this was an anomaly, as November was the fourth busiest month for Tucker between 1841 and 1851 and the seventh busiest for Coleman between 1836 and 1864, but between 1848 and 1870 it was Stafford's least busy month.

Figure 5.12 Numbers of prescriptions dispensed in 1850*



Sources: William Stafford, Prescription books, November 1849 – December 1851; Edmund. Coleman, Prescription book, July 1849 – July 1853; James Tucker, Prescription books, March 1847 – November 1853.

*Includes repeat customers/prescriptions

In total, these three chemists dispensed 6,134 prescriptions in 1850. They were just three of the fifteen chemists and druggists listed in an 1849 trade directory and shown in Table 5.4.[49] Gloucester's population in 1851 was 32,045. Making the conservative assumption that each of the 15 dispensed only 1,000 prescriptions per annum (less than half the number dispensed by Stafford) and well below Coleman's 1,293, this would mean around 15,000 per annum. This does not mean that almost half of Gloucester's population obtained a prescription that year, as a large proportion were repeats for the same customers, but it does suggest that dispensing was a very important

[49] E. Hunt & Co., *Hunt & co.'s Commercial directory; for the Cities of Gloucester, Hereford, and Worcester, etc.* (London, 1849).

part of the chemist's trade and that prescribed medicines were available to a significant proportion of the population.

Table 5.4 Chemists and druggists listed in Hunt's Commercial Directory, 1849

Benjamin	Bagley	69 Barton Street
John	Baines	27 Littleworth
Richard	Brookes	141 Westgate Street
Edmund	Coleman	45 Eastgate Street
Robert	Fouracre	The Cross
William Edmund	Harris	Northgate Street
John	Lovett	15 Westgate Street
Thomas	Pearce	134 Westgate Street
Charles	Philp	46 Eastgate Street
William F.	Price	46 Southgate Street
A.	Rose & Sons	23 Southgate Street
William	Stafford	10 Northgate Street
William	Trenfield	121 Westgate Street
James	Tucker	86 Northgate Street
	Vick and Smith	10 Southgate Street

Source: Hunt, E. & Co., *Hunt & Co.'s Commercial Directory; for the cities of Gloucester, Hereford, and Worcester, etc.* (London, 1849). GA GAL/K2/56098GS* B343/11933GS.

If this was the case, it has two important implications. Firstly, a large section of the public sought and had access to qualified medical advice. Secondly, dispensing, an area of supposed competition between doctors and chemists and druggists, had by this time been firmly ceded to the latter. The volume of dispensing activity undertaken by Gloucester's chemists and druggists is hard to reconcile with an article in *The Chemist and Druggist* in 1860 that claimed:

> surgeons, general practitioners, or by whatever name they are called, hold themselves forward to the public as professional men, and yet they carry on a greater trade in drugs, in many instances, than their neighbour the chemist and druggist, and the very fact of their being allowed to combine a trade and a profession induces them to be constantly sending the patient a little of something that will do him good.[50]

or with Homan's conclusion that prior to the twentieth century, 'most dispensing was done by the doctors themselves.'[51] Instead, the evidence seems to support Smith's assertion that 'among the more respectable reaches of the profession, the change to less

[50] *The Chemist and Druggist*, Vol.1, No.16 (15 December 1860), p.401.
[51] P.G. Homan, 'The Development of Community Pharmacy' in S. Anderson (ed.), *Making Medicines: A Brief History of Pharmacy and Pharmaceuticals* (London, 2005), pp.129-130.

heroic dosages and consequent fall in income heightened the attractiveness of the ethical "custom" of charging for "the prescription", which was then taken by a patient to a chemist, rather than for actual medicines dispensed by the doctor himself.'[52] This does not mean that chemists necessarily out-competed doctors for this trade. On the contrary, to dispense with dispensing may have made sound economic sense for some if not all of Gloucester's general practitioners. If so, rather than chemists and druggists representing 'a new and serious threat' to medical men, they unburdened them of dispensing medicines, thus allowing them to concentrate on the more rewarding business of doctoring and to move away from the pejorative association with trade that accompanied the selling of drugs.[53]

By the 1840s, the dispensing of medical prescriptions was clearly a major part of these businesses' trade. It allowed them to position themselves as a trusted and valued community resource and as mentioned already it facilitated new working relationships with Gloucester's medical men. The extent to which close relationships with members of the medical profession could be formed is illustrated by Figure 5.13, which shows that in 1850 the surgeon Charles Clutterbuck (see chapter three) was the source of 1,978 prescriptions dispensed by Stafford, representing 61 per cent of all Stafford's dispensing activity where the doctor was recorded.[54] The reasons for this are unclear. Geographical proximity does not appear to be a factor, as Clutterbuck lived at 61 Barton Street and Stafford's shop at 10 Northgate Street was not, therefore, the nearest.

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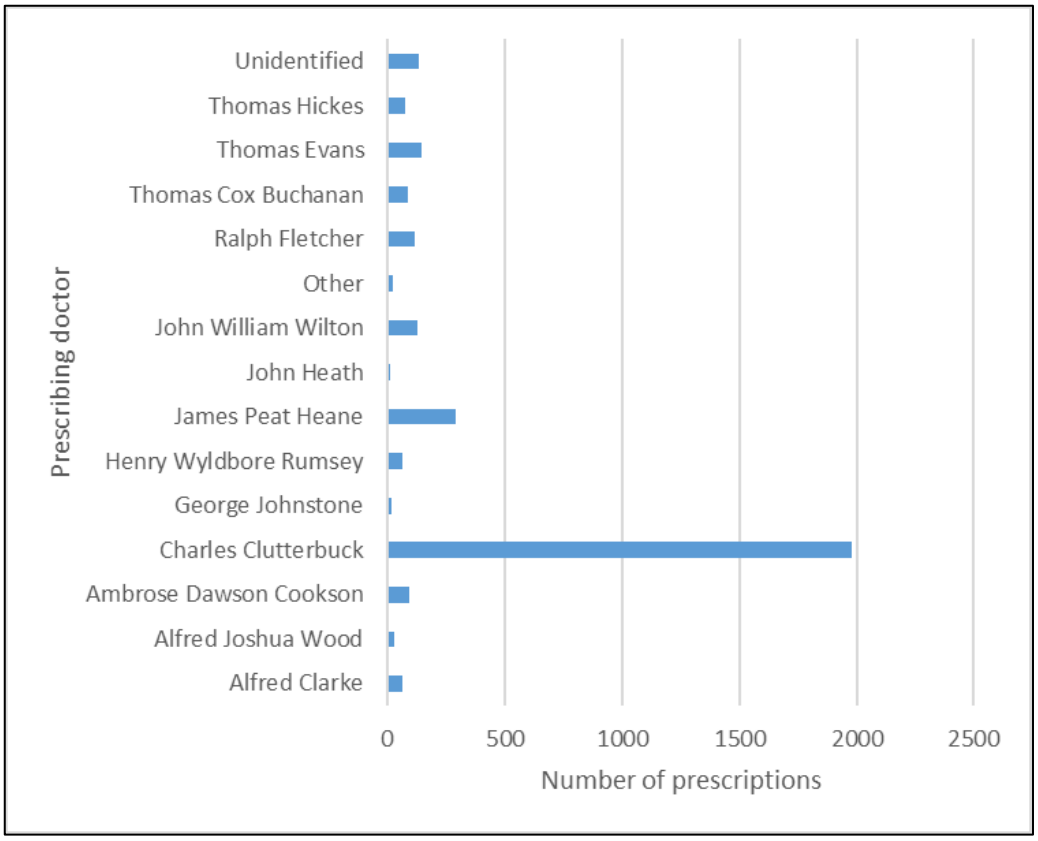
[52] F.B. Smith, *The People's Health 1830-1910* (London, 1990), p.371.

[53] I. Loudon, 'Medical Practitioners 1750 – 1850 and Medical Reform in Britain' in A. Wear (ed.), *Medicine in Society* (Cambridge, 1992), p.230.

[54] In 269 cases the doctor's initials were not recorded and in another 132 cases the doctor could not be identified from the initials or name recorded. The rest could be identified as amongst Gloucester practitioners known to have been in practice at the time. However, as names of the doctors are an assumption based on their initials matching a known practitioner (which was usually all that was recorded), it is possible errors could occur.

Figure 5.13 William Stafford: Prescriptions dispensed in 1850 by prescribing doctor[55]



Source: William Stafford, Prescription books, November 1849 – December 1851.

That an arrangement or understanding of some kind existed between the two seems highly probable but, so far, no definitive evidence of it has been found. It is possible it may have resembled those found by Fissell in eighteenth-century Bristol whereby '"charitable" practitioners might see patients gratuitously but give them inscrutable prescriptions that could be filled only by one particular druggist or apothecary. Needless to add, the druggist owed the practitioner a large kickback' but this seems unlikely given the reputations of the two men[56] However, Smith also found that 'doctors who gave 'free advice' to poor clients recouped by directing their scripts to particular chemists with whom they were in partnership' so this cannot be ruled out.[57] Treating large numbers of working-class patients, as Clutterbuck appears to have done, was problematic for doctors. Charles Dickens described how 'the whole mass of the

[55] Excludes prescriptions where the prescribing doctor was not recorded. Includes repeat customers/prescriptions.
[56] M.E. Fissell, *Patients, Power, and the Poor in Eighteenth-Century Bristol* (Cambridge, 1991), p.120.
[57] Smith, p.373.

poor in this country is thrown upon the almost unassisted charity of the medical profession; a charity to the support of which the public contributes scarcely a tithe. No burden in any degree resembling it is sustained by any other profession, or by any trade.'[58] As discussed earlier, in Gloucester, a predominantly working-class city, it may help to explain why there were not more general practitioners and why their numbers did not increase in line with population increase. It is possible Clutterbuck, like Eliot's fictional Dr Lydgate, had resolved to 'simply prescribe, without dispensing drugs or taking percentage from druggists.'[59] Equally, perhaps he was taking a percentage, leaving it to Stafford to determine who could and could not afford to pay and, if so, what amount. The relationship between Stafford and Clutterbuck may also have had something to do with the posts Clutterbuck held. In 1850, he was the Medical Officer to the Workhouse, the Infirmary which at the time was in the process of being rebuilt.[60] Previously, he had been one of the original eight attending medical officers appointed when the Dispensary was founded in 1831, a position he held until 1847.[61] Thus, Clutterbuck had been involved in treating the city's poor for many years. Whitfield has pointed out how 'the complete separation of duties, between the prescribers of medicines and the dispenser, was of utmost importance to the poor, because the temptation to supply medicines that were at hand and the easiest to prepare was removed, and the best drugs could be ordered without regard for the trouble that might be required in their preparation' and this may well have relevance here.[62]

If Clutterbuck was treating large numbers of poor patients *gratis*, or at reduced rates, it may have made sense to collaborate with a chemist to spread the risk posed by these patients/customers. By charging a nominal amount for a prescription and leaving the customer to pay the chemist and druggist a fixed fee for the medicines, doctors could keep some cash coming in, rather than having a prolonged or indefinite wait for any payment. Also, they avoided the problem of having to stock medicines, or

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[58] C. Dickens (ed.), 'Medical Practice Among the Poor,' *Household Words,* No.239 (21 October 1859), p.217.
[59] G. Eliot, *Middlemarch*, (London, 1994 [1871-2]), p.147.
[60] J. Churchill, *The London and Provincial Medical Directory* (London, 1850), p.224.
[61] The others were Messrs Meyler, Williams, J.W. Wilton, W. Wilton, J.F. Cooke, J.P. Heane, Buchanan, Hickes, Carden and Wood). In addition, there were two consulting physicians; J. Baron and H. Shute and two consulting surgeons R. Fletcher and W. Cother – source: The Gloucester Dispensary and Vaccine Institution, *Report of Meeting held on 30 August 1831 for Inaugurating the Dispensary, with Rules, and List of Subscriptions* (Gloucester, 1831).
[62] M. Whitfield, *The Dispensaries: Healthcare for the Poor Before the NHS. Britain's Forgotten Health-Care System* (Bloomington, IN, 2016), p.97.

medicinal ingredients, which might not be used, or might not be paid for by recipients. Thus, much of the risk was transferred to the chemist. For those who, like Clutterbuck, treated large numbers of poor patients, there was the added advantage of avoiding the reputational damage that could result from having to refuse to supply medicines to patients who could not pay for them. There were other advantages to taking a pragmatic approach: the patient got advice at a fee they could afford, the doctor got some remuneration, and the chemist and druggist benefitted from volume sales. It is also possible Stafford was as altruistic as his obituary claimed:

> From his early medical training he had acquired an accurate and comprehensive knowledge of diseases and their remedies. For years he was esteemed as the medical adviser of the poor of the city and county, and he was the poor man's physician. His advice to children was valuable, and he was frequently sought by anxious parents. His demeanour to children was affable and agreeable, and his happy cheerful smile inspired their confidence. He was a most genial man and was extremely benevolent, and if he knew that any man or woman who consulted him was too poor to pay for his or her bottle of physic, he or she were not charged. Sometimes his poor patients were not only presented with a bottle of physic or a box of pills but with a gratuity in addition. He was unostentatious in his gifts and he was truly charitable. His noble heart sympathised with human want and misfortune and he never declined to give assistance whenever a genuine appeal was made to his inherent benevolence.[63]

This hardly seems a viable long-term business model, unless Stafford found other ways of recouping the cost of medicines from his poorer customers or was able to subsidise his losses through his income from paying customers. Unfortunately, neither Stafford nor any of the other chemists recorded how much they charged in their prescription books but it seems unlikely many of his customers could have afforded to pay the full price.

The reasons for this apparent largesse might also lie partly in the political ambitions of the two men. Clutterbuck was Liberal Councillor for East Ward and would be elected Mayor the following year (Figure 5.14). When he died in 1854, Stafford was elected to his East Ward constituency, although Stafford was a Conservative. It is conceivable this was a politically motivated, short-term expedient as many of Stafford's customers did live in East Ward but bearing in mind their differing allegiances this does not seem likely. Whatever the precise nature of their relationship it appears to have been unique, but this is something that would benefit from more detailed research covering a longer period.

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[63] *Gloucestershire Chronicle*, 9 April 1898, p.5.

Figure 5.14 Charles Clutterbuck, Mayor of Gloucester, 1851-1852

Source: Portraits of Mayors 1845–1937, Gloucestershire, GA, Gloucestershire Borough Records, MS, GBR/L6/30/41.

In 1850, Edmund Coleman by comparison dispensed only eight prescriptions from Clutterbuck and was not dependent to the same degree upon any single doctor for business. His customers presented prescriptions from a more even distribution of medical men (Table 5.5) but John William Wilton was the most frequently recorded, accounting for 354, or 31 per cent, of all prescriptions where the doctor was recorded and legible. The next most frequent were Thomas Cox Buchanan and Thomas Evans, accounting for 12 per cent and 11 per cent respectively. Stafford in contrast dispensed only 128 prescriptions written by Wilton in 1850. This might have been because Coleman's shop was close to Wilton's surgery, as in 1851 Wilton lived in King Street, which intersects Eastgate Street. Coleman dispensed 135 prescriptions issued by Buchanan, compared to 87 dispensed by Stafford. For Evans, the figures are more even: 121 by Coleman and 144 by Stafford. The initials of other doctors appear only infrequently, if at all. This may mean their patients patronised different chemists, that

these doctors dispensed their own medicines, or that they saw fewer patients and this is again an area that would benefit from future research.

Table 5.5 Edmund Coleman: Prescriptions dispensed in 1850 by prescribing doctor

Medical Practitioner	Number of prescriptions
Alfred Clarke	1
Alfred Joshua Wood	101
Ambrose Dawson Cookson	81
Charles Clutterbuck	8
Fortescue Morgan	3
Henry J. Boughton	1
Henry Wyldbore Rumsey	58
James Peat Heane	65
John Health	3
John Manley	1
John William Wilton	354
Other	179
Ralph Fletcher	9
Thomas Cox Buchanan	135
Thomas Evans	121
Thomas Hickes	4
William Henry Hickman	2
William White Williams	1
Illegible/Not recorded	166
Grand Total	**1293**

Source: Edmund Coleman, Prescription book, 1849 – 1853.

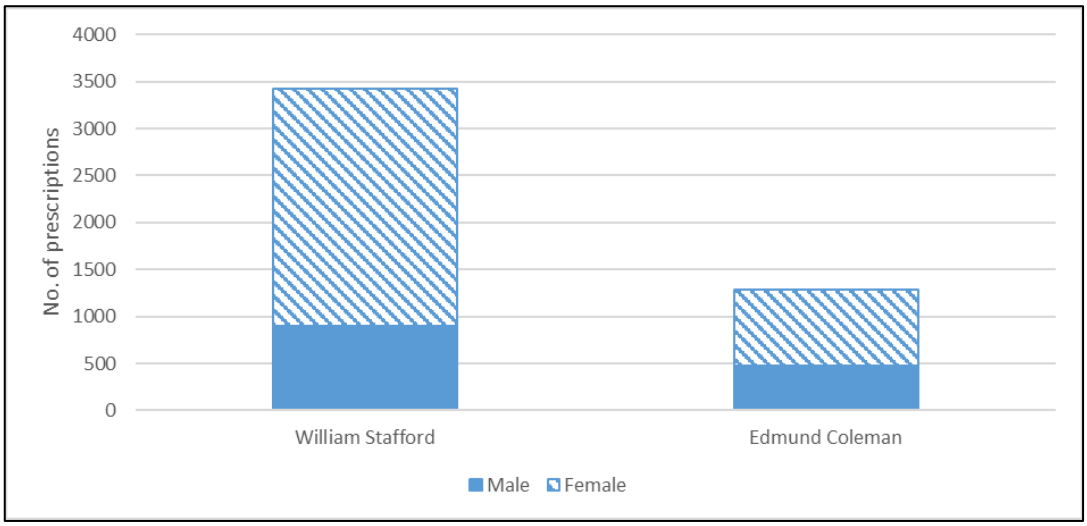
Significantly, analysis of the customers recorded in the prescription books reveals that most of them were women.[64] Figure 5.15 shows that in 1850, 74 per cent of entries in Stafford's book and 63 per cent of entries in Coleman's book recorded the customer as either 'Mrs' or 'Miss'. Neither Stafford nor Coleman differentiated between spouses when recording the customers' details, whereas they did record where the prescription was for a third party such as a child or servant.[65] In 1850, Stafford recorded 663 such instances. 633 of these were for children, 25 for servants, and five

[64] In a significant number of cases the abbreviation for Mister or Misses was illegible – these cases were recorded as Mr and therefore the number of males is, if anything, an overestimate. The customer in this case refers to the person collecting the prescription, not who it was actually for.

[65] In James Tucker's prescription book for 1850, only once was a wife recorded as a third party and never a husband.

for other family members, or where the relationship is unclear. Prescriptions for older children appear recorded under the child's own name prefixed with the title 'Master' or 'Miss.'[66] As the books do not differentiate spouses and this gender disparity cannot be credibly explained by any difference in morbidity, or even by women being more likely to seek medical advice, it can only be assumed that the name recorded was that of the *collector,* not the patient.

Figure 5.15 William Stafford and Edmund Coleman - prescriptions dispensed in 1850 by gender of collector



Source: William Stafford, Prescription books, November 1849 – December 1851; Edmund Coleman, Prescription book, July 1849 – July 1853.

If this is the case, we must conclude that the task of collecting prescribed medicines fell predominantly to women: something that accords with Stobbard's observation that from the late 1700s onwards 'women especially appear as active, knowledgeable, and discerning consumers…often responsible for decisions about household consumption and played a formative role in shaping the world of goods.'[67] Loeb too noted how 'although she did not earn the money, the woman of the house could significantly control the way that it was a spent…the ultimate decision (to buy or not to buy) was usually hers.'[68] In the previous chapter we saw how much medical advertising was directed at female consumers and this makes perfect sense if purchasing

[66] These can sometimes be identified as children by the address being a school.
[67] J. Stobart, 'Leisure and Shopping in the Small Towns of Georgian England: A Regional Approach,' *Journal of Urban History*, Vol.31, No.4 (May 2005), p.480.
[68] L. A. Loeb, *Consuming Angels* (Oxford, 1994), p.34.

medicines formed part of the wider activity of shopping – something to which a humorous article from 1859 entitled 'Love among the drugs' alludes:

> If you look into any newly- established Chemist's shop in a country town, at any hour, you will probably see some neatly-dressed young female waiting to be served. Early and late, winter and summer, spring time and autumn, the same phenomenon presents itself, We have observed it on so many occasions, that we long since began to theorise upon it, and we fancy with some success. Is the feminine tooth in perpetual suffering? for chemists are dentists as well as druggists. Are delicate little fingers continually being pinched in malignant wickets? Do chilblains need medical advice; or is honey required for chaps when the thermometer is at 93 degrees in the shade? We have no hesitation in giving these questions a most unflinching negative. How then do we account for the shops of young chemists being the chosen resort of the gentle sex? Simply in this way: because the young chemist is looking out for a partnership – not chemical, but connubial – and every pretty and sensible young person – maid or widow – knows it, and turns that knowledge to profitable account. That is out theory. In a year or two a change takes place. Instead of a lady being constantly before the counter, one is occasionally seen behind it. The most meritorious candidate has been selected for preferment. With proper feeling the Opposition retire, and business is allowed to flow in its natural and legitimate channels. The sale of cosmetics is greatly reduced, depilatories are in less request, and casualties, such as the pricking of thumbs or burns from Italian irons, of very rare occurrence. The young chemist is no longer a marked man – his individuality has fallen like a drop of rain, and been swallowed up in the mighty ocean of matrimony – *Once a Week*. [69]

Interestingly, what this article also supports is the point made in chapter four that many medicines were aimed at those with minor or cosmetic ailments too trivial to require medical advice. For such customers, a trip to the chemist and druggist could wait until payday, or normal shopping day. Figure 5.16 supports this, showing considerable variation in the days of the week prescriptions were collected. In 1850, 28 per cent of Stafford's dispensing activity occurred on Saturday, followed by Monday (23 per cent) and Wednesday (21 per cent). The days on which the highest proportion was dispensed to females were Monday and Sunday (both 75 per cent), closely followed by Saturday (74 per cent). The days most favoured by males were Tuesday (33 per cent) and Friday (32 per cent).

Figure 5.16 also shows Saturday as the busiest dispensing day for Coleman, but here dispensing was more evenly distributed across the other days. For both, Sunday was by far the quietest day. Stafford and Coleman appear to have been active churchgoers and Sunday trading was the subject of political campaigning in the 1850s, with the Sunday Trading Prevention Bill being narrowly defeated in 1851. Around this time, one George J. Wait wrote to the *Gloucester Journal* in 1851 to complain that 'the

[69] *The City of Gloucester Guardian,* 24 September 1859.

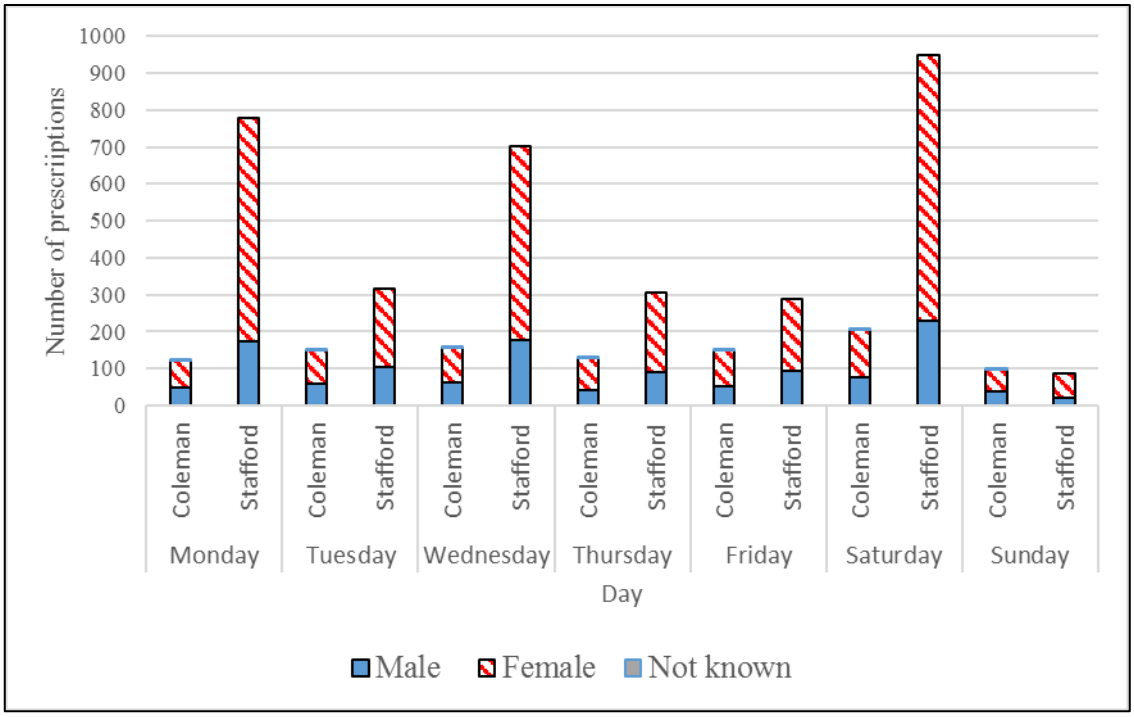
necessity of working on the Sabbath, or keeping open shop, cannot now be justified on any reasonable ground'.[70] The trade was itself similarly critical of those chemists and druggists who opened on a Sunday, as one contributor to *The Chemist and Druggist* made clear:

> A firm determination and unity of purpose on the part of those with whom the matter rests, would soon overcome every obstacle, and procure for us all those opportunities for recreation and mental acquirements, denied which, the life of a retail chemist is no better than one of perpetual drudgery. Sunday trading cannot be too strongly denounced. What plea can be successfully urged in its favour? I allude not to the dispensing a prescription or supplying medicines which are "urgently required;" these should be regarded as exceptional cases.[71]

Thus, it is likely that both Stafford and Coleman only dealt with emergencies on Sunday. As far as the variations across the rest of the week are concerned, it seems improbable this was the result of anything other than the pattern of the working week. A correspondent writing in the *Gloucester Journal* in 1851 stated that 'most thoughtful masters pay their workpeople on the Friday.'[72] If this was the case, it makes sense for Saturday and Monday to have been the most common collection days and as the male breadwinner would likely be working six days a week, for women rather than men to have collected prescriptions.

[70] *Gloucester Journal,* 9 August 1851, p.3.
[71] *The Chemist and Druggist*, Vol.1, No.7 (15 March 1860), p.149.
[72] *Gloucester Journal,* 9 August 1851, p.3.

Figure 5.16 Edmund Coleman and William Stafford: Number of prescriptions by gender of collector and day of the week dispensed, 1850.



Source: Edmund. Coleman, Prescription book, July 1849 – July 1853; William. Stafford, Prescription books, November 1849 – December 1851.

Coleman's books are more confusing in this respect because, as mentioned earlier, it appears that unlike Stafford, who recorded the date of collection, Coleman may, at least some of the time, have recorded the date the prescription was issued as there are older dates out of chronological sequence in the books, sometimes several years prior to the preceding and succeeding entries. For example, a Mr Willow apparently presented a prescription dated 30 March 1847 in January 1850; Reverend E. Lilley one dated 5 September 1844 in October 1850; William Oakley one dated 16 January 1848 in November 1850, and Reverend Charles Crawley one dated 10 October 1845 in December 1850. This suggests that prescriptions were being re-used, sometimes long after they were originally issued.[73] That this was the case is supported by a complaint in *The Chemist and Druggist* about different prices being charged by different chemists for the same prescription:

> A correspondent, signing himself "Fair Play" in No.10 of "The Chemist and Druggist," complains about the different prices demanded for prescriptions by different members of the trade. He says the same quantity of medicine will be made up and sold by one dispenser for 1s 4d, by another for 1s 2d, and by a third for 10d. He proposes a certain

[73] Holloway, 'The Regulation of the Supply of Drugs,' p.86.

> "private mark" should be used be chemists and druggists; that the first dispenser should charge a "fair" and "remunerative" price for the medicine, and then place this price upon the prescription paper, shrouded under the secrecy of the private mark, to guide and govern all future dispensers before whom it may be brought.[74]

If patients could obtain medicines without seeking further medical advice, prescriptions therefore effectively become instruments of self-medication, to be used whenever the patient thought appropriate. This raises the intriguing possibility that medical advice might only be sought once to secure regular access to prescription medicines, something that might go some way to explaining why there does not appear to have been any abundance of 'irregular' suppliers in Gloucester. It may also however have been one of the factors constraining the number of medical men despite the rapidly increasing population. Furthermore, if patients did not need to see their doctor regularly to retain access to prescription medicines, this may also have had an impact on their loyalty to any individual doctor. Here Stafford's books present a mixed picture. In some cases, prescriptions for individuals who could be positively identified as repeat customers were written by the same doctor each time. However, as Stafford seems to have recorded the date the prescription was presented or collected, rather than the date it was issued, if the constituent medications did not change, we do not know whether this was simply *the same* prescription being re-presented. Assuming for now, each was new, then in one case, that of William Taylor aged 74[75], an agricultural labourer, and his wife Comfort, aged 52, of Barnwood, of ten prescriptions dispensed between February and June 1850, in the eight instances on which the prescribing doctor was recorded, each time this was James Peat Heane. Similarly, Hannah Sandberg (79) of Theresa Place, appeared seven times between January and February 1850, and each time the prescribing doctor was Henry Rumsey. Mary King (46) of Twigworth, the wife of a farmer and dealer, and one of her daughters, between them also appeared seven times between May and December 1850, all with prescriptions written by Charles Clutterbuck.

Elsewhere however, the doctor did change. For example, Mrs Teague (39) of Tibberton, the wife of a cordwainer, presented six prescriptions in March and April 1850, five written by Henry Rumsey and one by Thomas Evans. A Miss Spencer of Barton Terrace presented eight prescriptions during July and August 1850, seven of

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[74] *The Chemist and Druggist,* Vol.1, No.11 (14 July 1860), p.237.
[75] Ages are taken from the 1851 Census.

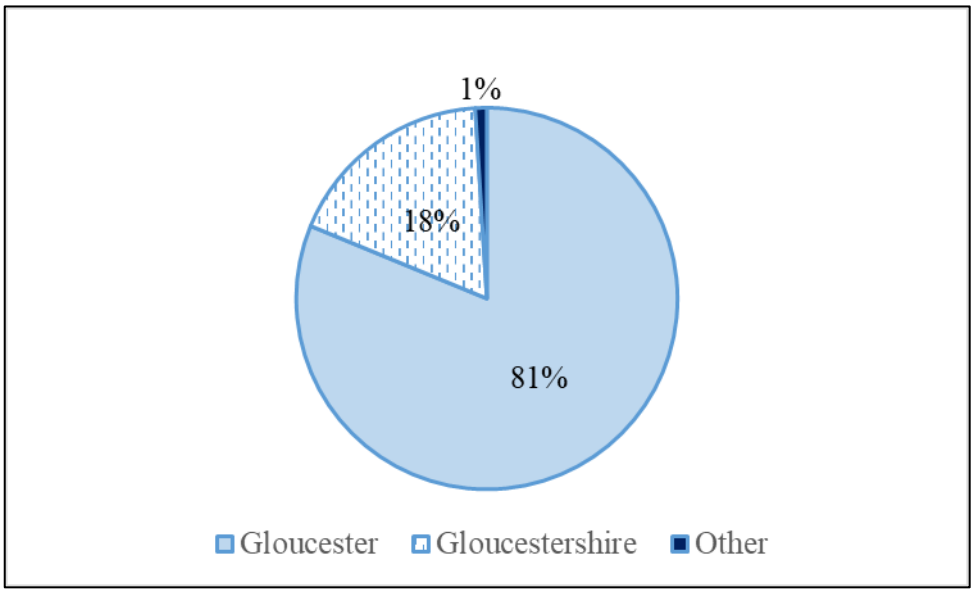
which were written by James Peat Heane and one by Thomas Evans; Sarah Baylis (50), a widowed charwoman living in Columbia Street, presented six prescriptions between January and March 1850, five written by Alfred Clarke and one by J.W. Wilton. Elsewhere, Mrs Maysey of Worcester Street, aged 50, the wife of a retired butcher, presented nine prescriptions between July and September 1850 written by doctors Evans, Wilton and Wood. Her son Henry (11) had another two prescriptions in July from doctors Clarke and Wood.

Although overall staying with one doctor appears the norm, these examples suggest changing doctor was not unusual, even part way through a course of treatment, Interestingly, they also show that changing doctor was not a purely middle-class phenomenon, although the circumstances under which the change occurred may have differed for working-class patients, for whom it might have been more a matter of finding a doctor prepared to see them *gratis,* or at a reduced fee, than of choosing another practitioner. Importantly, any fickleness on behalf of patients was manifesting itself in changing between one *regular* medical practitioner and another, suggesting again that intra-professional competition was potentially more of a threat to livelihoods than patients seeking the services of 'irregulars'. That working-class patients took this approach points to the value they too placed on regular advice.

Differentiating working- from middle-class customers was only possible in Stafford's books because uniquely he recorded the street address of the customer. As mentioned earlier, cross-referencing prescription books with census records has not been attempted before and offers an important new perspective on healthcare in the Age of Reform. For reasons unknown, Stafford's recording of addresses became increasingly erratic from mid-1850 onwards to the point where it was less useful to try to match the records for 1851 than those for 1850. Figure 5.17 shows that in 1850, 81 per cent of all prescriptions where an address was recorded were for residents of Gloucester, with 18 per cent from elsewhere in Gloucestershire and only one per cent for customers from outside of the county. Stafford's shop at 10 Northgate Street was next to the New Inn, very near to The Cross, the centre of the city, and within easy walking distance of the railway station, the coaching stop, and the docks (but not the nearest to any of them). It was also only a few minutes' walk from the Infirmary in Southgate Street. Customers from the surrounding shire could easily have brought their

prescriptions in to be dispensed while in the town on other business. This out of town trade suggests reputable chemists like Stafford served communities beyond the immediate environs of the shop.

Figure 5.17 William Stafford, 1850: Prescriptions dispensed by geographical location of customer*



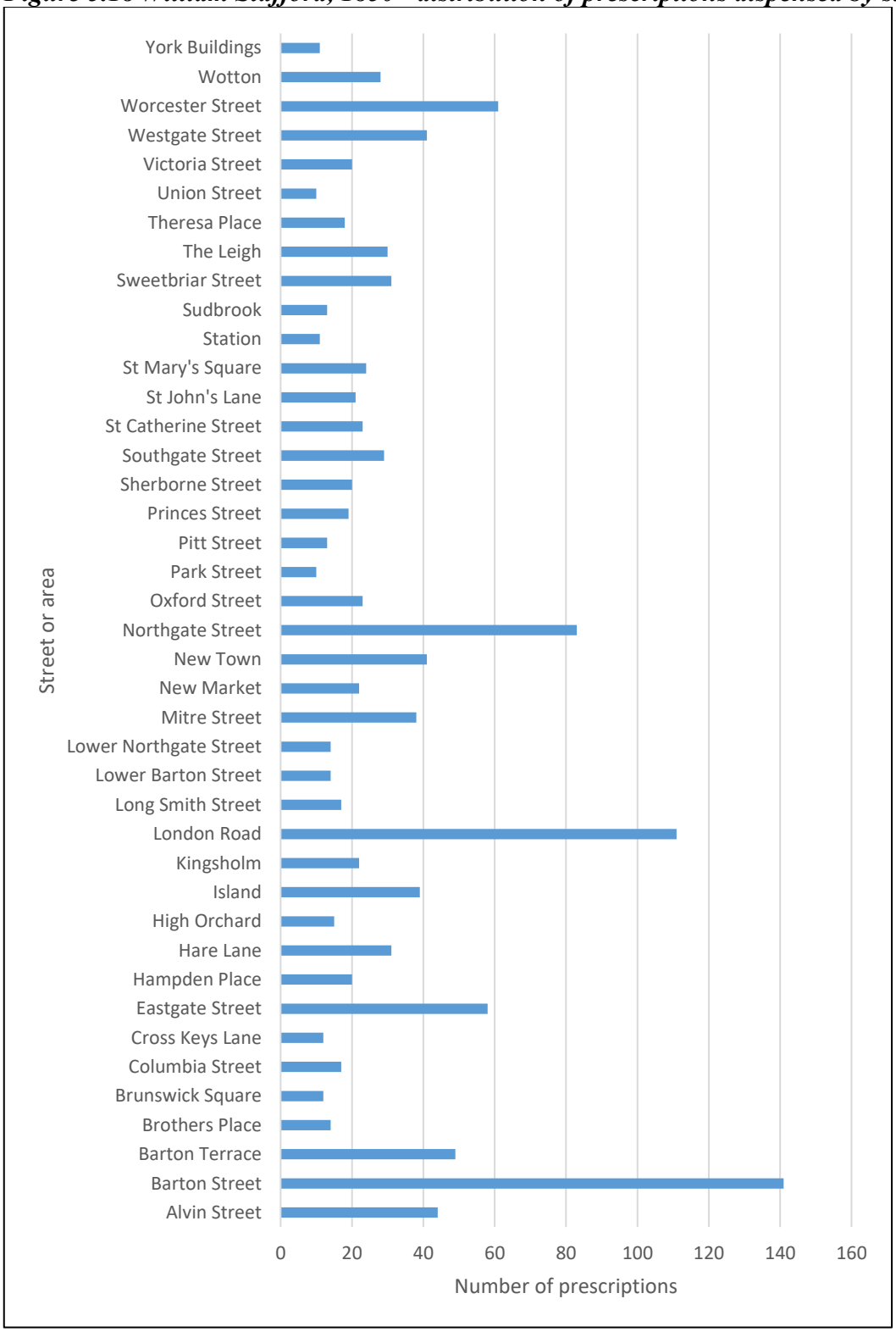
Source: William Stafford, Prescription books, November 1849 – December 1851.

*Includes repeat customers/prescriptions

As Figures 5.18 shows, most customers however resided in the neighbourhood immediately surrounding the shop and this speaks of the importance of Stafford's business to the local community he served. Taking as an example one of the streets closest to the shop, between November 1849 and December 1850, 40 prescriptions were dispensed to customers from Mitre Street, representing 23 discrete customers.[76] Mitre Street was exclusively working-class and for the eleven households that could be traced in the census, the occupation of head of household is shown in Table 5.6.

[76] Mitre Street has since disappeared and now approximates to the Oxbode. It should be noted that these cases were matched based upon street address, sex and surname alone so cannot be definitively confirmed as the same individuals. However, the socio-economic complexion of the streets as a whole supports the hypothesis.

Figure 5.18 William Stafford, 1850 - distribution of prescriptions dispensed by street*



Source: William Stafford, Prescription books, November 1849 – December 1851.

*Results for Gloucester only, showing those streets/areas that produced ten or more prescriptions in 1850 (including repeat customers/prescriptions).

Table 5.6 William Stafford: Prescriptions dispensed to customers in Mitre Street, Gloucester, Nov. 1849 – Dec. 1850

Surname	Forename	Street	Occupation, or of head of household from 1851 census
Ackerman		Mitre Street	
Barnett		Mitre Street	
Bridges		Mitre Street	Grocer's porter
Brookes		Mitre Street	Shoe Maker
Brooks		Mitre Street	
Brown		Mitre Street	Coach Painter
Butt		Mitre Street	
Cubberlake		Mitre Street	
Cullis	Edwin	Mitre Street	Cordwainer
Dyer		Jacques Buildings	Labourer / Bricklayer
Griffith		Mitre Street	
Griffiths		Mitre Street	
Jenkins	Eliza	Mitre Street	
Mills		Mitre Street	Painter and plasterer
Morgan		Mitre Street	
Phillips		Mitre Street	Cordwainer
Read/Reid		Mitre Street	Ostler and grocer [Reed]
Sweetman		Mitre Street	Brewer
Taylor		Mitre Street	
Vaughan		Loot Alley	Carpenter
Watts		Mitre Street	Shipwright
Wimbo	Elizabeth	Mitre Street	
Wrenn	Fanny	Mitre Street	

Source: William Stafford, Prescription books, 1849 – 1851 and Ancestry.com, *1851 Census* [database on-line]. Provo, UT, USA: Ancestry.com Operations Inc, 2005. Original data: Kew, The National Archives, *Census Returns of England and Wales, 1851*, HO 107.

The example of Mitre Street shows that Stafford's customers came from working as well as middle-class areas and a further example presents a similar picture. Hare Lane was also predominantly working-class and similarly located close to Stafford's shop. Here, 16 out of 23 customers could be traced as shown in Table 5.7.

Table 5.7 William Stafford: Prescriptions dispensed to customers in Hare Lane, Gloucester, Nov. 1849 – Dec. 1850

Surname	Forename	Occupation, or of head of household (from 1851 census)
Bailey		Chimney Sweep
Ballinger	Esther	Plumber
Cape		
Cox		Printer (compositor)
Dark	Amelia	Horsekeeper
Drinkwater	A.	Labourer
Evans		Head Master King's School
Forth		
Harding	H.V.	Mariner's wife
Harris		Post Boy
Hayward		Cordwainer
Higgins		
Jackson		Shoemaker
Kilminster		Plasterer
Knott		Bootmaker
Neale	Joanna	
Osman		Plasterer and Slater
Reid		Railway Contractor
Robinson		Labourer OR Painter
Snowsell		Plasterer
South	Ann	
Tooth		
Williams	Mary Anne	

Source: William Stafford, Prescription books, 1849 – 1851 and Ancestry.com, *1851 Census*

The socio-economic variety of Stafford's customers is confirmed by looking at a few examples: George Wintle, aged 38, resided at 40 Eastgate Street with his wife and six children and was a partner in the firm of Wintle and Arkle, Wine Merchants. The 1851 census also records two servants at the household address.[77] The family appeared 49 times during 1849-1850, receiving prescriptions from Thomas Cox Buchanan and Henry Wyldbore Rumsey for the adults, their children, and the servants. In contrast, Jane Beard of Barton Street was the wife of a plasterer. In 1850, she is recorded eight times collecting prescriptions on behalf of her son (four times in December alone) supplied by Charles Clutterbuck and Thomas Cox Buchanan. William Terrett (7) of

[77] Note all ages are as recorded in the 1851 census.

Alvin Street, was the son of Thomas Terrett (42), an innkeeper. A regular customer was Sarah Snowsell of Hare Lane (40), the wife of Thomas Snowsell (58), another plasterer, who had three children and lived with her husband's sister and niece. Charles and Frances Smart of Barnwood, (both aged 65) were a gardener and a laundress, with three grown-up children living at home. They were also regular customers. Edmund Boughton (27) of Barnwood an iron merchant living with his wife, three children and three servants was another customer, as was Reverend Daniel Capper (46), the Rector of Huntley, who lived with his wife, two children, and five servants. Their status contrasted with that of Ann Shott (10) of Swan Lane, Gloucester, the daughter of John Shott, a labourer. Thomas Andrews (58) was an accountant and one of three lodgers at Eliza Ann Howde's lodging house on London Road. Walter Jelf (81) meanwhile was a gentleman and lived with his wife Elizabeth (81) also in London Road. Some of Stafford's customers came from Gloucester's most deprived neighbourhoods, including the Island (45), Sweetbriar Street (31), Sudbrook (13), and Dockham (7). Sweetbriar Street appeared regularly in sanitary reports as an area of concern and in 1851 was notable for high numbers of itinerant, unskilled and semi-skilled occupations with very few middle-class households, as shown in Appendix V.

This evidence casts some doubt upon Biddle's conclusion (shared by many others) that 'for labouring-class patients the cost of independently employing the services of a doctor was such that it was usually their last resort.'[78] It also questions Holloway's claim that 'the high status of [a] neighbourhood and clientele explain the prominence…of prescription-dispensing.'[79] It appears working-class people did not necessarily favour less expensive alternatives to regular medical advice, supporting instead Porter's assertion that in the nineteenth century 'it is indisputable that professional medicine became readily more available to a growing segment of the population, and being treated by the doctor became a way of life.'[80] It also supports Whitfield's conclusion that 'it was probably more important to the poor than to the rich to have their ailments promptly attended to. Their bread depended on their health, and

[78] R. Biddle, 'Dissecting the Medical Marketplace: The Development of Healthcare Provision in Nineteenth-Century Portsmouth,' unpublished PhD thesis (Oxford Brookes University, 2009), p.237.
[79] Holloway, *Royal Pharmaceutical Society,* p.47.
[80] R. Porter, 'The Patient in England, c.1660-c.1880' in A. Wear (ed.), *Medicine in Society* (Cambridge, 1992), p.100.

to be able to get a doctor at once often saved many a day's work to a poor man.'[81] These issues will be explored further in the next chapter.

It is also useful to look at variation in where doctors' patients came from. 81 per cent of Charles Clutterbuck's patients whose address was recorded, 85 per cent of Thomas Evans' patients and 95 per cent of Thomas Cox Buchanan's patients resided in the city of Gloucester. Looking in detail at Evans' patients, in the year 1850 (Table 5.8) eight prescriptions were dispensed to one patient, Mrs Brown, a resident of Long Smith Street. Evans' other patients in Gloucester all lived within easy walking distance of both his home at Bear Land House (on the corner of Long Smith Street and Bear Land) at the south-western edge of the city centre. In most cases, neither Evans nor Stafford was the nearest provider to the patient's home (four patients lived in Barton Street/Barton Terrace for example).

Table 5.8 Addresses of patients of Dr Thomas Evans, 1850

Address	Count*
Albion Hotel	1
at Bellamy's	1
at Mrs Dowling's, London Road	1
at Rev'd W. Holmes'	1
Barton Street	4
Barton Terrace	1
Beaufort House	4
Bromsgrove	1
Brunswick Square	2
Cheltenham Road	4
Cheltenham Turnpike	2
Chepstow	2
Clarence Street	1
College Green	1
Coombe End	1
Hampden Place	1
Huntley	1
Island	2
Journal Office	1
Ledbury	1
Little Dean	2

[81] Whitfield, p.81.

Address	Count*
Littleworth	1
London Road	9
Long Smith Street	8
Mitcheldean	1
Northgate Street	1
Nr. Ross	1
Oxford Terrace	2
Pitt Street	2
Ross	1
Shurdington	1
Southgate Street	3
Tibberton	1
Wellington Parade	1
Westgate Street	2
Wooton	1
Worcester Street	15
York Buildings	1
Grand Total	**86**

*Includes repeats.
Source: William Stafford, Prescription books, 1849 – 1851.

Evans also saw patients from Bromsgrove, Chepstow, Ledbury, Mitcheldean, Newnham, Ross-on-Wye and Stroud. More surprisingly perhaps, Clutterbuck also wrote prescriptions for patients from Ashleworth, Birdlip, Cam, Coaley, Corse Lawn, Dymock, Eldersfield, Elmore, Framilode, Hardwick, Hartpury, Huntley, Kilcot, Minsterworth, Newent, Newnham, Painswick, Ruardean, Rudford, Shurdington, Standish, Stourport, Taynton, Whitcomb, and Whitminster. Others meanwhile, such as Ambrose Cookson and James Heane, were only recorded as treating patients from Gloucester and neighbouring villages. As a physician, more of Evans' patients came from higher-income households and streets than lower-status surgeons like Cookson and Heane. Patients who could afford Evans' fees also apparently trusted Stafford's to make up their prescriptions. Providing this service to patients of a physician of Evans' stature is indicative of the high regard in which Stafford was held.

Overall, the body of evidence presented in this chapter challenges the stereotype of the chemist and druggists as an unscrupulous and dangerous quack, preying upon the gullible poor. Instead, this analysis has shown that the dispensing of medical

prescriptions was a major part of the trade of each of these businesses, one that establishes them as reputable and trusted tradesmen serving customers in their local communities from across the socio-economic spectrum.

5.5 Conclusion

The picture that has emerged of chemists and druggists challenges some of the key assumptions of the medical marketplace paradigm and has implications that go beyond the city of Gloucester to the wider healthcare economy. It has been shown that some doctors and chemists and druggists were working more closely together than the literature suggests, or the medical establishment liked to admit. Stafford and Clutterbuck provided a significant and valuable community healthcare resource serving a wide range of local people and a significant proportion of Stafford's customers appear to have been working-class. The precise relationship between Clutterbuck and Stafford in unclear, but it seems likely they enjoyed a close and cooperative business relationship and it is possible that, as his obituary suggested, Stafford dispensed medicines *gratis* to poorer customers from genuinely philanthropic motives.

There remains potential for more analysis of the prescription books, but the research undertaken here casts significant doubt on the assumption that 'the poor were irregular consumers of doctors' services' and instead sought the services of irregulars and proprietary medicine vendors.[82] The volume of dispensing activity and the social diversity and geographical proximity of customers to the shop, demonstrates the importance of the chemist and druggist to Gloucester's healthcare economy. It provides further evidence that qualified medical advice was a preferred pathway, by whatever means it could be obtained. Stafford alone dispensed 3,498 prescriptions in 1850 and a significant proportion of these appear to have been for working-class patients.[83] This lends support to Loudon's claim that 'the market for medical care came from a wide range of social classes and…people did indeed frequently consult the regular practitioner.'[84] By the 1840s, the dispensing of medical prescriptions was clearly an important part of the chemists and druggists' trade and if this had once been a source of conflict with general practitioners, the battle had been won long before. We have seen

[82] S. Cherry, *Medical Services and the Hospitals in Britain, 1860–1939* (Cambridge, 1996), p.42.
[83] Includes repeat customers and repeat prescriptions, but multiple item prescriptions are counted as one prescription.
[84] I. Loudon, *Medical Care and the General Practitioner 1750-1850* (Oxford, 1986), p.102.

how, rather than occupying a place amongst the medical fringe, through their dispensing activity, chemists and druggists had become integral to the regular medical offering. This has important implications for plurality and competition; what has emerged here is not 'free range medicine,' but something much more structured and stable, with a constructive accommodation between doctors and chemists that is generally assumed. If a medical marketplace had existed in Gloucester, the idea that was terminated by the 1858 Medical Act is clearly misplaced and at the very least a revised chronology is needed.

Other important observations can be made: chemists and druggists served the health needs both of those under medical care and those who self-medicated and given prescriptions did not expire, the divide between the two appears less clear-cut than the literature implies. Furthermore, the volume of dispensing activity varied widely from day to day, suggesting collecting medicines was a part of regular shopping activity. If this was the case, it implies customers were routinely seeking medical advice for less serious conditions, where collection could wait until shopping or payday. Most prescriptions were collected by women, which helps to explain why so much medical advertising was aimed at them. Overall, the evidence calls into question the notion that chemists and druggist were a malign presence in the healthcare economy in the Age of Reform, poorly serving those too poor, or foolish, to seek qualified medical aid. Combined with the evidence from preceding chapters, there is much to suggest rogue traders, the unscrupulous, and incompetent were a minority. The evidence also challenges the rather patronising view of their customers as penny-pinching and credulous. Instead, it supports the notion that this was a highly segmented marketplace, in which people mostly made rational choices commensurate with their circumstances and what was available to them. The ways in which choice was exercised are complicated but the caricature of a reckless and naïve self-doser grazing a 'bazaar' of options is far from the reality of most people's experience of healthcare in this period.

These conclusions have come from analysis of healthcare suppliers, but to have confidence in this interpretation it is necessary to now look in more detail at customers and the demand side of Gloucester's healthcare economy. Bringing the supply of and demand for healthcare together in this way is another area of weakness in the current historiography, which, as discussed throughout this study has, despite the oft-stated aim

of finding the ‘patient’s voice,’ focussed too heavily on suppliers of one sort or another. It is impossible to reach a holistic understanding of healthcare without reference to both suppliers and consumers and for this reason, patients and their families are the subject of the next chapter.

Chapter Six: Customers

6.1 Introduction

The preceding chapters have explored Gloucester's healthcare economy during the Age of Reform from various perspectives, questioning whether this can best be conceived as a 'medical marketplace.' It has been shown how rather than being characterised by plurality, diversity, choice and competition, this was instead a space dominated by regular medical practitioners and chemists and druggists. Furthermore, after a rapid increase in the early 1800s, by the 1840s the number of both doctors and chemists and druggists had stabilised and by 1870 had reached a rough parity at a number per head of population lower than other studies have cited elsewhere, suggesting competition within and between these two groups may also have been less intense than some of the literature has suggested. In Gloucester, what appears to have existed was a relatively small, stable and interconnected group of doctors and pharmacists, who between them supplied the bulk of the healthcare available in the city. The growth in the number of institutions, which are anomalous to the medical marketplace model, and their increasingly important contribution to the organization and professionalization of medical practice, casts further doubt over the model's utility. In chapter four, an analysis of healthcare advertising found further evidence to contest the existence of a medical marketplace. Here it was shown that within the market for proprietary medicines and other advertised healthcare products and services, a high degree of customer segmentation was present. Rather than competing with doctors for the custom of the gullible poor, these products were aimed more at those groups who could afford healthcare, but were least well-served by the medical offering, who might otherwise do nothing, and were receptive to alternatives. Chapter five argued for a reappraisal of the relationship between doctors and chemists and druggists. An analysis of prescription books showed that by the 1840s chemists and druggists were not just supplying proprietary medicines but were dispensing medical prescriptions in very significant volumes and to customers from across a wide socio-economic spectrum. Some of them had close working relationships with local doctors, co-operating to provide an important community healthcare resource.

These conclusions have come through detailed analysis of the suppliers of healthcare, but it is also essential to look at the users of their products and services and to hear the 'patient's voice.' Sparks and Penner have suggested that 'the relevance of health and often its urgency moves the status of medical culture to the centre of lived experience'[1] and Porter and Porter that 'the micro-history of bedside medicine…is…the story of innumerable decisions made in times of crisis, in matters of life and death.'[2] Despite this, as chapter one identified, an important gap in the historiography surrounds how people perceived and navigated the medical marketplace and how they interacted with the various types of healthcare suppliers they encountered. For example, Smith found 'our present knowledge about the proportion of private income spent on medical care is skimpy'[3] and King that 'the question of how far the sick and disabled who [found]…themselves in a workhouse can be said to have had agency remains one of the core lacunae in the literature.'[4] Wright too noted that 'much remains to be researched, especially how caring varied over time, by class, geographical location, and family life cycle.'[5]

As discussed in chapter one, the historiography of the medical marketplace paradigm emphasises diversity, plurality, choice and competition. For Condrau, this was a logical development when 'throughout history, patients… rarely encountered doctors and were looked after by their families, nurses or perhaps even left to their own devices.'[6] Similarly, Porter and Porter claimed that 'the individual or the family unit was the typical nexus of self-help' and the ethos of self-reliance exerted a powerful influence over healthcare choices.[7] Wild too found that in the eighteenth century,

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[1] L. Penner and T. Sparks, 'Introduction' in L. Penner (ed.), *Victorian Medicine and Popular Culture* (London, 2015), p.3.
[2] D. Porter and R. Porter, *Patient's Progress: Doctors and Doctoring in Eighteenth-Century England* (Cambridge, 1989), p.29.
[3] F.B. Smith, *The People's Health 1830-1910* (London, 1990), p.372.
[4] S. King, 'Poverty, Medicine, and the Workhouse in the Eighteenth and Nineteenth Centuries: An afterword' in J. Reinarz and L. Schwarz, (eds), *Medicine and the Workhouse*, (Rochester, N.Y., 2013), Kindle edition, ch.11.
[5] D. Wright, 'Familial Care of 'Idiot' Children in Victorian England' in P. Horden and R. Smith (eds), *The Locus of Care: Families, Communities, Institutions and the Provision of Welfare since Antiquity* (London, 1998), p.191.
[6] F. Condrau, 'The Patient's View Meets the Clinical Gaze,' *Social History of Medicine*, Vol.20, No.3 (2007), p.533.
[7] R. Porter and D. Porter, *In Sickness and in Health: The British Experience, 1650-1850* (London, 1988), p.197.

'before calling in a physician, it was not uncommon for the…patient first to experiment with home remedies or all-purpose proprietary mixtures…folk cures, empirical nostrums, and orthodox medical remedies were taken in succession or in combination [and] the regular physicians…scolded their patients for "irresponsible" self-medicating behaviour.'[8] Marland noted similar behaviour in the nineteenth century, asserting that 'doctors' bills…could be a burden even to the middle classes, and it seems they were prepared to try self-medication or the services of fringe doctors and chemists and druggists before calling in a regular medical practitioner.'[9] Reflecting the self-reliant ethos of the period, it has been said that 'self-medication with patient or proprietary medicines made a significant contribution to the total therapeutic effort.'[10] Walvin described how 'the great bulk of Victorians relied, in times of illness, not upon doctors or hospitals, but upon the practice of traditional folk medicines and upon local, community expertise.'[11] All of these historians stress the importance of individual agency; of people sorting things out for themselves with rival suppliers competing to service their needs. These arguments are persuasive, but caution is required. This study has shown that agency was often directed, constrained, or frustrated by structural factors and that choice was not indiscriminate. Even working-class patients have been shown to have been accessing regular medical attention in numbers significant enough to suggest this was their preferred option. We have seen too that different suppliers occupied different strata of the healthcare economy and did not necessarily compete for the same business but were instead used by different customers at different times depending on a complex combination of circumstances.

For the poor, when formal healthcare was accessed, individual agency was often constrained by structural factors. Tomkins has noted how 'contact was regulated by third parties like the Poor Law and charities, or rationed via membership of a sick club or friendly society'[12] and 'access to medical care by the poor and working population of

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[8] W. Wild, *Medicine-by-Post: The Changing Voice of Illness in Eighteenth-Century British Consultation Letters and Literature* (New York, 2006), p.26.
[9] H. Marland, *Medicine and Society in Wakefield and Huddersfield 1780-1870* (Cambridge, 1987), p.214.
[10] P.S. Brown, 'The Venders of Medicines Advertised in Eighteenth-Century Bath Newspapers,' *Medical History,* Vol. 19, No. 4 (October 1975), p.352.
[11] J. Walvin, *Victorian Values* (London, 1987), p.30.
[12] A. Tomkins, ''The Excellent Example of the Working Class': Medical Welfare, Contributory Funding and the North Staffordshire Infirmary from 1815, *Social History of Medicine*, Vol. 21, No.1 (March 2008), p. 13.

England was decidedly patchy before the twentieth century.'[13] Numerous barriers meant healthcare was rarely accessed exclusively from a single supplier and was often cobbled together from a variety of different sources. Hanly has described how the poor would 'look to, and in turn give support to, their 'kin' or network of friends, family and associates often living close by and who provided a raft of help and care in times of difficulty.'[14] Fissell too, while arguing that 'healthcare was an economic free-for-all, an open market,' also recognised how 'such openness was not solely predicated on a cash economy.'[15]

This chapter examines how different people of socio-economic backgrounds engaged with the healthcare economy during the Age of Reform. By adopting a qualitative approach throughout, it balances a discussion that has so far relied heavily on quantitative analysis. This change of methodology mitigates Penny Kane's criticism that 'the major limitation of demography…is that it does look at aggregates; it cannot tell us about the behaviour of individuals, let alone why they behaved as they did. For that, one has to learn individual stories and listen to individual voices.'[16] The chapter is shorter, reflecting the relative sparsity of source material, but this belies its importance to the overall aims of the study.

6.2 Sources and methods

One of the problems of a quantitative approach to healthcare is that it can exaggerate the role and importance of formal healthcare provision. The qualitative approach of this chapter therefore represents a necessary counter-balance. It comprises several case studies drawn mainly from letters, diaries and coronial records. The limited availability of such material dictates that those at the top and bottom of the socio-economic ladder are over-represented, but this also has the advantage of highlighting the experiences of those groups for whom the concept of a 'medical marketplace' had very different meanings, if any at all. The sources for this chapter bring a different perspective on the

[13] *Ibid.*
[14] M. Hanly, 'The Economy of Makeshifts and the Role of the Poor Law: A Game of Chance?' in S. King and A. Tomkins (eds), *The Poor in England 1700-1850: An Economy of Makeshifts* (Manchester, 2003), p.80.
[15] M.E. Fissell, *Patients, Power and the Poor in Eighteenth-Century Bristol* (Cambridge, 1991), p.10.
[16] P. Kane, *Victorian Families in Fact and Fiction* (London, 1995), p.x.

debate surrounding healthcare provision in the Age of Reform, but it must be recognised that such material is both fragmentary and subjective. Philipson has cautioned that neither the poor nor the elite were ever a homogenous entity': every patient's experience was to some extent unique and given the few accounts of illness that survive, determining how representative they might be is problematic.[17] The challenges this creates are well recognised: Porter has pointed out that 'perhaps the sick person is always singular'[18] and Keir Waddington has cautioned that 'experiences of illness are essentially personal and hard to quantify.'[19] Digby too has referred to 'the difficulty of giving a coherent account that [is] more than a fascinating anthology of personal accounts of illness'[20] and King that, in respect of the poor, 'it is difficult to understand what the medical treatment they received meant for them, how representative it was, and under what ideological conditions it was granted.'[21] Most historians working in the field have faced these problems but individual testimony is nevertheless a resource that cannot be ignored or replicated elsewhere. Lane recognized that 'the most difficult sources, yet the most interesting, especially in personal terms, are the accounts of illness, professional advice and treatment written by the patients themselves.'[22] The case study approach adopted in this chapter is rich in detail, with emblematic examples representing broader themes.

The rarity of surviving letters and diaries and the absence of coronial records for Gloucester city has necessitated the use sources drawn from the wider shire. This raises issues around the extent to which they can be said to be reflective of experiences in the city of Gloucester. Conversely however, they provide the opportunity to observe how some aspects of healthcare varied between town and country. Inevitably, letters and diaries mostly come from the aristocracy and gentry, who had the means and foresight to preserve them. First-hand testimony of this kind from working-class households is

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[17] T. Philipson, 'The Sick Poor and the Quest for Medical Relief in Oxfordshire ca. 1750–1834,' unpublished PhD thesis (Oxford Brookes University, 2009).
[18] Porter and Porter, *In Sickness and in Health,* p.13.
[19] K. Waddington, 'Health and Medicine' in: C. Williams (ed.), *A Companion to Nineteenth-Century Britain* (Oxford, 2007), p.413.
[20] A. Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine 1720–1911* (Cambridge, 1994), p.1.
[21] King, 'Poverty, Medicine, and the Workhouse.
[22] J. Lane, *The Making of the English Patient: A Guide to Sources for the Social History of Medicine'* (Stroud, 2000), p.xiv.

extremely rare and consequently 'remarkably little is known specifically about the life cycle and treatment histories of the poor.'[23] To some extent, these concerns are mitigated by mining the coronial records, which do provide detailed insights into the lives of the poor. However, coronial records are, by definition, unusual and exceptional cases, comprising fatalities that were considered suspicious or unexplained, including accidental death, suicide, neglect, abuse and murder. Nevertheless, as 'the records were generally compiled very soon after the event [they] provide a wealth of information on the circumstances surrounding the death' and they represent a rich and relatively under-explored resource.[24] Importantly, they are a good indicator of what was, and was not, 'normal' practice and behaviour.

The sources were too few to necessitate systematic sampling. Instead, each was chosen for the contribution it offered to the core objectives set out in chapter one. In the case of coronial records, reports were selected that provided details of medical treatments, self-medicating and diagnosis, or interactions between sick people and charitable institutions, or Poor Law officialdom. A total of fourteen cases were selected dating from the 1850s through to 1870. Inquest records can be relatively short in straightforward cases where only a few witnesses were called, or quite extensive where many witnesses provided testimony and/or the circumstances relevant to the cases were complicated or occurred over a prolonged period. Testimony is cited at length to provide necessary context.

6.3 Customers and the medical marketplace

The case studies presented here serve to illustrate the great variety of experience amongst healthcare consumers during the Age of Reform and the limits of individual agency in determining healthcare options. Fissell has observed how 'a patient-driven health-care system based upon the marketplace obviously privileged those patients able to exercise choice,'[25] and 'the wealthy had options denied other groups.'[26] To illustrate this point we start with an account of the final illness of Lady Theodosia Hale (1781-

[23] S. King, 'Poverty, Medicine, and the Workhouse.'
[24] E. Towner and J. Towner, 'Developing the History of Unintentional Injury: The Use of Coroner's Records in Early Modern England,' *Injury Prevention,* Vol. 6, No.2 (2000), p.102.
[25] Fissell, p.73.
[26] *Ibid*.

1845), the daughter of the 3rd Earl of Mayo and wife of Robert Hale Blagden Hale (1780-1855) of Alderley, Wotton-under-Edge (close to Gloucester), a former High Sheriff of Gloucestershire (1826). Her husband wrote a peculiarly detailed account of her last months of illness and death, in which he took an almost scientific interest. He recorded that his wife 'had for a long time past (more than twelve months) been afflicted with serious ailments complaining occasionally of pain in the side particularly the left side and suffering from want of appetite.'[27] The Hales first consulted a Mr Norman of Bath, who 'very minutely' examined Lady Hale and discovered 'a solid substance appeared to exist near the lower part of the stomach.'[28] Initially she gained some relief from 'drinking the Bath waters & from bathing.'[29] However, her symptoms worsened and in April 1845 her husband accompanied her to London where they 'consulted Sir B. Brodie and afterwards on the 13th Sir B. Brodie and Dr Chambers met in consultation: some medicine a strong Alkali was prescribed to be taken in small beer, clove tea, or other liquid. They again met on 20th the Disease (organic) was supposed to be occasioned by a weakening of the lower part of the stomach.'[30] Dr Chambers concluded that the disease was 'of a very serious nature, that it was not accessible [to] medicine but that there was no immediate danger to be apprehended.'[31]

On her return to Alderley, Lady Hale 'persevered in taking the Medicine prescribed though with great distaste for about 3 months i.e. till the middle of July. Sometimes appearing rather better her appetite improved but no <u>decided</u> change for the better appeared.'[32] During this time 'Mr Norman was consulted occasionally…Lady T.H. going into Bath for the purpose.'[33] In June the Hales met Brodie and Chambers again at the Cavendish Hotel in London, but by mid-July they were again going to Bath again to see Mr Norman. By then Lady Hale had become 'decidedly Dropsical' and was prescribed 'mercurial ointment.'[34] After this 'Mr Norman visited her occasionally

[27] Lady Theodosia Hale (1781-1845) wife of R.H.B. Hale - Account of her last illness and death, written by her husband, 1845, Gloucestershire, GA, Hale Family of Alderley. Family Papers, MSS D1086/F179.
[28] *Ibid.*
[29] *Ibid.*
[30] *Ibid.*
[31] *Ibid.*
[32] *Ibid.*
[33] *Ibid.*
[34] *Ibid.*

[having] corresponded with Sir Benj. Brodie & Doctor Chambers on the case.'[35] A rapid deterioration occurred in mid-August and she was no longer able to take solid food and was confined to bed. Norman visited on the 15th August and again on the 17th. He returned on the 21st, when 'some medicine was given to allay the sickness, for even liquid was now discharged almost as soon as taken, the sickness occurring as a matter of course and borne with great patience. She suffered much from heat in the mouth & throat & dryness for which she sipped barley water which however returned immediately.'[36] Lady Hale 'found taking the medicine so irksome that it was discontinued after the second time' and Lord Hale 'went into Bath & saw Mr Norman who prescribed a change of medicine': however Lady Hale died on the 23rd August 1845 from 'a considerable degree of disease [that] had existed for some time, probably many months, which had pervaded nearly the whole of the intestines. The sickness was caused by contraction of the stomach to great degree, the solid lump easily felt at the time was a tumour.'[37] Significantly, the Hales did not consult any medical practitioners from either Gloucester or Cheltenham, instead seeking advice in Bath and London, where they procured the services of no less a figure than Benjamin Brodie. Jalland found that among the upper classes such behaviour was not unusual and 'the number of such specialists consulted could be quite large when a family was confronted with the likely death of a loved one and wanted to be sure they had explored all possible avenues.'[38] Similarly, Digby found that 'by the mid-nineteenth century improved communication meant that even country-based families could regularly call on London practitioners, if they could afford to do so.'[39]

The prevalence of this resort to second opinions is illustrated by looking at some further examples. Thomas Estcourt of Shipton Moyne (near Tetbury) was diagnosed with heart failure in 1853. Initially, the family called in their regular doctor, Dr Wickham.[40] Dissatisfied with progress, it was proposed to send 'for Dr Williams after

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[35] *Ibid.*
[36] *Ibid.*
[37] *Ibid.*
[38] P. Jalland, *Death in the Victorian Family* (Oxford, 1996), p.105.
[39] Digby, *Making a Medical Living*, p.178.
[40] Letters, mainly from brother James during last illness and death of father, with letters of condolence 1853, Gloucestershire, GA, Sotheron-Estcourt family of Shipton Moyne, MSS, D1571/F566.

breakfast before Wickham's visit.'[41] Dr Williams attended and gave a detailed appraisal of the case, diagnosing 'disease of the heart.'[42] He prescribed 'medicines which shall act if they will upon the kidnies [*sic*] and liver and he expects from them relief.'[43] In addition, he recommended Holland's [gin] and water, ordering 'half a dozen bottles.'[44] Dr Williams is referred to as 'an agreeable man to consult, and in this case has applied his mind to the subject very satisfactorily.'[45] The family saw an improvement under Dr Williams remarking 'Dr Williams' visit has no doubt obtained this for us as Wickham would hardly have.'[46] However, within a few days Dr Wickham seems to have been back in charge of the case and Thomas was 'comforted by much understanding from Wickham' with the discomfort he was experiencing attributed to 'treatment pursued since Dr Williams' visit.[47] Wickham prescribed morphine for pain and castor oil and spirit of turpentine for constipation.[48] In this case, the family seem to have sought the second opinion without informing Dr Wickham, a snub at which he apparently could not afford to take offence.

Both of these cases speak of the continuing importance of patronage in the relationship between wealthy patients and their doctors. In Lady Hale's case, Mr Norman was summoned from Bath every other day in the final stages of her illness. Even Brodie saw Lady Hale in *her* hotel room rather than *his* surgery, supporting Bynum's finding that 'medical and surgical treatment at home was the preferred pattern for those above the status of "deserving poor", and a patient coming to London for an opinion by an eminent surgeon might well have it performed in a hotel room.'[49] Beyond taking the waters at Bath (then very much a mainstream option for the wealthy), neither account suggests the families showed any inclination to experiment with irregular offerings, even when orthodox medicine failed or the remedies prescribed were unpalatable. Each family had an abundance of choice but exercised it in a very

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[41] James to Edward Sotheron-Estcourt, 2 June 1853, *Ibid*.
[42] *Ibid,* 3 June 1853.
[43] *Ibid.*
[44] *Ibid,* 6 June 1853.
[45] *Ibid,* 3 June 1853.
[46] *Ibid,* 5 June 1853.
[47] *Ibid,* 21 June 1853.
[48] *Ibid,* 23 June 1853.
[49] W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge, 1994), p.190.

specific way that owed little to the existence of any medical marketplace beyond that which existed between rival medical practitioners. In each case choice consisted of deciding which doctor(s) to consult and when, not if, to do so. Both support Digby's finding that 'before hope had been abandoned… the doctor occupied a central position in the sickroom.'[50] Even when hope was abandoned the doctors remained in active attendance and regular medical advice continued to be the preferred option. Medical opinion was not, however, the sole voice to be heard in the upper-class sickroom and a third case, while echoing the patterns found above, also reveals that another important component in many people's response to ill health, and conspicuously neglected in the literature of the medical marketplace, was religious belief.

Josiah Marling (1816-1834) was the seventh son of William Marling, a prosperous Stroud clothier and founder of the firm of Marling & Co. His brother Samuel was 1st Baronet of Stanley Park, Selsley and Liberal M.P. for West Gloucestershire. Marling became seriously ill in 1834 and religious faith played an important role in the family's response to his illness. Helmstadter has described how 'traditionally illness had been considered either the result of sin or a call from God for moral reform. Religious improvement was therefore a key to the restoration of health or to a good death.'[51] Such attitudes, although tempered in an increasingly secular society, were far from redundant in the nineteenth century. When the family became concerned, a local doctor 'Dr Wilmot was consulted who considered his present debility as the result of his very rapid growth & said he wanted strengthening,' however 'his sickly appearance was noticed by everyone.'[52] Dr Wilmot urged him to see a 'Dr Smith & consult very seriously on his case as [illegible] that our belief was that he was going into a rapid decline.'[53] By the 19th of May 'his symptoms by this time were so bad that mother had determined to take him to London for further advice which was communicated to Mr Smith & asked for his candid opinion of the case. His answer was plain and [illegible] most melancholy.'[54] Upon being appraised of the prognosis,

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[50] Digby, *Making a Medical Living*, p.84.
[51] C. Helmstadter, 'Shifting Boundaries: Religion, Medicine, Nursing and Domestic Service in Mid-Nineteenth-Century Britain,' *Nursing Inquiry*, Vol.16, No.2 (2009), p.136.
[52] Josiah Marling, (1816-34). Notes on his life and last illness, 1834-1835, Gloucestershire, GA, Marling Family, MSS, D873/F34.
[53] *Ibid.*
[54] *Ibid.*

Josiah's 'agitation for the moment was considerable lest his repentance had not been sincere; one of his brothers endeavoured to console him & at his request engaged with him in prayer. He afterwards appeared more composed, and from this time entirely gave up the world & all its concerns, and bent all his endeavours to prepare for the change which evidently awaited him.'[55] Josiah died shortly afterwards and in a separate note it is recorded that despite 'recourse to the best medical aid…he was stated to be in a decided & rapid consumption [original underlining]' that the doctors could do nothing to control.[56]

In this case the failure of the doctors to effect a cure led the family fell back on their religious faith. Although the great evangelical revival of the early decades of the nineteenth century began to wane by the 1850s, throughout the Age of Reform England continued to be a predominantly Christian society and Biblical teaching regarding the treatment of the sick remained an important arbiter of behaviour. Bradley found that in this period 'the emotional effects of serious illness and sudden bereavement seem to have played a large part in bringing about Evangelical conversions'[57] and Hogarth has pointed out how 'medical hegemony was… undermined by the continuing power of religion; ill health was a spiritual, as well as a physical, crisis and clerical intervention might be as important – or more important than – medical treatment.[58] For the many believers, whether illness was mild or severe, and whether one would survive it or die, was in the gift of God. Consequently, some sufferers did not expect that any physician, however skilled, could cure them aside from the Will of God, nor did they believe they could buy their way to the restoration of health. This instilled a degree of fatalism in response to illness, lowered public expectations of what doctors, or medicines, could reasonably achieve, and at the same time, it may also even have disincentivised believers from experimenting with treatments. Jalland also found that 'in practice, religion and medicine often co-operated in the Victorian period, when Christian doctors shared with the families they treated many of the same aspirations for the 'good

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[55] *Ibid.*
[56] *Ibid.*
[57] I. Bradley, *The Call to Seriousness: The Evangelical Impact on the Victorians* (Oxford, 1976), p.50.
[58] S. Hogarth, 'Joseph Townend and the Manchester Infirmary: A Plebeian Patient in the Industrial Revolution' in A. Borsay and P. Shapely (eds), *Medicine, Charity and Mutual Aid: The Consumption of Health and Welfare in Britain, c.1550–1950* (Aldershot, 2007), p.92.

death.'[59] For those who had faith, resignation and repentance were important signs that the dying person would be among the Saved. As Marsden observed 'at a time when cure was always uncertain, a sick body was a soul close to salvation, or its opposite.'[60] In this case, the family adopted a fatalistic attitude and concentrated their energies on Josiah's spiritual preparation for death. The family's behaviour was certainly not unusual and religiously-inspired attitudes toward illness and death frequently appear elsewhere in the socio-economic milieu. A similar sense of fatalism can, for example, be discerned in letters written by Edward Bradley, an army sergeant, to his sister Mary Ann Dudfield of Tewkesbury. On the death of their father, Bradley wrote:

> I hope you are more cheerful and Happy to what you was, and not so sad and dull, we will all go the same road when our time comes we are hear [*sic*] today and often gone before tomorrow so you must cheer up as well you can trust in God he is our best friend and so as we are content to die when our time comes in hopes that we may all meet again at the Last Day.[61]

While, like the Marlings, this family actively sought medical assistance, their acceptance of illness as God's will may have assuaged the sense of desperation that, as chapter five argued, drove others to experiment with proprietary medicines and fringe practitioners. Inevitably, the picture is complicated and responses varied from one family to another, as a comparison with the next case illustrates.

Sarah Thomas, the daughter of the Minister of Fairford Baptist Chapel kept a diary in which she recorded caring for her sister Kate, an invalid who suffered from an undiagnosed chronic intestinal disorder (possibly Crohn's disease). For the Thomas family, London consultants appear to have been out of reach, but they too sought a second opinion when Kate's condition failed to improve, and from the best doctor they could find and afford. Kate was a patient of Mr Cornwall, the local general practitioner, but the family turned next to Dr Evans. This was most likely the Gloucester physician Thomas Evans. If so, the case illustrates again the inter-connectedness of Gloucester's

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[59] Jalland, p.77.

[60] G. Marsden, *Victorian Values: Personalities and Perspectives in Nineteenth Century Society* (London, 1990), p.127.

[61] Edward Bradley to Mary Ann Dudfield, 6 December 1866, Gloucestershire, GA, Brookes and Badham of Tewkesbury (now Thomson and Badham), solicitors. Clients: Dudfield and Bradley of Twyning. Letters addressed to Mrs. Dudfield at Twyning mainly relating to family affairs from her brother Edward Bradley, (serving in the army), her nephew (also in the army) and other relations and letters relating to the last illness and death of her brother…1825-1875, MS, D2079/II/3/F1.

healthcare economy with that of the surrounding shire. In this case, Mr Cornwall seems to have supported, or at least acquiesced, in the summoning of Dr Evans. Sarah left a detailed account of the consultation with Evans and Cornwall, which is worth quoting at length:

> Mr Cornwall called to say Dr Evans would be hear at 5 ½ and we had to break it to Kate as we had not told her of it. She did not like it at first. They arrived an hour later than arranged and after Dr Evans had warmed his hands at the fire we all went to the sick room and he made Kate tell her own tale. She answered every question with composure. The two doctors went downstairs to consult privately then returned to tell the treatment. Dr Evans said that she was appearing to have a succession of small blisters on the tender part of the bowels. By no means was she to take aperient medicine, but a little salad oil or lemon juice where necessary. She was not to let the bowels go over two days without moving and to use an enema with ½ pint of linseed tea at night. She was to lie much in bed and if she gets up to then lie on the sofa, but by no means to walk until fully recovered. If she felt strong enough to go out and the weather was fine then she must ride in the carriage or be drawn out in a chair. No meat was allowed but light nourishing meals. Milk mixed with water, soda water or brandy and water were advised for drinking. As they were leaving I asked the fee, and it was £10. Dr Evans said that he charged a guinea for every two miles beyond the railway. Charles said afterwards that such is the case again for Fairford having its own railway station, however, it has not, despite much talks and work on procuring it for the town. He then paid Dr Evans, who wrote out a prescription and gave it to Mr Cornwall. He admitted it was a critical case but he had reason to hope that Kate will be restored to health if she will be careful, but an internal complaint like that kind is very difficult to get at or to know exactly what is going on inside. The worst feature is that she has had it so long. He couldn't but say there is danger in the case and it often breaks out again after it is supposed to be cured and that it often leads to consumption. He examined her lungs and they are perfectly good now, but the bowels and liver both being disordered, irritated one another. It was after 8 o'clock when they left. I was far more excited than dear Kitty was and I spent the interval of their delay in coming in prayer, imploring God to bestow a blessing upon the doctor that he might have wisdom and skill to prescribe that which would conduce her recovery.[62]

The following day 'Mr Cornwall sent his servant with a bottle of white medicine and a blister, but not a syllable with it, he came in the evening and explained how to apply the blister.'[63] However, after one night:

> …the blister became so intensely painful that dear Kate could bear it no longer. At 3 this morning she called out to me and I lay there with her a while, then I woke Elizabeth to go into the garden for plant leaves, but she didn't like it much and didn't offer to hold the candle for me to show her the ones to pluck. She then lit the fire and we boiled water for me to make the cure, she then went off to bed and left me to do it alone. However, it worked well enough and the blister rose pretty well…Mr Cornwall called in the evening and is still not sure whether mischief is forming inside but tried to reassure me that Kate will make a fair recovery.[64]

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[62] J. Lewis (ed.), *The Secret Diary of Sarah Thomas 1860-1865* (Moreton-in-Marsh, 1994), pp.29-30.
[63] *Ibid*, p.30.
[64] *Ibid,* pp.30-31.

Religious belief again informed the behaviour and choices of this family who implored 'God to bestow a blessing upon the doctor that he might have wisdom and skill to prescribe that which would conduce her [Kate's] recovery.'[65] This Baptist family were directed in their actions by a shared faith, which did not dissuade them from persevering with regular medical treatments, but as in the Marling case, encouraged a self-reliant approach that in this case manifest in Sarah resorting to domestic remedies using garden herbs to relieve the pain of the doctor's blister. This lends some support to Cherry's claim that 'even after the 1858 Medical Act… self medication, family or neighbours continued to represent the first line of care.'[66] This case shows this situation was not confined to those unable to afford medical advice. Home remedies were not Sarah's preferred choice, but a specific response to the unpleasantness of the treatment her sister had been prescribed. Interestingly, there is no evidence Sarah contemplated any of the many commercial alternatives available and her use of a home-grown rather than a shop-bought remedy may reflect an important difference between urban and rural communities, where in the latter traditions retained a greater hold and medicine vendors were not as readily accessible. Nevertheless, it is not difficult to see how people in her situation might turn to proprietary medicines that (as chapter four attests) promised a mild and gentle alternative to such treatments as Dr Evans' blister. The case also challenges the belief of those such as Flanders for example, who argue 'many avoided medical men as much as possible. A great deal of the (unspoken) reason may have been cost.'[67] It was not Dr Evans' eye-watering bill of £10 for a 2 ½ hour consultation that led Sarah to resort to home remedies, but the unpleasant treatment combined with a faith in the power of prayer and self-reliance. This did not represent a rejection of orthodox medicine; qualified medical assistance was clearly *the preferred option,* but the unpleasant and ineffective treatment it offered meant domestic remedies still had a role to play.

The Thomas case is also a reminder that women 'were expected to provide the major part of loving care.'[68] This made them an important market for healthcare products and services. For Christians, like Sarah, ministering to the sick was a sacred

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[65] *Ibid*, p.30.
[66] S. Cherry, *Medical Services and the Hospitals in Britain, 1860-1939* (Cambridge, 1996), p.41.
[67] J. Flanders, *The Victorian House: Domestic Life from Childbirth to Deathbed* (London, 2003), p.309.
[68] Jalland, p.98.

duty and as Marsden pointed out, 'this domestic, religious and maternal role had…a more than familial dimension' that extended to treating servants and ministering to the sick poor.[69] Porter and Porter found 'home nursing was energetically pursued and well-organised, conducted by family and friends, and, above all, by regular domestics.'[70] Nursing care provided in the home by family members, or by servants, was an important component of the overall healthcare economy, yet it was consistently under-valued compared to professional (male) doctoring. Folbre has described how 'the moral elevation of the home was accompanied by the economic devaluation of the work performed there'[71] and whereas 'in 1800, women whose work consisted largely of caring for their families were considered productive workers. By 1900, they had been formally relegated to the census category of "dependents," a category that included infants, young children, the sick, and the elderly.'[72] In addition to the kind of informal nursing of family members undertaken by Sarah Thomas, many women were employed on a casual or part-time basis in nursing-related occupations. Nursing is important to this study as it represented a significant component of the healthcare economy but occupied a peripheral position at the fringe of any medical marketplace, lying as it did at the intersection with domestic service and social care. Although chapter three did not look at nursing occupations, these individuals appeared in significant numbers in the censuses and formed part of what Borsay described as 'a diverse collection of healers and supporters.'[73] Table 6.1 shows nursing-related occupations in 1851 census of Gloucester:

Table 6.1 Nursing occupations from 1851 census of Gloucester and environs.

Occupation	Number
Matron	6
Midwife	1
Monthly Nurse	3
Nurse (institution)	27
Nurse (domestic and community)	50*
Nurse Girl	7
Nurse Maid	25
Nurse Midwife	1
TOTAL	**122**

[69] Marsden, p.125.
[70] Porter and Porter, *In Sickness and in Health,* p.194.
[71] N. Folbre, 'The Unproductive Housewife: Her Evolution in Nineteenth-Century Economic Thought,' *Signs*, Vol.16, No.3 (Spring 1991), p.465.
[72] *Ibid*, p.464.
[73] A. Borsay, 'Nursing, 1700-1830: Families, Communities, Institutions' in A. Borsay and B. Hunter (eds), *Nursing and Midwifery in Britain since 1700* (Basingstoke, 2012), p.23.

*Includes 1 receiving parochial relief and 1 described as an 'inmate' (aged 91) presumably of an almshouse although this was not recorded.

Source: Ancestry.com, *1851 Census* [database on-line]. Provo, UT, USA: Ancestry.com Operations Inc, 2005. Original data: Kew, The National Archives, *Census Returns of England and Wales, 1851*, HO 107.

The six matrons (employed by the various institutions) were effectively housekeepers and 'were not expected to have any experience of nursing.'[74] Leaving them and the twenty-seven nurses working in institutions aside, there were still eighty-nine individuals engaged in some form of nursing in the community. Most of these would have domestic roles and as Abel-Smith pointed out 'historically the antecedents of the nursing profession were domestic servants.'[75] Beyond those recorded in the censuses, there were probably many more prepared to nurse of the sick on an informal basis for a small fee. Even those nurses employed in institutions were treated as servants, not medical staff, and were not expected to perform, or know how to perform, any medical procedures. Tomkins has noted how, in the early 1800s, nurses were often 'as poor as their patients.'[76] Only in the 1860s, with the arrival of the St Lucy's Home of Charity in Kingsholm (discussed in chapter three), did paid nursing in Gloucester achieve the degree of respectability necessary to attract middle-class women.[77] Here the nurses received 'instruction kindly given to them by some of the principal medical men of the city.'[78]

Nurses did not really compete with other healthcare suppliers for custom, but rather occupied a discrete niche, fulfilling a role that otherwise would have to be undertaken by women like Sarah Thomas and they represented an important community resource. Competition did arise however between doctors and midwives. Throughout the nineteenth century, the vast majority of births among all social classes took place in the home with Carpenter claiming this amounted to '90 per cent of all deliveries in Britain.'[79] Women in labour 'sought treatment in hospitals only if they were forced to, through poverty, illegitimacy, or obstetrical complications.'[80] Until the widespread

[74] Woodward, p.29.
[75] B. Abel-Smith, *A History of the Nursing Profession* (London, 1960), p.4.
[76] Tomkins, ''The Excellent Example of the Working Class, p.215.
[77] Gloucester Infirmary, *Rules for the Government of the General Infirmary at Gloucester, 1851* (Gloucester, 1851, p.33.
[78] [Unknown], *Gloucester Directory* ([unknown] 1867), p.40.
[79] Carpenter, p.163.
[80] G. Williams, *The Age of Miracles: Medicine and Surgery in the Nineteenth Century* (London, 19810, p.82

acceptance of the method of transmission of puerperal fever, it was an inconvenient truth for the medical profession that 'midwives probably had a lower case-mortality rate than doctors because they delivered their patients at home'[81] and as Porter remarked, 'the safest form of childbirth was traditionally away from hospital and from the [male] doctors' clutches.'[82]

Home deliveries were traditionally the domain of the female midwife, but by the mid-1800s, 'the increasing professionalization of medicine meant that experienced midwives were being squeezed out of middle-class childbirth,'[83] a trend Branca linked to 'women's desire to be better mothers.'[84] Coronial records suggest that by the 1850s in Gloucester, the activity of midwives was becoming confined to working-class births. For doctors, midwifery was 'often the most wearying and worrying part of the job' and was, of itself, financially unrewarding.[85] Nevertheless, 'it became an article of faith that delivering babies created a bond between the patient and the family doctor.'[86] Doctors thus looked covetously on this trade. Wilson charted the eighteenth-century rise of the man-midwife to the point where 'among the aristocracy it appears that the female midwife had been abandoned by 1780,' but he also observed 'local variation in the balance between midwives and medical men continued throughout the nineteenth century.'[87] The number of midwives is impossible to establish. Branca found 'no precise information is available on the actual number of midwives… due to the lack of registration and also to the confusing system of classification of midwives in the nineteenth-century census returns.'[88] She also pointed out that 'we have no direct data as to how many women were attended by midwives and how many by doctors.' [89] Midwives formed part of the body of healthcare suppliers that Marland describes as 'doctoring on a part-time basis, as a favour or paid service to family or neighbours, who

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[81] Smith, p.42.
[82] R. Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present* (London, 1997), p.712. Puerperal fever was statistically less likely to occur with a midwife delivery than if a doctor was involved as doctors often saw many cases in succession, or came straight from an autopsy, without washing their hands.
[83] Flanders, p.18.
[84] P. Branca, *The Silent Sisterhood: Middle-Class Women in the Victorian Home* (London, 1975), p.79.
[85] I. Loudon, 'Childbirth' in I. Loudon (ed.), *Western Medicine: An Illustrated History* (Oxford, 1997), p.211.
[86] *Ibid.*
[87] A. Wilson, *The Making of Man-Midwifery: Childbirth in England 1660-1770* (London, 1995), p.200.
[88] Branca, p.79.
[89] *Ibid.*

passed on remedies, helped procure abortions, attended at births and nursed the sick.' [90] The only midwife listed as such in the 1841 and 1851 censuses was Frances Wall, the wife of a turner and gas fitter, who was still apparently practising midwifery at the age of 63. In addition to Wall, the 1851 census for Gloucester recorded only one 'nurse midwife' (see Table 6.1); surely an under-representation.

The medical establishment attacked midwives for their lack of formal training and the fact that these rivals were both female and working-class compounded their prejudice, something increasingly shared by middle-class commentators and best remembered now in Dickens' creation, the uncouth, alcoholic nurse-midwife Sairey Gamp.[91] However, the lower fees charged by midwives meant they continued to be an attractive option for working-class mothers and to find evidence of their activities it is now necessary to turn from the middle to the working-class home. Although the risk midwives posed above and beyond that inherent to all childbirth in this period was almost certainly overstated by the doctors, it was the case that 'a woman attended by a midwife whose delivery became difficult was in for a very bad time indeed.'[92] Coronial records document only those cases where things did go badly wrong, but in so doing they also provide an important insight into the social norms surrounding midwifery. This point is illustrated by the case of Emily Holding of Wotton-under-Edge, near Gloucester, who went into labour with (illegitimate) twins in October 1868 and engaged a local midwife, Ann Munday.[93] It was a difficult labour; one child was delivered healthy but the second was already dead in the womb. The midwife, not having the knowledge or instruments to deliver the dead baby, appears to have left the family to their own devices. Emily's condition deteriorated and her 'father was very anxious for her to have a Doctor.'[94] Emily herself 'wished a Doctor to be sent for but she did not like to send unless her Mother was there.'[95] The mother had left the house when Emily went into labour, leaving her in the care of her Ann Munday and her sister and husband.[96] By the time a surgeon arrived to deliver the dead child puerperal fever had

[90] Marland, *Medicine and Society*, p.255.
[91] And there was no formal system for licensing midwives until the Midwives Act of 1902.
[92] Smith, p.42.
[93] The 1861 census recorded her as aged 63, a midwife, wife of David Munday (64) a Chelsea Pensioner, and as having been born in Clapper Queen, Ireland.
[94] Coroner's Inquest Report: Emily Holding, Wotton Under Edge, 1 October 1868, Gloucestershire, GA, County Coroner: Lower division, Inquest files, MS CO1/I/14/C/23.
[95] *Ibid.*
[96] *Ibid.*

taken hold. The surgeon, Mr Bullock 'expressed himself strongly about the neglect of the deceased' and before the Coroner testified that:

> It was a protracted case and one requiring immediate skilled attention – A woman could not have been expected to have delivered her of the second – there was no effort of nature and the child must have [been] dead some time before she was delivered of the first – I do not think she could have lived 40 hours had she not been assisted… I consider that Mrs Munday ought to have examined her …I do not think that any person was justified in leaving a woman in her condition for such a time - I do not say it was intentional neglect...it is not a common case. If proper advice had been resorted to in the first instance these consequences might have been avoided – It was not such a case as a woman midwife could be expected to contend with – there was great risk in leaving her as she was left – I cannot say positively that her death was accelerated by the previous neglect but it was highly dangerous to leave her so long without proper investigation.[97]

The charge in this case was that the midwife should have realised when the birth was beyond her capability to deal with and called in a doctor immediately. It was thus not her attendance at the birth that attracted censure but her behaviour once she became out of her depth, which clearly transgressed a social norm. Emily's reluctance to have the doctor until her mother was present may reflect prevailing sensibilities and represents another way in which non-economic considerations influenced individual agency. With childbirth, as with the other cases discussed shortly involving sick children and infants, to summon medical assistance in the event of serious illness was an expectation held not only by the medical profession but by the wider community. The influence of this entrenched expectation should not be under-estimated, and it likely acted as one disincentive to experiment with irregular offerings. It was thus potentially an important impediment to the supposedly unfettered choice offered by medical marketplace. Seldom was an individual completely free to exercise autonomous agency unencumbered by the weight of social expectation.

In the care of the sick, as in the delivering of babies, Sarah Thomas' diary describes physically exhausting and emotionally draining work, but the burden became greater the less social and financial capital the family possessed. When Edward Bradley's children were admitted to hospital with scarlet fever, he wrote to his sister that 'mother as [sic] gone to look after the children poor Willy is ordered off to Hospital so there is only Me and Alice at home. I have to send the food clothes washing it is our

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[97] *Ibid.*

hospital all they find is the doctor and the medicine.'[98] Among other letters to Mary Ann Dudfield, when her mother was taken seriously ill in 1863, her brother-in-law wrote:

> …your Mother has been sadly afflicted with Paralysis has lost her speech and the use of her limbs as well as being unconscious of anything that is going on. She has poor soul for a very long time been in a very helpless state and been in the Doctor's hands but now she is quite prostrate not able to assist herself in any office or way whatever. It is very bad for Eliza [Mary Ann's sister] for she has been very poorly indeed for some time past and has had no assistance in the matter.[99]

He added that 'poor Eliza is almost worn out and cannot write at present.'[100] Another case, described by Reverend John Sale, Curate of Dymock in Gloucestershire from 1872 to 1884, emphasises how little support was available to some people:

> Mrs Winter nice clean woman – sister-in-law of Mrs Morgan talkative – husband has been ill & such illness he has had (fainting fits I sh. think) the woman does not know what. The doctor will not tell her and says keep sharp tools out of his way – he is also [illegible] he starts and sheaks [sic] & then falls – but soon recovers – as the other day when taking the cup of tea he said what do you call that pushed it away – tumbled down & after recovering said what have you been doing with me – what a smell – she has hurt her elbow.[101]

Mrs Winter appears to have lacked any support from family, friends, or neighbours and the vicar, as was so often the case, acted as the only external source of support. Informal care highlights both commonality and variance in the experiences of people of different classes, but it is through the lens of working-class experience that some of the most significant limitations of the medical marketplace paradigm become apparent. Unfortunately, evidence of the sort provided in Mary Ann Dudfield's letter collection is conspicuously rare. To observe how sickness impacted upon the lives of the poor, or how they accessed healthcare and interacted with the healthcare economy, it is necessary to further explore the coronial records.

In a working-class home, the kind of attention Sarah Thomas was able to devote to her sister could be impossible. Some families found themselves unable, or unwilling, to cope with sick relatives, especially when all the adults in the household were working

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[98] Edward Bradley to Mary Ann Dudfield, 20 September 1870.
[99] Joseph Meason to Mary Ann Dudfield, 6 February 1863.
[100] *Ibid.*
[101] Diary of Rev John E Sale, c.1873-c.1877, and accounts, 1916-1935, Gloucestershire, GA, Rev. J. E. Sale, curate of Dymock, MS D8465/1.

and the sick or elderly relative was no longer capable of working themselves. Confronted with such circumstances, one option, for those who could afford a small weekly payment, was to farm out sick relatives to paid carers; something that could have a disastrous outcome for the unfortunate recipient. Emblematic of the lack of agency and choice available to those who found themselves subject to such arrangements is the case of Jane Carnall of Thornbury, a 73-year-old widow, who had 'been decaying for some time' and who died in the care of one Mary Ann Savery, the daughter of someone who looked after one of her grandchildren. [102] Savery was paid 4 shillings a week to look after Jane in her home. Such arrangements were not unusual and provided valuable income for those with a spare room. Mrs Carnall was placed with Savery on 18th July 1865. Jane's daughter testified at the Inquest that on 14th September:

> I received another letter yesterday from Mary Ann Savery urging me to come and see my Mother and that without a great alteration she would not be here long – I came today and found her dead. She had a bruise on her lip and was much thinner than when she left Bristol – I saw her six weeks ago she made no complain [*sic*] then except that she did not like the man Savery - she was sat in a chair – she asked me to comb her hair and complained that she was not allowed a chamber utensil – she was in a downstairs room = her bedroom was a room inside that I did not go into it – she was not able to say more to me – she was paralysed.[103]

Another witness, Hester Thorne stated:

> William Savery's I recollect deceased coming there – I did not speak when I saw her again in 7 or 8 days and asked how she was – she appeared much the same – she was sat in a chair near the kitchen window – I saw her rise up and sit down again – there was a bed fixed in the doorways between the pantry and the kitchen – I went into the room [?] at times whilst she occupied it but noticed nothing – I never saw her eat that I recollect – some weeks ago I missed her and I then inquired what was done with her William Savery said we have put her up stairs – I never saw her afterward – about a fortnight ago I went into Savery's house and sat down and smelt a very nasty disagreeable smell and left the house – Mrs Savery came to my house for some water a few days afterwards and she complained that she was not able to look after deceased – that she was filthy – she complained often and one day she said she could not go near her she had not taken any food for several times and she supposed it was her stubbornness and she asked me what she ought to do – I told her she ought to give her up – she said I can't get the Parish Order for her as I have two shillings a week from the Board and if they know I have her in the house they will take that off my little boy – I told her if she was not able to look after she ought to send to her – any one might have looked after her for the four shillings a week seeing how little she ate – I never saw her ill used – Last Sunday week I sat in the house half an hour William Savery said he should be glad when the old buggar was gone from

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[102] Coroner's Inquest Report: Jane Carnall of Thornbury, 14 September 1865. Gloucestershire, GA, County Coroner: Lower division, Inquest files, MS CO1/I/11/C/24.
[103] *Ibid.*

> there for he would not stay there if she did – whenever Mrs Savery spoke of her she used this term – a little girl eleven years old looked after the deceased – from her expression I don't think she would have been kind to deceased.[104]

The surgeon, Edward Long, who certified the death stated in his evidence:

> I had been attending her some days before and asked how it was she had not come before she said she had got well and thought she could do without – she said we have an old woman in the house who smells very bad – I asked no questions – I never saw deceased alive. I have made a post mortem examination of deceased's body – I found the body in a very emaciated condition there was a slight bruise on her right arm – a mark on her lip was not occasioned by violence nor [were] there any external marks of violence about her – On opening the body the muscles were devoid of all fat and internally the same – the lungs were one mass of tubercular disease and there were tuberculous deposits on the liver and on all the other internal organs – she was a mass of disease internally and must have been quite helpless – and must have required the greatest attention – there was no food whatever in her stomach – she was not capable of digesting solid food – I am of the opinion that her death was caused by tuberculous deposit – chiefly on the lungs – which would be very much accelerated by want of cleanliness and fresh air and want of proper nourishment.[105]

Although the verdict returned was 'death in the natural way and by the visitation of God,' seemingly because the doctor was 'of the opinion that her death was caused by tuberculosis deposit,' this was clearly a case of neglect and abuse. Such cases, although rare, were encouraged by a Poor Law system that forced those who found themselves in poverty to explore all possible avenues before applying for parish relief. Thus, there was an incentive for the poor to take in lodgers like Mrs Carnall and then spend as little as possible on keeping them. King and Tomkins have noted how 'recent developments have seen historians increasingly according agency to the parish poor,'[106] King arguing that 'the poor could actively shape the conduct and outcome of the relief process.'[107] Jane Carnall's case is a reminder that, for some, poverty when combined with age and infirmity could conspire to disempower the individual to the point where 'for such a person, speaking of "health-care options" is no more than ironic.'[108] Horden found 'numerous testimonies to the fragility and unpredictability of support networks among the poor' and in this case those networks failed entirely.[109] In this case rather than being

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[104] *Ibid.*
[105] *Ibid.*
[106] S. King and A. Tomkins, 'Introduction' in King and Tomkins, *The Poor in England,* p.7.
[107] S. King, 'Negotiating the Law of Poor Relief in England, 1800-1840,' *History*, Vol.96, No.324 (October 1996), p.413.
[108] Fissell, p.94.
[109] P. Horden. 'Household Care and Informal Networks' in Horden and Smith, p.52.

an autonomous agent, Mrs Carnall herself became the commodity in an ill-conceived business arrangement.

The attitude of Mr Long, the Medical Officer, who 'asked no questions,' shows the extent of bureaucratic indifference, something Tomkins and others associate particularly with the more uncaring, punitive regime of the New Poor Law.[110] Tomkins found that 'perceptions of workhouse life before 1834 were not so laden with stigma and… the institution was not viewed with such resentment and fear before the successful injection of these attributes through the designs of the Poor Law Commission.'[111] The New Poor Law wilfully ignored the link between illness and pauperism and the 1834 Act made no specific provision for the sick poor, despite the fact that 'the poor law… [was] the main source of medical aid for the poorest in the population since sickness was a primary cause of poverty.'[112] In the 1840s, it was found that 'as many as three quarters of the poor who required relief were actually sick' and as a result 'workhouses became largely infirmaries.'[113] Despite this, 'any proposals for the improvement of the medical system were received with suspicion and were generally rejected by the central authorities, who, neglecting to appoint a medical officer, remained ignorant of the necessities of the sick and of their own duties in this field.'[114]

The case of Isaac Mosely of Bitton, which came before the Coroner in May 1867, exemplifies much that was wrong with the system after 1834. A lodging house keeper, Mary Wilmot, with whom Mosely had lately resided, gave evidence that:

> …he went into Bristol in the Omnibus and he told me when he came home that he thought he had hurt himself in getting into the Bus and he was very ill all night – before this he used to complain of difficulty in retaining his water but on Saturday evening and from that time he complained of being unable to pass his water and he was very ill and appeared to be in excessive pain and my son went to Mr Fryer but he did not come until five o'clock on Sunday night he then attended to him and drew his water and Mr Fryer said he should have a truss as he was badly ruptured – deceased was a pauper patient –

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[110] Coroner's Inquest Report: Jane Carnall of Thornbury.
[111] A. Tomkins, 'Workhouse Medical Care from Working-Class Autobiographies, 1750 – 1834' in Reinarz and Schwarz, *Medicine and the Workhouse*, ch.4.
[112] A. Negrine, 'Practitioners and Paupers: Medicine at the Leicester Union Workhouse, 1867-1905' in *Ibid,* ch.9.
[113] Carpenter, p.27.
[114] R.G. Hodgkinson, 'Poor Law Medical Officers of England: 1834-1871,' *Journal of the History of Medicine and Allied Sciences* (July 1956), p.299.

> my daughter obtained an order from the Relieving Officer Mr Tyler – the order was not sent until Sunday morning.[115]

Mrs Wilmot's daughter, Mary Saunders, testified that she had gone to the Relieving Officer, Mr Tyler, and took the note he provided 'about half past two o'clock on Sunday afternoon and gave it to Mr Fryer and told him the deceased was in great pain and he said he would be down presently.'[116] She then testified that:

> Mr Fryer gave me a paper on Monday to apply to Mr Tyler the Relieving Officer for a truss and I took it to Mr Tyler on Tuesday at eleven o'clock and he told me that the deceased was to come to his pay room on Oldland Common on Friday and gave me back the order – This was at the Union Workhouse at Keynsham on the Board day and some Guardians were there – Mr Tyler took the paper out of my hand and asked me what business I had there – he said what had such a man to do with it who was earning 14 shillings a week.[117]

Charles Wilmot (Mary's husband) was then called and described how:

> I went to Mr Tyler a little after eleven o'clock on Saturday night and asked him to come to deceased and told him he had stoppage in his water and was in great pain – Mr Fryer told me to have hot vinegar applied to his bowels and if he was worse to come to him – I did as he ordered and staid up most of the night with deceased who continued in great pain – but when I bathed him he seemed easier.[118]

At this point the Coroner, William Gaisford, added that:

> Mr Fryer admits that Harriet Wilmot called on him on Wednesday morning between 10 & 11 o'clock and he refused to come to the deceased without an order and he admits that he had such an order afterwards.[119]

The surgeon who performed the post-mortem, John Lodge, found that death was the result of blood clots in the brain but added:

> The bladder was much distended and he must have suffered great pain from the water not having been removed – I should attend and relieve an ordinary patient in such a state twice a day or at all events three times in two days = I should not have left such a patient 25 hours without relief – On the present instance the walls of deceased's bladder were thickened and its capacity lessened and that would produce more spasmodic action and

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[115] Coroner's Inquest Report: Isaac Mosley, 7 May 1867, Gloucestershire, GA, County Coroner: Lower division, Inquest files, MS CO1/1/13/B/14.
[116] *Ibid.*
[117] *Ibid.*
[118] *Ibid.*
[119] *Ibid.*

> pain than as if the bladder were in a natural state but this condition of the bladder could not have been known without a post mortem examination.
>
> In an ordinary case such excitement as deceased was subject to from the pain of not having his water drawn could not have occasioned the extravasation of blood – the state of deceased's heart would have accelerated this.[120]

Defending his actions under oath, the Medical Officer, Mr Fryer claimed that:

> I had an order between half past two and three o'clock on Sunday to visit him and I saw him about five o'clock that evening – I was not at home at the time it is stated the order was first brought to my house – it was as early on Sunday as I could possibly attend – I saw him on Monday again at his own house. On Tuesday I met him a mile and a half from his house on his way to my house about two o'clock – I was surprised to see him so far and did not think it right and told him to go back to my Surgery and I would attend to him there and I drew his water between 12 and 1 o'clock that day – he then told me he felt quite well and asked me if he might have a pint of beer – I told him not to have beer but a little gin and water and if he was able to come and see me next day between one and two o'clock – On Monday morning I gave Mrs Wilmot a Medical Certificate that he required a truss – I found he had hernia on the Sunday which I reduced and it was quite necessary that he should have had a truss – I met his body being brought dead to his lodgings between one and two o'clock on Wednesday as I was going to his lodgings to draw his water – I thought he could reasonably from the condition he was in on Tuesday go 24 hours without having his water drawn – I am satisfied that the cause of death is apoplexy and quite concur with what Mr Lodge says – had I known that deceased had been in such pain and been sent for I should have gone earlier – I have two private patients about the same age similarly afflicted whose water I only drain once in 24 hours – I had no reason to suppose that deceased was other than an ordinary case of retention of urine.[121]

As discussed in chapter two, Poor Law medical officers were not unaccountable and as Price pointed out 'doctors, like other professionals, were judged by comparison to what an "ordinary man" would do under the circumstances' and 'had no exceptional rights.'[122] The care provided by Fryer fell far enough short of what was expected for a police sergeant, James Maley, to refer it to the Coroner on the grounds that:

> Since this morning deceased left his lodgings about 11am and went to meet Mr Fryer at his Surgery at Oldland Common where Mr Fryer told him to come at 12 o'clock. Mr Fryer not being there [the] deceased went into a Hatter's Shop near the Surgery belonging to Mr William Joy and where he used to work and told Mr Joy that he was in such pain that if Mr Fryer did not soon come to draw his water from him he should soon be dead Mr Joy left deceased in the shop and went out for a few minutes and when he returned he found the deceased lying on the floor quite dead.[123]

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[120] *Ibid.*
[121] *Ibid.*
[122] K. Price, *Medical Negligence in Victorian Britain: The Crisis of Care under the English Poor Law, C1834-1900* (London, 2015), p.4.
[123] Coroner's Inquest Report: Isaac Mosley.

The Coroner's ruling was critical of Fryer's behaviour, recording that the death was caused by 'extravasation of blood on his brain' and that 'such extravasation of blood was brought on from mental excitement pain and emotion from the inattention of his medical attendant in not draining his water.'[124] The role of Tyler, who initially refused to issue the order for medical relief because he suspected Mosely had the means to pay, did not however occasion any censure. This type of behaviour from relieving officers was not uncommon; the reforming Gloucester surgeon, Henry Rumsey referred to 'the suffering caused by the Relieving Officer having the power to refuse or grant orders for medical relief, the needless delay which the system occasioned, and the frequent hesitancy and disinclination of the poor to go to him' and advocated the removal of 'any and every check between a sick man and his medical attendant.'[125] The case illustrates how great an influence bureaucracy had over healthcare outcomes for the poor. The failings of the Poor Law system, combined with individual indifference, determined the fatal outcome for Moseley, who was denied any of the choices associated with a medical marketplace. Although this is an extreme case, it again emphasises the degree of variability of experience at the fringes of the healthcare economy. Some medical men resented what Hodgkinson described as 'the stigma attached to being a doctor to the destitute'[126] and rural Poor Law work was not well remunerated and involved long hours riding many miles often covering several parishes. A minority it seems took this a license to treat their patients with contempt and although, by this point in time, the General Medical Council had the power to strike off the incompetent and negligent, they remained protected by a system that lacked transparency and accountability. Reinarz and Ritch found in a study of Birmingham that 'medical officers were rarely punished even in clear cases of neglect.'[127] The behaviour of Fryer and that of Long in the Carnall case was not however typical and it sits in contrast to that of Charles Clutterbuck in his tenure as Medical Officer to the Gloucester Union.

In both the Moseley and the Carnall case, the medical marketplace of plurality, diversity, choice and competition had no relevance. In the hierarchical and class-

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[124] *Ibid.*
[125] R.G. Hodgkinson, R. G., *The Origins of the National Health Service: The Medical Services of the New Poor Law, 1834-1871* (London 1967). p.24.
[126] Hodgkinson, 'Poor Law Medical Officers of England,' p.313.
[127] J. Reinarz and A. Ritch, 'Exploring Medical Care in the Nineteenth-Century Provincial Workhouse' in Reinarz and Schwarz, *Medicine and the Workhouse*, ch.7.

structured society of mid-Victorian England, individual agency could not always be exercised and the barriers to access to healthcare could prove insurmountable. The parsimonious and obstructive behaviour of Poor Law officialdom was also apparent in the case of Caroline Weeks of Horfield, which came before the Coroner in August 1855. This case also provides an insight into how the poor negotiated the healthcare system and ordered the limited options available to them. When Mrs Weeks became ill her husband first tried unsuccessfully to treat his wife with medicine he had bought from a local chemist. As the previous chapters have shown, this was the stock response of those of limited means and who held an expectation that recovery might occur with minimal outlay. Such behaviour would not be considered unusual now and it does not necessarily infer any rejection of regular medical expertise in favour of cheaper alternatives. On the contrary, when Mr Weeks perceived the seriousness of the situation he persuaded the wife of the local clergyman to obtain an order from the Relieving Officer, Mr Smith, for his wife to have medical attention. In her testimony Mrs Richards stated:

> I called on the deceased at her husband's house on Thursday week last. I found her [Caroline Weeks] ill in bed. I asked her if she would like to have the Parish Doctor she said she should. I went immediately to Mr Smith the relieving officer he said that nothing would induce him to send for the Parish Doctor in the present case – he said there were no written rules but only two to go by – the one where there was destitution and the other where there was no private property – that she had two little pigs and might pawn one and get ten shillings which her husband could get her medical advice with – that there would be a board held the next day at the Clifton Union at which her husband could attend and that he would say nothing to prejudice his case or to that effect – I afterwards heard Weeks say that he did not attend.[128]

The importance of people like Mrs Richards, acting as 'Lady Bountiful,' or what might now be called a 'community broker,' facilitating access to healthcare for the poor, is difficult to quantify. Digby found that 'the large extent of individual philanthropy directed at improving health and treating the sicknesses of the poor is easy to underestimate [because] much of the evidence has disappeared, whilst other material lies scattered in a myriad of household accounts and diaries.'[129] Peterson suggests that 'visiting the poor was one of the commonest forms of charity throughout the Victorian

[128] Coroner's Inquest Report: Catherine Weeks of Horfield, 6 August 1855, Gloucestershire, GA, County Coroner: Lower division, Inquest files, MS, CO1/I/1/C/1.
[129] Digby, *Making a Medical Living,* p.243.

period'[130] and that 'by mid-century women were increasingly conducting their parish work in cooperation with local clergy.'[131] The presence of the Lady Bountiful was an aspect of enduring paternalism in the healthcare economy, especially in rural communities, where Gerard has argued they made a 'significant contribution to social welfare and social stability'[132] Bradley noted how 'it had always been the practice among well-off ladies in the country to visit the poor and distribute food and clothes among the sick and needy'[133], where, according to Gerrard, 'the Lady Bountiful came to know the life history of every person in a small, fairly stable community'[134] In the early 1800s, 'the effect of Evangelical propaganda was greatly to extend this practice and to give new purpose and direction to the lives of many middle-class women at a time when they particularly needed it.'[135] There has been much debate over the motivations, scale and value of this work, but as Peterson also points out 'the search for excitement or the mere impulse to conform to upper-middle-class norms could not, in themselves, sustain women in the demanding and sometimes harrowing work of charity.'[136] Many were earnestly committed to this work, inspired by the same Christian faith that motivated Sarah Thomas, and although it is easy to criticise them with the benefit of hindsight, their importance in facilitating healthcare for the poor should not be undervalued.

The avenues explored by Weeks are emblematic of the experiences of the poor in the 'economy of makeshifts,' which King has argued 'was more an expression of despair and communal failure than a triumph of individual ingenuity.'[137] The precarious position of the sick poor and the hostile environment they encountered should they be forced to look to the parish for relief, inevitably meant that some simply refused to summon medical aid even *in extremis*. This was the decision of Henry Curtise of Yate, Gloucestershire, a farm labourer who died in July 1856 from 'inflammation of the

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[130] M.J. Peterson, *Family, Love, and Work in the Lives of Victorian Gentlewomen* (Bloomington, IN., 1989), p.133.
[131] *Ibid*, p.134.
[132] J. Gerrard, 'Lady Bountiful: Women of the Landed Classes and Rural Philanthropy,' *Victorian Studies*, Vol.30, No.2 (Winter 1987), p.207.
[133] Bradley, *The Call to Seriousness,* p.124.
[134] Gerrard, p.192.
[135] Bradley, *The Call to Seriousness,* p.124.
[136] Peterson, *Family, Love, and Work,* p.138.
[137] S. King, 'Making the Most of Opportunity: The Economy of Makeshifts in the Early Modern North' in King and Tomkins, *The Poor in England*, p.251.

stomach and bowels.'[138] Before the Coroner, it was described how he 'complained of pain & was stooped down & could not stand upright – He complained of pain chiefly over the navel – His feet were as cold as clay…he was in great pain – He tried to lie down on the bed could not for pain' but 'did not send for a doctor he said he could not afford it' and although his next-door neighbour 'pressed his wife very much to send for one…they did not seem willing.'[139] Doing nothing in this way was probably not unusual, as Rumsey's finding (discussed in chapter three) suggests, and it supports Smith's conclusion that 'the casual labouring poor, just above the level of the destitute, may well have been unable to afford medical help'[140] The case makes the findings of chapter five, that large numbers of Gloucester's working-class households, including casual labourers, did find ways to access medical advice, the more remarkable. It is difficult to draw conclusions from this single example, but it may be the case that this is an area in which significant variation between town and country occurred. In the city, Curtise would have had the option of the Dispensary, or perhaps even the services of a sympathetic duo like Clutterbuck and Stafford.

Another case in which medical assistance was declined was that of Anna Wheeler of Hullen in the parish of Henbury, whose daughter described how 'on Saturday last she complained of her stomach and bowels – she said she felt as though her stomach was dropping from her bowels – she frequently cust her stomach when she eat [sic] – I wanted to send for a doctor but she was not willing.'[141] The reasons for Wheeler's decision were not recorded, but her daughter was forced to treat her mother as best she could:

> I got her some brandy which she took and it eased her – In the afternoon the pain came on again – I put a mustard plaister to her bowels before she went to bed – She wanted some cyder but I thought it was not proper for her and I gave her a little weak brandy and water and went up to bed with her at about nine o'clock – she then said she was very easy and comfortable and went to sleep.[142]

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[138] Coroner's Inquest Report: Henry Curtise, Yate. Farm labourer, Visitation of God (inflammation of stomach and bowels), 30 July 1856, Gloucestershire, GA, County Coroner: Lower division, Inquest files, MS, CO1/I/2/C/11.
[139] *Ibid.*
[140] Smith, p.372.
[141] Coroner's Inquest Report: Anna Wheeler of Henbury, 18 May 1856, Gloucestershire, GA, County Coroner: Lower division, Inquest files, MS, CO1/I/2/A/31.
[142] *Ibid*.

This description has some parallels with that of Kate Thomas in the way that home remedies were used as a fall-back option. Again, there seems to have been no inclination to experiment with proprietary medicines. As coronial records usually gave details of any medication the deceased took in the days and hours before their death, including self-help remedies, the fact these accounts do not make any reference to proprietary medicines suggests they were not used. This further supports the case presented in chapter four that these remedies were aimed not at the poor, but at those who could afford to pay for healthcare but were poorly served by the regular medical offering.

For others, there simply was not the time to contemplate choices if medical treatment failed and for these people also, the array of alternatives offered by the medical marketplace also had little relevance. In the pre-antibiotic age, infections could rapidly deteriorate from trivial to life-threatening, quickly overtaking any attempted interventions. Emblematic of this large cohort of sufferers is the case of George Tilley, the kennel man of the Berkeley hunt, who died of "erysipelas" in December 1855.[143] Two surgeons gave evidence at the inquest into his death. The first, John Cox Hicks, who described himself as a surgeon practising in Berkeley stated:

> The deceased came to my surgery between 8 & 9 o'clock on Friday morning last and showed me his right arm which I examined minutely.
>
> I observed erysipelatus inflammation extending from a little below the bend of the arm to a little above the bend on the inside – It was very red and swollen as is always the case under similar affection – it was an enflamed [sic] surface and not in spots - I applied tincture of iodine which caused it to turn yellow – I did this to check the erysipelatus inflammation and I advised him to go home and keep himself perfectly quiet and to suspend the arm in a sling – he said he was very anxious to go to the kennels as they were very busy and I dissuaded him – I gave him some pills composed of calomel and extract of colocynth 3 grains of the former and 7 of the latter in two pills to be taken immediately and some Epsom Salts to take afterwards. I also gave him a lotion composed of liquid[?] ammonia acetates & spirits of camphor to apply to his arm – that is what I am in the habit of prescribing for erysipelas with good effect – nothing else of any consequence took place between us – I saw him again late in the evening at his house – he was suffering a good deal of pain in his arm and I prescribed Dover's powders with calomel to take at bed time – I observed that his arm was still considerably inflamed and that there were watery bladders on the surface of the skin the effect of inflammation – I still gave him the same lotion but a little stronger I examined him up to the shoulder – I asked him how he felt he said in a good deal of pain.

When Hicks next saw his patient on Friday morning:

[143] It seems likely this was actually sepsis.

> …he was still suffering from the same symptoms & the inflammation was going on and I stripped him up to his shoulder – I advised[?] him to continue the same applications – I observed that the watery bladders had burst and more had formed – this was from inflammatory action – I saw him again a little after nine o'clock the same evening. I found him worse – mortification had commenced in the arm above the bend of the arm extending to the shoulder and the side under the hollow of the arm and below the arm pit – I prescribed a restorative composed of ammonia camphor opium and aromatic confection to support the system and as he was very restless I gave him some Dover's Powders.[144]

Tilley died shortly afterwards. Although he sought medical advice quite promptly, there was nothing in the remedies Hicks had at his disposal that could halt the progress of such an aggressive infection. Even so, a second surgeon Henry Mills Grace thought he could have done better when called to give his opinion of the case:

> If a patient had come to me in the state mentioned by John Long and in good health I should have used powerful medicines and spirit lotions to apply to his arm and he may have required depletion in the left arm – It would have occasioned me alarm that the patient was employed in the kennels as deposed – it was just the description of case that frequently occasion the dissecting room amongst the students and which always require active treatment– I should have applied liquor ammonia autatis and spirit of wine as a lotion and have poulticed the knuckle – It is my ordinary practice in erysipelatus inflammation to make incisions with the view of obtaining blood from the part affected to release the inflammation and to get suppurative action set up – if I had found the spirit lotion succeed in allaying the inflammation I should have continued it but if the inflammation had spread I should have adopted other means and made the incisions from the information now given me – that is what I mean by active treatment – I should have given large doses of calomel with saline mixtures having first well evacuated the bowels – I should have given him 4 grains of calomel every three hours and if I had found that it purged him I should have commenced opium until I had affected the system – it was a kind of case that required very active treatment – I should expect to see watery bladders form on the surface of the skin – I should have seen him on the Saturday morning again - If I had found mortification commenced I should have considered it a hopeless case – I may have then altered my treatment by giving stimulants I should have felt greatly alarmed if I had found that mortification had commenced in the arm extending to the shoulder and the side and below the arm pit as stated. For my own satisfaction and that of the relations of the deceased I should have visited him again the first thing in the morning and after that if he had been alive it would have depended upon the state he was in – I think under the circumstances stated for me his death was very quick – I consider that the progress of the disease would depend on the activity of the treatment.
>
> I have no doubt but am positive that the abrasion upon the knuckle was occasioned before his death – I have heard an explanation from Mr Hickes and should not from that alter the opinion or evidence I have before given upon this case.[145]

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[144] Coroner's Inquest Report: George Tilley Berkeley Hunt Kennelman, accidental death skinning an infected horse, died of erysipelas Inquest 17 December 1855, Gloucestershire, GA, County Coroner: Lower division, Inquest files, MS, CO1/I/1/D/32/.

[145] *Ibid.*

In this era, probably only early amputation of the limb could have saved Tilley, but both patient and doctor were confounded by the virulence of the infection. Tilley did not appreciate the seriousness of his condition until it was too late. Many proprietary medicines claimed to treat erysipelas, but there was no time for Tilley to have explored this option either. Although Tilley sought medical advice, it is not hard to imagine how the victims of fast-acting infections might die before medical aid could be procured and thus form a substantial component of Rumsey's third of fatalities occurring without any regular medical involvement. The fact that Tilley sought medical help shows again how this was the preferred option in the event of serious illness. Why he summoned help and Wheeler did not can never be known. One may speculate that it could have been because Tilley was in employment, meaning he could afford it and saw the necessity of effecting a cure to preserve his income, whereas Wheeler may have felt treatment to have been an avoidable burden for her family.

The incapacitation or death of a working man could be calamitous for the whole family. Vincent found that 'loss of earnings and increased expenditure during the final illness, plus the cost of the funeral could impoverish a family' and Winter that 'death, injury or sickness of a breadwinner could plunge family income below the subsistence level.'[146] When Edward Bradley died in August 1872, by the following January his son William had been reduced to sending begging letters to his aunt asking for 18 shillings (which he claimed was the fee for his mother to stay in a workhouse infirmary at 5 shillings a week).[147] There was thus an economic imperative to seek the best, rather than the cheapest, help available if a) it was the breadwinner who was ill, b) the condition was serious enough to warrant it and c) there was a realistic prospect of a cure. Chapter five showed however that many working-class people also sought medical advice for less serious conditions and not only for the breadwinner. They may have had held fatalistic attitudes toward illness and death, but this did not prevent them from making rational, pragmatic choices and caring for family members as best they could. Strange has been critical of an historiography that 'seems to deny the working-class autobiographer the capacity for human emotion which he implicitly confers on

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[146] D. Vincent, *Bread, Knowledge and Freedom: A Study of Nineteenth-Century Working Class Autobiography* (London, 1981), p.58; J. Winter, 'Widowed Mothers and Mutual Aid in Early Victorian Britain,' *Journal of Social History,* Vol.17, No.1 (October 1983), p.123.

[147] William Bradley to Mary Ann Dudfield, 23 January 1873, D2079/II/3/F1.

those in wealthier circumstances.'[148] Working-class families were prepared to invest in medical advice if they could and in this respect, their priorities and aspirations differed little from their middle-class counterparts. When Edward Bradley's daughter contracted scarlet fever in London in 1868 he wrote to his sister that 'the Doctors are very attentive to the little dear for I have had the best advice'.[149] In his own final illness, his sister was advised that 'he has had two Doctors and they give no hope,'[150] lending some support to Fissell's claim that 'patients, even poor ones, exercised some control over their practitioners, choosing them according to their own criteria.'[151] In Bradley's case, as in the others discussed here, there is no evidence that the family ever resorted to proprietary medicines or irregular practitioners.

Having said this, as we have seen, the barriers to accessing medical aid were numerous and sometimes insurmountable. Barry and Jones have observed how 'often the medical needs either of the deserving poor or of the potential labour force stood in stark contrast with the types of medical care available.'[152] To talk about these people as 'healthcare shoppers' is absurd. Their cases serve to highlight how the medical marketplace model has been constructed around the experiences of struggling doctors, rather than offering a holistic interpretation of healthcare provision. Many groups of people lay outside of the narrow commercial sphere it describes. One such group comprised working-class people who had suffered serious injury. They, more than any other group were the speciality of the Infirmary, which as was discussed at length in chapter three, did not operate on a commercial basis.

Emergency cases from across the county presented themselves for assessment by the House Surgeon and Apothecary, who would decide if they were suitable for admission. The casebooks of one of them, the long-serving G.W. Charleton, record emergency cases arriving from across Gloucestershire and even occasionally from further afield (reflecting Gloucester's status as a busy port and railway hub); another example of the interconnectedness of Gloucester's healthcare economy with that of the

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[148] J.M. Strange, *Death, Grief and Poverty in Britain, 1870-1914* (Cambridge, 2005), p.11.
[149] Edward Bradley to Mary Ann Dudfield, 23 March 1868, D2079/II/3/F1.
[150] *Ibid,* 8 July 1872.
[151] Fissell, p.68.
[152] J. Barry and C. Jones, 'Introduction' in J. Barry and C. Jones (eds), *Medicine and Charity Before the Welfare State* (London, 1991), p.7.

wider shire.[153] One of those to come to the Infirmary for treatment was William Warner of Dursley, who was admitted in December 1867, having accidentally slipped into the river at Coaley Ford.[154] Warner found the hospital regime intolerable and soon discharged himself complaining that 'he had been kept very short of beer.'[155] In chapter three it was discussed how self-discharging was common; many patients being unable or unwilling to conform to strict rules and regulations aimed at their moral reform and which imposed standards of personal hygiene and orderly behaviour they were unaccustomed to. An alcoholic like Warner would have found them particularly irksome. As these patients often had nowhere else to go, the bureaucratic procedures of the Infirmary had a serious impact on outcomes for those who could not abide by its rules. In this case, a witness noticed Warner 'seemed to have lost flesh and to be more infirm than when he went to the Infirmary.'[156] Upon his return, he went to the Swan Inn at Coaley where he had previously been lodging, but:

> …they had refused to take him – he began to cry and said he was not able to walk to his Grandson's at Cambridge – he had a little beer and a biscuit given him and went out again to try for a bed but could not get one and we made him up one – he slept there and in the morning had a pint of cyder and some bread and butter and cheese and left between ten and eleven – he did not complain of anything but weakness and cold - I know he could not of later years retain his water long and noticed that he went in and out frequently in the evening.[157]

Warner's decision to discharge himself is understandable, but in so doing he placed himself in dire straits. His grandson obtained an order for his admission to Dursley Union Workhouse, as no family member was seemingly able or willing to take him in. On arrival Warner was:

> …placed in the sick ward…and got into bed directly – I [John Saunders, an inmate] brought him his food and he made no complaint whatever about seven o'clock in the evening he got out to make water but could not and he told me he was in great pain and had not made water for three days – I told the nurse directly and Mr McPherson the Assistant Surgeon came about 8 o'clock – I assisted him in [?] to drain his water but he was not able to stand - he was then put on the bed on his back and Mr McPherson then

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[153] Case books of admissions to the Infirmary, kept by Dr G. W. Charleton, house-surgeon, 1833-1867, Gloucestershire, GA, Gloucestershire Collection archives. Archives from the Austin Catalogue. Gloucester: Hospitals: Infirmary, MSS, D9125/1/4905.
[154] Coroner's Inquest Report: William Warner, Dursley, died as a result of operation to relieve retention of urine, 6 January 1868, Gloucestershire, GA, County Coroner: Lower division, Inquest files, MS, CO1/1/14/A/4.
[155] *Ibid.*
[156] *Ibid*.
[157] *Ibid*.

> endeavoured to drain his water and drew a quart or more from him and he died almost directly – Mr McPherson treated very quietly and gently and deceased did not complain whilst under the operation - I did not hear deceased say a word before he died.[158]

Once again, Warner encountered structural barriers in the form of a slow bureaucratic process, which delayed his access to treatment until it was too late. At least, in contrast to the actions of Fryer and Long, the Assistant Surgeon, Samuel McPherson's conduct appears to have been caring and diligent, treating the patient 'very quietly and gently.'[159]

If injured adults were the domain of the Infirmary, children were much more likely to be treated at home. As discussed earlier, the Infirmary was unusual in admitting those five years old and over and home was generally thought the proper locus of care for sick infants and children of all classes. It has already been seen how much healthcare advertising was directed toward parents and children are one group where, according to Branca, 'there was a heavy reliance on quack medicines'[160] The prevalence of self-doctoring of children is evidenced in coronial records because unfortunately it led to a steady trickle of fatalities from accidental overdosing and poisoning. Mistakes were inevitable when dangerous drugs, particularly opiates, were administered without proper advice or instruction, when medicine packaging contained no compulsory warning labels and when in any case, many people were illiterate or semi-literate. Furthermore, Obladen also highlighted that 'their inconsistent alkaloid content, due to biological variability and adulteration' was a contributory factor,[161] citing research by the London Sanitary Commission in 1853, which sampled laudanum from 21 pharmacies and found 'their opium content ranged from 3% to 21%, and the alkaloid content of opium from 2.7% to 14%, which resulted in a 36-fold difference in morphine concentration.'[162] Lomax too concluded that 'the danger of poisoning was increased by the uncertain composition of both nostrums and pharmaceutical preparations'[163]

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[158] *Ibid.*
[159] *Ibid.*
[160] Branca, p.106.
[161] M. Obladen, 'Lethal Lullabies: A History of Opium Use in Infants,' *Journal of Human Lactation*, Vol.32, No.1 (February 2016), p.79.
[162] *Ibid,* p.81.
[163] E. Lomax, 'The Uses and Abuses of Opiates in Nineteenth Century England,' *Bulletin of the History of Medicine*, Vol.47, No.2 (March 1973), p.170.

Quantifying the scale of the problem is difficult. Obladen has gone as far as to claim that 'it seems likely that treatment for "difficult teething" was an early iatrogenic catastrophe for infants'[164] and Berridge suggested opiate use was widespread and accompanied by a general ignorance of how the drug worked and the risk of overdosing.[165] Referencing coroners' returns of deaths by poisoning in England and Wales, she found these revealed that in 1839 '186 out of a total of 543 such deaths were the result of opium poisoning' and later that 'figures on opium beginning in the early 1860s showed… 126 deaths from opiates in 1863… out of a total of 403 poisoning fatalities.'[166] These figures included adults and suicides, but children were peculiarly vulnerable to accidental overdosing because 'given the small body size of children in the nineteenth century… the tolerance for error even under medical supervision was small. When dispensed by the local grocer in preparations on unstandardized strength to an ill-educated, barely literate mother the risks were higher.'[167] Branca found that 'in 1847, 23,347 children under five died from convulsions and 4,534 died from teething' and in both categories, many of the deaths were caused by an overdose of drugs.'[168]

An emblematic example is that of baby George William Martin of Cam, Gloucestershire, who died aged three months in 1865, from an accidental overdose of laudanum. Ruth Seaborne, a sixteen-year-old girl, was nursing the child when:

> …it was troubled very much with wind - Eliza Martin sent her husband for some peppermint but he could not get any – the child seemed to be in great pain and Mrs Martin asked him if he thought one drop of laudanum would hurt it – as she said she did not like to see it suffer – he brought a teacup with a drop of laudanum he said in it – he put some water with it and said he did not think it would do any harm – [illegible] too much water with the first lot and he went away and afterwards brought something in the teacup and told me to give it to the baby – it was about 2 teaspoonsful and looked like water – I gave it all to the baby.[169]

The local surgeon, Mr Dutton, testified that:

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[164] Obladen, p.78.
[165] V. Berridge, 'Victorian Opium Eating: Responses to Opiate Use in Nineteenth-Century England,' *Victorian Studies*, Vol.21, No.4 (Summer 1978), p.440.
[166] Berridge, 'Victorian Opium Eating, p.443.
[167] T.E. Jordan, 'The Keys of Paradise: Godfrey's Cordial and Children in Victorian Britain,' *Journal of the Royal Society of Health,* Vol.107, No.1 (February 1987), p.21.
[168] Branca, p.107.
[169] Coroner's Inquest Report: George William Martin, aged 3 weeks, Cam, 6 March 1865, Gloucestershire, GA, County Coroner: Lower division, Inquest files, MS, CO1/I/11/A/14.

> I was sent for between 11 & 12 that night the Father told me he had given it some laudanum – a drop – I found the child in a comatose condition perfectly insensible coldish – the pupils very much contracted – I asked to see what was given and the father shewed me this bottle – I believe it to be laudanum. I should consider a single drop of laudanum sufficient to poison a child of that tender age – and highly improper to be given except under medical direction to a child under twelve months – deceased died on Friday – the symptoms presented agreed with those of poisoning by opium.[170]

Explaining his actions to the Coroner, the child's father stated:

> I cannot read I fetched this bottle from my grandfather's last Thursday week – I was sent by Ann Barnfield for some laudanum for my wife – my grandfather thought it was not proper for her – Mrs Barnfield gave her 7 or 8 drops on the 23rd – I endeavoured to drop one drop into the teacup but I cannot say it was not more - my wife said it was too weak and I put it in a basin and I put about the same quantity of laudanum and less water and held it for Ruth to give it to the child – I intended to do the child good – about an hour afterwards it became stupid and sleepy and died about 8 o'clock on Friday morning last.[171]

Although unusual this case was not unique. Another with obvious similarities is that of two-week-old William Meredith of Thornbury, who died in June 1863. This time a lethal dose of laudanum was inadvertently administered on the mother's instructions by a monthly nurse, Sarah Cossham:

> I was attending Mrs Meredith as Monthly Nurse and she wrote for two pennyworth of syrup of Rhubarb and laudanum – it was not by my direction – the note was given to the girl and she returned with the stuff in a bottle. On Thursday last about eight o'clock in the evening I gave the deceased a little more than half a teaspoonful of it by Mrs Meredith's orders – she poured it out – soon afterwards it began to make a moaning noise and laid very stupid and quiet and never recovered about ten o'clock it had a fit and Mr Salmon was sent for and it was under his care until it died about three o'clock on the following day – the child was restless before it was given the stuff and it was to quiet it and give it sleep. I gave it some peppermint tea – I knew nothing of it being a dangerous medicine – I should not have given it not knowing what it contained but my mistress said she was in the habit of giving it to the children and always had it from the Vaughan's.[172]

James Vaughan, the chemist and druggist involved, stated:

> Last Wednesday evening (the 3rd instant) Mr Meredith's nurse brought a written order for a pennyworth of laudanum and a pennyworth of syrup of Rhubarb mixed together my daughter put it up and labelled the bottle Syrup of Rhubarb & Laudanum mixed – I saw the laudanum – there was a quarter of an ounce of laudanum and half an ounce of syrup of Rhubarb – I was not told what it was for – such a quantity would have been too large a dose for an adult to have taken at

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[170] *Ibid.*
[171] *Ibid.*
[172] Coroner's Inquest Report: William Meredith aged 2 weeks of Thornbury, 10 June 1863, Gloucestershire, GA, County Coroner: Lower division, Inquest files, MS, C01/I/9/B/13.

> once – I did not say or write what quantity should be taken – it is a very unsafe medicine to give a child of two weeks old – I should not like to give even two drops to an infant. I should not have supplied it had I known it was for such an infant – I consider that it is not required that a Chymist should label a mixture made according to order "poison" – though it contained poisonous ingredients – the nurse took it with her in a bottle.[173]

By the time the surgeon, William Salmon, arrived he was unable to revive the baby as 'it had been given quite 30 drops of the mixture of laudanum and tincture of Rhubarb.'[174] Salmon considered this 'a very dangerous mixture in the quantity mentioned – I should not give any laudanum whatever to a child of that age – two drops has been known to kill an infant & four drops a child of nine months – this infant must have had from ten to twelve drops.'[175]

The dosing of children and infants with opiates was likely as widespread as Berridge suggests. Obladen has noted how 'soothers had been a part of the European habit of self-medicating since the Middle Ages'[176] with Branca suggesting 'the consequences of this practice were graver for the child because its system was too fragile for most of these patent cure-alls.'[177] According to Smith:

> Many reformers linked factory work and maternal neglect with deaths from overdoses of sedatives. The practice of giving infants 'quieteners' was much older than the nineteenth century but it probably became more widespread amongst all classes as supplies of Eastern Mediterranean opium increased through the growth of the French drug industry, and distribution in Britain became more effective.[178]

Alarm at the widespread use of soothers was fuelled by a press crusade. Among the most notorious of these products was 'Mrs Winslow's Soothing Syrup' (Figure 6.1).

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[173] *Ibid.*
[174] *Ibid.*
[175] *Ibid.*
[176] Obladen, p.79.
[177] Branca, p.106.
[178] Smith, p.95.

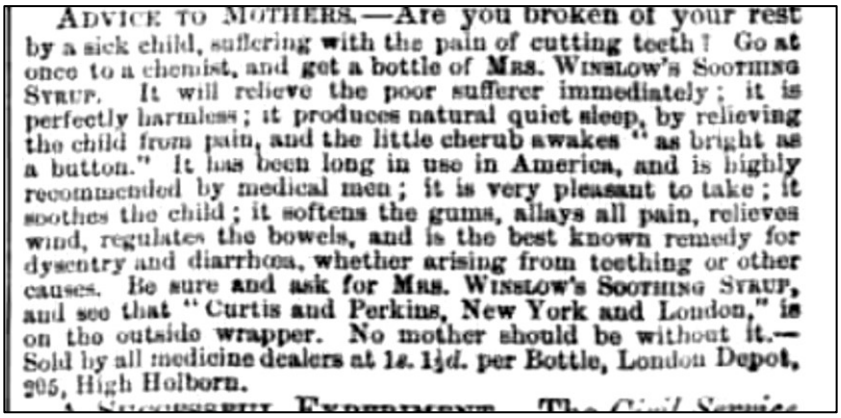
ADVICE TO MOTHERS.—Are you broken of your rest by a sick child, suffering with the pain of cutting teeth? Go at once to a chemist, and get a bottle of MRS. WINSLOW'S SOOTHING SYRUP. It will relieve the poor sufferer immediately; it is perfectly harmless; it produces natural quiet sleep, by relieving the child from pain, and the little cherub awakes "as bright as a button." It has been long in use in America, and is highly recommended by medical men; it is very pleasant to take; it soothes the child; it softens the gums, allays all pain, relieves wind, regulates the bowels, and is the best known remedy for dysentry and diarrhœa, whether arising from teething or other causes. Be sure and ask for MRS. WINSLOW'S SOOTHING SYRUP, and see that "Curtis and Perkins, New York and London," is on the outside wrapper. No mother should be without it.—Sold by all medicine dealers at 1*s.* 1½*d.* per Bottle, London Depot, 205, High Holborn.

Figure 6.1 Advertisement for Mrs Winslow's Soothing Syrup, 1868.
Source: *Gloucester Journal*, 17 October 1868, p.2. Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

Jordan described the use of *Winslow's Soothing Syrup* and another, *Daffy's elixir*, as 'a sinister practice,' one which was roundly condemned by the medical profession at the time.[179] Thompson cautioned his readers regarding the dangers of a similar product, *Godfrey's Cordial*:

> GODFREY'S CORDIAL – is one of the dangerous quack carminatives frequently given to children. It contains opium, and fatal consequences are often the result of its administration. In February of the present year – 1852 – one fatal case at least, of poisoning by this compound was reported, and it was stated at the inquest, that one teaspoonful of that used would contain five drops of laudanum. The remarks made upon "Dalby's Carminative" apply equally to this legalized but dangerous compound.[180]

The temptation for malnourished, over-worked and exhausted working mothers to resort to these products made them a serious threat to infants. There was no suggestion in either of the cases above of the poisoning having been anything more than a tragic accident, but as Lomax points out that 'no one will ever know how many of these children were killed by design rather than by accident, nor even how many opiate deaths escaped attention altogether [as] the coroner was under no obligation to order either inquest or autopsy in cases of sudden death.'[181] Contemporary commentators and some of the subsequent literature on the subject has laid the blame for the problem at the door of the chemists and druggists. Henry Rumsey was amongst those who believed 'the poor placed their children and themselves in danger by consulting druggists rather than regular practitioners.'[182] In the Meredith case, Vaughan was certainly culpable

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[179] Jordan, p.21.
[180] S. Thompson, *A Dictionary of Domestic Medicine and Household Surgery* (London, 1852), p.261.
[181] Lomax, p.172.
[182] S.W.F. Holloway, *Royal Pharmaceutical Society of Great Britain 1841-1991: A Political and Social History* (London, 1991), p.71.

morally if not legally when he 'did not say or write what quantity should be taken' for what he admitted was 'a very unsafe medicine to give a child of two weeks old.' An article that appeared in *Punch* in 1848 under the title 'Poisoning Made Difficult' gives an insight into the public disquiet surrounding these issues in the years immediately prior to the Sale of Arsenic Regulation Act of 1851 and the Pharmacy Act of 1852:

> In a recent police report, which appeared in the Times, an unfortunate woman, named SARAH RICH, was stated to have been brought before MR. HAMMILL, at Worship Street, charged with having attempted to commit suicide with laudanum. The charge was preferred by the authorities to the London Hospital, and supported by MR SAMUEL BIRCH, House Surgeon to that Institution; not for the purpose of having the poor creature punished, but with a view to the discouragement of a certain branch of counter-practice: of that part of the art and mystery of a chemist and druggist which consists of trafficking in death. The prisoner, it appeared, had bought sixpennyworth of laudanum at two different shops – the money taken, and no questions asked or directions given. She had swallowed her fatal bargain, and would have been lost but for the saving efficacy of the "Purgatory of Suicides" superintended by MR, BIRCH.
> *Ne quid nemis.* Free Trade doubtless is a very fine thing, but the best of principles may be ridden to death, as that of Free Trade evidently is, in the permission of unrestricted sale of poisons. We would suggest an improvement in the chemico-commercial dialogue as it stands at present in the drama of life and death: *videlicit*.
>
> *Poor woman – "Three penny-worth of laudanum!"*
> 'Prentice – "Yes, Ma'am directly
> Threepence the laudanum – and the bottle is A penny-fourpence"
>
> We object to both the question and the answer, but more particularly to the latter – for which SHAKESPEAR (and what problem has he not solved?) has supplied the model –
>
> "Such mortal drugs I have but Mantua's law
> Is death to any he that utters them."
>
> For "death" read "fine and imprisonment" and the desideratum will be obtained. The response will then run somewhat thus: -
>
> *Prentice "*Laudanum did you say!"
> Where's your prescription? It is poison, Ma'am.
> We cannot serve it but by warrant, signed
> By a physician, or the officer
> Of Public Health. We really can't indeed,
> Under a penalty of fifty pounds
> Or a year's imprisonment."
>
> We commend this important alteration in the social dogma to the consideration of our legislative play-wrights; and if they will attend to it, we feel quite confident that suicide will less frequently occur both in London and elsewhere; and that much fewer husbands and children will be poisoned in Essex.'[183]

Although as chapter five showed, most chemists and druggists were respectable tradesmen who provided their communities with a trusted and valued healthcare resource, the actions of an unscrupulous minority tarnished the reputation of the trade. Some had little ethical concern for their customers and 'would sell them what they wanted,'[184] fuelling the accusation that:

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[183] P. Leigh, 'Poisoning Made Difficult,' *Punch,* 28 October 1848, p.188.
[184] M. J. Petersen, *The Medical Profession in Mid-Victorian London* (Berkeley, CA, 1978), p.226.

> …the business of a chemist and druggist, regarded merely *as a business*, differs in no degree from any other trade. It is not conducted upon any sentimental principles; it is not governed by any particular trade-fellowship or class-feeling, although it almost rises to the so-called dignity of a "profession," and it is carried on for personal sustenance and gain. …It is compelled to do as its neighbours do who live by shopkeeping, or must resign itself to failure and disgrace.[185]

Ironically, the medical profession encouraged chemists and druggists to think of themselves in this way. This may be another area where significant local variation occurred between town and country, with competition in Gloucester (where, as we have identified, rivals fought over reputation and customer service) acting as a commercial disincentive to reckless dispensing. It is also important to note Berridge's observation that 'retail sales were not limited to pharmacists, nor did sales have to be made through pharmacist's shops…Many small corner shops sold opiates.'[186] As Berridge also pointed out, these shops 'were kept by people little removed in status from the population of the surrounding area they served. They, and some of the chemists in the poor areas, were often ignorant and ill-taught.'[187]

Both the above cases illustrate how working-class parents were prepared to resort to self-dosing their children rather than seeking medical advice. The reasons for this were likely complex. Partly, in a vicious circle, high levels of infant mortality meant babies and young children did not have a high-enough likelihood of survival into adulthood to warrant investment in expensive medical help. According to Branca, 'it is difficult to say when women sought medical attention for a sick child. Judging from the mortality rates it would appear that it was not often enough or soon enough.'[188] Press reports of coroner's inquests and criminal trials were certainly censorious of delays in summoning qualified medical aid at what was considered to be the appropriate time (Figure 6.2).

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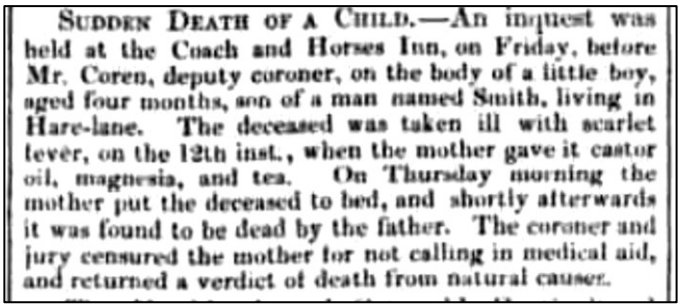
[185] *The Chemist and Druggist*, Vol.1, No.11 (14 July 1860), p.239.
[186] Berridge, p.439.
[187] *Ibid.*
[188] Branca, p.108.



SUDDEN DEATH OF A CHILD.—An inquest was held at the Coach and Horses Inn, on Friday, before Mr. Coren, deputy coroner, on the body of a little boy, aged four months, son of a man named Smith, living in Hare-lane. The deceased was taken ill with scarlet fever, on the 12th inst., when the mother gave it castor oil, magnesia, and tea. On Thursday morning the mother put the deceased to bed, and shortly afterwards it was found to be dead by the father. The coroner and jury censured the mother for not calling in medical aid, and returned a verdict of death from natural causes.

Figure 6.2 'Sudden death of a child'

Source: *Gloucester Journal,* 27 August 1870, p.5 Newspaper Image © The British Library Board. All rights reserved. With thanks to The British Newspaper Archive (www.BritishNewspaperArchive.co.uk).

Such reports both reflected and reinforced the view that seeking qualified medical advice was the only proper response to serious illness and we do find that where parents perceived they were dealing with a serious problem medical assistance was usually summoned. In 1869, toddler George Clifford inadvertently drank hot water from a kettle when left unattended in the home. His mother's immediate reaction was to 'put some sweet oil on his lip.'[189] However, when 'he was taken with coughing and brought up phlegm' she 'became alarmed and took him to Dr Grace who gave [her] some medicine for it.'[190] Similarly, another child, Kate Limbrick, was taken ill after taking tea and cake with other children during an outing to Rockhampton Rectory in 1870 and began vomiting that evening. Her mother 'gave her some Rhubarb and Magnesia which [she] got from Mrs Prichard.'[191] This is another case where a Lady Bountiful makes an appearance, something advice manuals for middle-class women encouraged. Mrs Beeton, for example, advocated such interventions in her *Book of Household Management* (1861):

> If people knew how to act during the interval that must necessarily elapse from the moment that a medical man is sent for until he arrives, many lives might be saved, which now, unhappily, are lost. Generally speaking, however, nothing is done – all is confusion and fright; and the surgeon, on his arrival, finds that death has already seized its victim, who, had his friends but known a few rough rules for their guidance, might have been rescued.[192]

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[189] Coroner's Inquest Report: George Henry Clifton, Alveston, 18 February 1869, Gloucestershire, GA, County Coroner: Lower division, Inquest files, MS, CO1/I/15/A/13.

[190] *Ibid*

[191] Coroner's Inquest Report: Kate Limbrick, child, Rockhampton, 20 September 1870, Gloucestershire, GA, County Coroner: Lower division, Inquest files, MS, CO1/I/16/C/17.

[192] I. Beeton, *Beeton's Book of Household Management.* Facsimile edition. (London, 1982 [1861], p.1061.

In this case, the remedy was unsuccessful and the following morning Kate 'threw up the Rhubarb & Magnesia' and at this point her father 'went for Mr Grace' (the surgeon).[193] In the meantime her mother 'gave deceased some castor oil and put mustard plaisters on her feet which had got very cold' and her grandmother suggested she 'put some hot water for a bath.'[194] The surgeon, Mr Grace, testified that the 'deceased's father came for me on Sunday morning – I did not see him – I had a message that he would call again but he did not.'[195] This case has parallels with that of Tilley in the speed with which the illness took hold; by the time Grace finally appeared on the scene the child was dead. In both examples, the parents called for a doctor when they *perceived the illness or injury was life-threatening*. In contrast, the two accidental deaths of infants that occurred through self-medicating by parents, occurred when the parents thought they were dealing with a minor ailment. These findings point toward stratification in the healthcare economy, with different suppliers called upon in certain situations and not others.

6.4 Conclusion

The sources presented in this chapter have been lightly handled in the historiography of the medical marketplace and yet they raise important doubts over some of the central tenets of the model. All the cases discussed here, although taken from across the wider shire, could just as easily have taken place in the city, although the ways the protagonists responded hints at both areas of commonality and variance between urban and rural communities. For the poor, the city provided more options, most notably the Dispensary which only saw patients from within a mile radius of Gloucester. However, we have also seen people from the wider shire making use of the Infirmary. It was shown in chapter five that some eighteen per cent of William Stafford's trade came from the county outside of Gloucester city and we have seen in this chapter doctors being summoned to wealthier patients from nearby towns, pointing to the interconnectedness of Gloucester's healthcare economy with that of the wider shire.

The cases here reveal the existence of important social norms surrounding healthcare that were likely common to both environments. Even in the areas of

[193] Coroner's Inquest Report: Kate Limbrick
[194] *Ibid.*
[195] *Ibid.*

childbirth and the treatment of sick children and infants, where resort to midwives or self-medication was more prevalent, there clearly existed a shared recognition of the point at which regular medical assistance was the only acceptable course. This reinforces the case that what existed in Gloucester and Gloucestershire was, by the 1850s, a stratified healthcare economy dominated by the medical profession. Reflecting on the points made in the introduction, the chapter casts further doubt upon the characterisation of the nineteenth-century healthcare economy as a place where 'patients chose from a bazaar of medical practitioners.'[196] This was far from a free-for-all of competing suppliers and it has been shown that both middle- and upper-class families often did not concern themselves with alternatives to regular medical advice at all, instead seeking second or third opinions from more prestigious doctors if they did not perceive any improvement. Porter and Porter's claim that in the eighteenth century 'the mobilization of the market enfranchised the consumer…[and] it was not until 1858 that the regular profession reasserted control over medical services' is not substantiated by the evidence presented here, which suggests doctors had achieved dominance well beforehand.

For wealthy families, patronage and 'bedside manner' continued to be important to the doctor-patient relationship.[197] Fickle patients appointed and dismissed their doctors at will. Importantly, it did not mean they sought out alternatives to qualified medical advice or rejected medical opinion. Their decision-making was confined to choosing which doctor(s) to consult and the array of choice offered by a medical marketplace was of little relevance to them. At the other end of the socio-economic milieu, some doctors wielded a degree of power over the sick poor that would have been inconceivable with wealthy private patients. Even here though, it is clear the poor too valued regular medical advice and went to considerable lengths to obtain it. Even those who could not afford it clearly recognised its value. Although self-help was still widely practised, this tended to be in specific circumstances: commonly, for trivial ailments where medical aid was thought an unnecessary extravagance (as it surely would still be today), where it formed the recourse of the desperate and disillusioned, or in the treatment of those children and infants who were not perceived to be seriously ill.

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[196] Fissell, p.68.
[197] Porter and Porter, *Patient's Progress*, p.28.

The difference between rich and poor was not so much one of attitude, but of circumstance. Doctors had to be persuaded to attend the poor, and although they usually did so, it has been shown that structural forces, in the form of Poor Law bureaucracy, could interfere with access and occasionally prevent it entirely. Jenner and Wallis have cautioned that 'we should never assume that the consumer of medicine was an independent economic agent' and some of the stories discussed in this chapter have demonstrated the limits to individual agency, especially amongst the poor.[198] These cases support the proposition that the 'medical marketplace' model overstates the ability of consumers to determine the complexion of healthcare supply through personal choice. The chapter has highlighted the great variety in individual experience, in which the strength of community and familial support networks have been shown to have been of crucial importance. For the poor, in what was a healthcare 'economy of makeshifts,' accessing healthcare was a process of improvisation and the assets an individual possessed, in terms of people around them able and willing to help, was critical to outcomes. It involved calling upon a range of different resources; neighbours, clergyman, 'Lady Bountiful,' and negotiation with gatekeepers, in the form of relieving officers, or Infirmary subscribers. For the poor, healthcare was bound up with society's attitude toward, and management of, poverty, with the sick subject to moralising judgements, indifference, and sluggish, unresponsive, bureaucratic processes. Resort to self-medication, which was commonplace, particularly in treating babies and infants, was, in this environment, hardly a matter of choice.

Rather than consumer curiosity, or gullibility, it was the therapeutic impotence of doctors that was the more important driver in people resorting to alternatives. Both Carpenter and Flanders have commented on how the ineffectiveness of orthodox medicine against an array of common ailments goes a long way to explaining both the appeal of proprietary medicines and the continuing presence of irregulars.[199] We have seen now how this extended to self-medicating with home remedies. This was an avenue explored primarily by those least well-served by the regular medical offering, who were not necessarily poor. These people did not experience any 'bazaar' of unlimited and equal choice, and we have seen how healthcare choices were seldom

[198] M.S.R. Jenner and P. Wallis, 'The Medical Marketplace' in M.S.R. Jenner and P. Wallis (eds), *Medicine and the Market in England and its Colonies c.1450–c.1850* (Basingstoke, 2007), p.9.
[199] Carpenter, p.24; Flanders, p.310.

based on economic factors alone – religious belief, age, gender familial and community networks, or the lack of them, all had an important role. Overall, the findings of this chapter accord with the contention throughout that the supposed plurality, diversity, choice and competition of a medical marketplace has been over-stated. If we look at healthcare from the perspective of the patient rather than the supplier, it is difficult to perceive the existence of anything much resembling a medical marketplace at all. Long before 1858, this was already a healthcare economy dominated by regular doctors and chemists and druggists. Alternatives, which we have seen mainly comprised home remedies or self-dosing with purchased drugs, were the resort of specific groups in specific circumstances, and generally used when medical advice was either considered unnecessary, could not be obtained, or could do no good.

Chapter Seven: Conclusions

For the past thirty years, the 'medical marketplace' paradigm has held a dominant place in the social history of medicine in Britain. It has been seen how this model has been used to describe the healthcare economy of the early modern period through to at least the middle of the nineteenth century. Born of a realisation of the importance of economic factors in the evolution of medical practice, the model has formed part of a broader historiography charting the rise of consumerism. The medical marketplace model moved away from a view of linear progress in medicine, driven primarily by scientific discovery and the achievements of 'great' individuals. Instead, it claimed to take a patient-centered approach, presenting a chaotic picture of an environment in which regular doctors were forced to fight for authority and business in an unregulated free-market. Returning to Bynum's description, it was a place where 'competition could come in many forms; fellow practitioners, hospitals and dispensaries… chemists and pharmacists who sold medicines directly to the public; advice books that encouraged every man to be his own doctor; itinerant "specialists", mountebanks and drug peddlers; shrewd mail-order merchants, homeopaths and other sectaries…challenged the very basis of medical orthodoxy.[1] In this environment, characterised by plurality, diversity, competition and consumer choice, rank-and-file doctors occupied a precarious position and struggled to make a living.

This is a beguiling narrative, but we have seen that there are important deficiencies and gaps in this interpretation. The literature review showed a historiography comprised of several discrete threads that have not yet been convincingly brought together into anything resembling a compelling holistic explanation of the workings of the nineteenth-century healthcare economy. The principle gaps include:

- The lack of any generally accepted definition of the term 'medical marketplace' and a sparsity of comparative studies, which has led to uncertainty around the extent of plurality, diversity, choice and competition, the degree of local variation, and the chronology of the medical marketplace's demise.

[1] W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge, 1994), p.196.

- An unbalanced view that places excessive emphasis on the most commercialized areas of the healthcare economy and fails to convincingly accommodate the role of institutions.
- Despite a self-consciously 'patient-centred approach,' an historiography that still largely views healthcare from the perspective of medical practitioners.

This study has presented a case for a more holistic paradigm and has given balanced attention to doctors, chemists and druggists, the proprietary medicines trade and to customers. It has also introduced important sources to the debate that have been lightly handled in the literature so far, such as prescription books and coronial records.

Gloucester was chosen for investigation because its rapid industrialisation and urbanisation created all the public health challenges synonymous with the nineteenth-century urban environment and because nearby Cheltenham, an affluent spa town, exercised a considerable gravitational pull upon its healthcare economy. Gloucester was thus both typical and atypical. It was emblematic of the urban-industrial healthcare landscape of England, but its proximity to Cheltenham, with its electric range of healthcare choices, also highlights the extent of local variation in healthcare. The study focused on the years between 1815 to 1870; a period that can justifiably be termed the Age of Reform, as it encompassed the series of regulatory measures attributed with having created the modern professions of medicine and pharmacy thereby ending the 'medical marketplace'.

Overall, the body of evidence from Gloucester has called into question some of the principal assumptions upon which the medical marketplace paradigm rests. It has challenged the enduring stereotype, fostered by the nineteenth-century medical profession, of those who sampled irregular healthcare as gullible, ignorant, or unable to afford regular medical advice. In fact, the picture was complex and nuanced, with the healthcare economy characterised by a high degree of customer segmentation and stratification. It has been shown that the ability of consumers to determine the nature of supply through autonomous individual agency has been overstated and healthcare choices at all levels of society were influenced and constrained by structural factors. We have also seen how long before the 1858 Medical Act (the supposed death-knell of the medical marketplace), Gloucester's healthcare economy was far from the free-market anarchy described by Porter, Digby and others. Instead, it was characterised by

stability, structure and hierarchy; with the medical profession already established at its pinnacle. Consequently, the part legislation played in the process of modernisation must be questioned, or at least the relative importance of the 1815 Apothecaries Act *vis-à-vis* the 1858 Medical Act reassessed. Importantly too, the medical profession had achieved an ascendant position well before it was able to offer truly effective treatments, something that contests the earlier narrative of progress driven by scientific discovery.

Gathering the evidence for an alternative paradigm began in chapter three with a detailed deconstruction of healthcare supply in Gloucester between 1815 and 1870. It set out the case for the city's suitability for analysis, discussing Gloucester's development into an important regional port and communications hub, and the industrialisation and urbanisation this brought, and the impact it had upon public health and demand for healthcare. This was followed by a survey of institutional healthcare providers in the city that showed how institutions grew in number and importance during the nineteenth century and became increasingly influential as the locus of medical authority, organisation and expertise. Consequently, despite treating a relatively small number of patients, they were shown to have had a disproportionately significant influence on Gloucester's healthcare economy and must also be considered in terms of the contribution they made to consolidating the position of regular medical practice in the city. Institutions created new medical roles and responsibilities that in turn influenced the status of doctors in the wider community. This manifested itself, for example, in the ways doctors chose to self-identify in the census where the nomenclature they used changed from generic 'physician' or 'surgeon' to listing qualifications and college memberships.

Securing a medical post was shown to have been an essential step in establishing a successful medical career in Gloucester. The Infirmary was the locus of medical education in the county and honorary infirmary posts were highly prized and intensely fought over, both for the access to interesting cases they presented, and for the patronage and networking opportunities they provided. There was a clear hierarchy attached to institutional posts, but there was competition for even the lowest of them and it was common for doctors to hold several lower-tier posts simultaneously to boost income and exclude rivals. The networking opportunities institutional posts offered

provided a platform for doctors to form groups and societies, which served as a vehicle to showcase their credentials as learned gentlemen, lobby for their professional interests, and to police the profession at the local level. In Gloucester, they also provided a platform from which doctors were able to enter civic and political life to an extent not found elsewhere in other studies. Several Gloucester doctors and chemists served as local councillors and five of them served as mayor between 1815 and 1870.

The medical marketplace struggles to assimilate institutions, despite their being of critical importance to the evolution of medical practice and to the changing doctor-patient relationship. Institutions are problematic because they operated on a charitable, not-for-profit, basis or were provided through the mechanism of the Poor Law and were thus peculiarly unresponsive to consumer demand. Hospital benefactors, administrators and doctors regarded their (working-class) patients not as customers but as objects of charity to whom assistance was granted not sold. Thus, those who used them had a very different patient experience to those who could afford to buy healthcare on the open market. The Infirmary, Dispensary and Workhouse all made a significant and increasing contribution to the overall therapeutic effort in Gloucester. As the century progressed, more institutions appeared and tended to specialize rather than compete directly with each other for customers, although they certainly did for donors, subscribers and staff. Access to the healthcare provided by these places was, in theory at least, tightly controlled so as to exclude "undeserving" and hopeless cases. If admittance was gained, attempts were made at moral reform as well as physical cure. In practice, rules were enforced with varying zeal and some patients probably knew how to play the system to their advantage. Caution is however required in ascribing them too much agency. What these institutions provided and to whom was determined less by need and more by the priorities of founders, benefactors and, in the case of the Workhouse Infirmary, by a centralised bureaucracy and the idiosyncrasies of local guardians. Institutions stratified healthcare by dividing the sick between those eligible for admission and those who were excluded, often on non-health related criteria.

Outside of the institutions, the second half of chapter three looked at commercial healthcare providers through a quantitative analysis of trade and medical directories and census returns. It set out to identify the parameters and composition of Gloucester's healthcare economy, looking at the relative numbers of regular doctors, chemists and

druggists and irregular providers operating in the city, and how this changed over time. Detailed attention was given to competition, both within regular medical practice and between regular and irregular providers. What emerged was that competition was noticeably less intense in Gloucester than has been described elsewhere. Quacks and other irregulars were found to be a relatively small and a marginal presence and did not represent serious competition to regular doctors. In fact, the evidence challenged the notion of an overstocked and ultra-competitive 'marketplace and it was shown how after a dramatic increase in the number of both doctors and chemists and druggists in the 1820s and 30s, by the 1840s this temporal trend levelled off, despite the city's population continuing to rise unabated. Well before the 1858 Medical Act, the numbers of doctors and chemists and druggists in Gloucester had stabilised and there were consistently fewer of each per head of population than other studies have found elsewhere. Gloucester's socioeconomic composition was the most likely reason, allied to its proximity to Cheltenham, where the density of providers was akin to that of London. These findings both call into question the wisdom of using per head of population ratios as a measure of competition and highlight the degree of variation that could occur even between neighbouring towns. What was clear however was that by 1820, regular doctors and chemists and druggists between them dominated the supply of healthcare in Gloucester. By 1860, they had reached near numerical parity but there was no clear evidence of an inverse correlation in the size of the two groups. It seems likely competition between them may never have been as intense as some of the literature suggests.

Both the medical profession and the chemists and druggists trade appear to have been stable and close-knit. Individual doctors and pharmacists often enjoyed considerable longevity in business and many were born in the county or city and spent their working lives in familiar streets serving the people they grew up around. Most chemists and druggists lived above or near to their shops, which were usually located in the prime retail locations centred around The Cross. This does not support the stereotype of the chemist and druggist as a fly-by-night character, only interested in making quick profits peddling cheap and dangerous rubbish to a gullible public. On the contrary, these people were for the most part established, trusted, and reputable tradesmen who were well integrated into their local community, fulfilling a role not dissimilar to that of a modern community pharmacist. Overall, the evidence did not

support the existence of a 'medical marketplace' characterized by plurality, diversity, choice and competition – if such an environment had ever existed, it had disappeared from Gloucester much earlier than the historiography would suggest and likely it only ever featured in certain strata of the healthcare economy.

In Gloucester, as elsewhere, a wide range of retailers sold medicines, but most significant were chemists and druggists, who acted as agents for the big London manufacturers as well as selling their own nostrums. The medicines trade was shown to have been an adaptation of domestic medicine to the needs of an urban society and it represented perhaps the most overtly commercialized stratum of the healthcare economy. The industry advertised prolifically in the Gloucester press as part of the range of healthcare-related offerings that accounted for a consistently large proportion of advertising space. Chapter four comprised a sample survey of advertisements from the Age of Reform. It revealed a vibrant scene predicated on the self-reliant *zeitgeist* of the age, which encouraged self-diagnosing and self-medicating, and was fuelled by a parallel industry in advice literature that appealed to ingrained traditions of self-help. Medicine manufacturers were early pioneers in the use of illustration and catchphrases in their advertising and while they were temporarily eclipsed in terms of innovation in the middle years of the century, this was short-lived and appears limited to newspaper advertising. The language and techniques used were both surprisingly sophisticated for products supposedly aimed at the uneducated poor. The use of orthodox, if outmoded, medical theory suggests manufacturers tried to position these medicines within the conventional medical milieu and to attract customers who were at least literate enough to appreciate their many references to the medical pantheon past and present, and pseudo-scientific theories relating to the circulation of the blood and role of the nervous system.

The focus of attention in chapter four was on the strategies advertisers used to build trust and establish legitimacy, warnings regarding imitation and counterfeiting, pricing, and the targeting of specific customer groups. These themes and features revealed much about why customers bought these products in such volumes. It was shown that although this was a competitive industry, with little regard for ethical advertising, battles between competitors were fought over reputation, not price, which demonstrated remarkable stability over time and between suppliers. It was shown that

many proprietary medicines were not cheap, while at the same time allegations of counterfeiting and publicly aired disputes over secret formulae were rife, suggesting advertisers thought customers were more likely to be receptive to claims of efficacy and pedigree than the prospect of a bargain. This is supported by the fact that their agents often comprised long-established and reputable local businesses. Contrary to the protests of the contemporary medical establishment, few proprietary medicines were dangerous and not all were useless. Many were consciously marketed as mild and gentle alternatives to heroic doses of heavy-metal based treatments still favoured by doctors, for example in the treatment of syphilis.

Overall, the impression the advertisements gave is of an educated, discerning, and more likely middle-class, consumer. Furthermore, this market was highly segmented. Rather than appealing to all those too poor to afford medical advice, manufacturers and suppliers were more interested in groups who could afford doctors but who, for a variety of reasons, were least well-served by the regular medical offering. Five principle groups of people were identified as being of recurring interest; those whose ailment was cosmetic, or too minor, to justify the cost of recourse to medical assistance, for example remedies for pimples, or hair loss; those too embarrassed to contemplate medical assistance, commonly venereal disease sufferers, women with menstrual abnormalities, and the mentally ill; those beyond the powers of medical assistance, or where a surgical option was too terrifying to contemplate; those travelling to places devoid of Western medicine; and those who, for a variety of reasons, were disenchanted with orthodox medicine, with one of the principal groups comprising those who had experienced the iatrogenic effects of regular medical treatment. Within these overlapping groups, many advertisements were explicitly directed toward women and mothers were the target of a range of products for sick infants and children. The balance of evidence suggested that the proprietary medicines trade did not for the most part directly compete for customers with regular doctors and the threat it posed to medical livelihoods may well have been exaggerated. Its continuing success was surely in part a reflection of the therapeutic impotence of regular medicine and these remedies satisfied an unmet need in a not entirely dissimilar way to the alternative and complementary medicines of today, by providing comfort and hope to those the medical profession did not need to, could not, or would not, help.

As mentioned already, proprietary medicines were widely stocked by Gloucester's chemists and druggists, who were the nexus between orthodox medical practice and this market in self-help healthcare. The other major component of their trade was the dispensing of medical prescriptions and chapter five examined the four surviving sets of Gloucester chemists' prescription books dating from before 1870. Prescription books have rarely featured among the sources in the literature of the medical marketplace. The aim was to use them innovatively to establish the size of the market in prescription medicines, the source of the prescriptions in terms of which doctors were involved, and what prescription books offer in terms of understanding the characteristics of the customer.

The results revealed a consistently high level of demand for prescription medicines, something that challenges the notion that the public either eschewed medical advice in favour of proprietary medicines or went to empirics, rather than seeking qualified medical advice. The volume of medicines being dispensed on prescription, and crucially, the proportion being dispensed to working-class households, strongly suggests that most of Gloucester's citizens considered qualified medical advice their preferred option, at least in the event of serious ill health, and that they found ways to access it. One set of books, those of William Stafford, uniquely recorded the address of the customer enabling the matching of customer records to the 1851 census. Such an exercise has not been undertaken anywhere else in the historiography. The analysis showed that Stafford's customers were socially diverse but mostly lived within a geographically confined area within easy walking distance of his shop, highlighting its importance as a local community resource for both working and middle-class residents. If prescriptions were collected for a spouse, it appears both Stafford and Edmund Coleman recorded the name of the collector rather than the patient and it was found that in 1850 74 per cent of Stafford's customers and 63 per cent of Coleman's dispensing customers were women. Saturday was the busiest dispensing day for both. These two findings suggest medical prescriptions were collected as part of the regular routine of shopping, which in turn implies they were not just obtained in emergencies, but for ailments where the treatment could wait until pay-day (normally Friday). They also help to explain why so much healthcare advertising was directed at women. Interestingly, prescriptions appear never to have expired and could be represented at the holder's discretion, thus effectively becoming another form of self-medication. This is

an aspect of nineteenth-century healthcare that has received scant attention in the literature and is strongly deserving of more detailed analysis.

Chemists and druggists held the diligent dispensing of medical prescriptions to be of critical importance to a business model founded not on selling high volumes of cheap, inferior medicines, but on reputation and customer service. This was evident from the notices they posted in newspapers when moving to the city, emphasising the proprietor's personal attention in dispensing medical prescriptions. Occupying prestigious retail locations, Gloucester's chemists and druggists regarded themselves as respectable tradesmen. Some of them qualified as pharmaceutical chemists, suggesting these individuals aspired to professional status, something also borne out by their civic and philanthropic activities. All four sets of surviving books show that dispensing of medicines was a significant part of their trade. This suggests this area of potential competition with doctors had by the 1830s been firmly ceded to Gloucester's chemists and druggists. The settlement of this trade facilitated a new relationship between the two groups, one exemplified by that between Stafford and Charles Clutterbuck. By the 1840s, any competition between them had clearly subsided and instead, the dispensing trade drew them into an ever-closer relationship. By then, most of Gloucester's doctors were writing prescriptions for chemists to dispense, although the volumes varied significantly from one to another and over time. These variations might be because only four sets of books survive, but it also likely reflects differences in the volume and types of patients different doctors saw.

Further evidence of the dominant position of orthodox medicine was found in chapter six, which completed this holistic overview of healthcare by looking at customers. Drawing upon a wide range of personal accounts from letters, diaries, journals and coronial records, it highlighted the diversity of experience encountered by healthcare consumers and demonstrated again that although there was diversity and plurality in this market there was also segmentation, with a clear structure and order to healthcare provision that customers understood and accessed according to their means and expectations. The sparsity of surviving material, which necessitated a widening of geographical parameters to the county as a whole, had disadvantages, but also served to illustrate the degree of variation between urban and rural experience, as well as the interconnectedness of city and shire. The introduction of coronial records to the

medical marketplace debate represented a new and important contribution, giving a unique perspective on the healthcare experiences of the poor and marginalised.

The sources presented in chapter six showed how different types of supplier were called upon at different times and in different circumstances, but overall there was no general preference for cheaper alternatives to regular medical advice. Although across social classes the initial response to the onset of illness was often to do nothing, for most regular medical advice was the preferred option in the event of serious ill health or injury. However, whereas the rich could choose *which* regular doctors they wanted and regularly sought second or third opinions if the results were not satisfactory, the sick poor (especially in rural areas), were rarely able to choose their doctor. There was some evidence of working-class patients seeking second opinions, but for the poor medical assistance was often bound up with the management of poverty. Those forced to look to the parish or charitable institutions faced moral judgement and sluggish bureaucratic processes that could delay or prevent their access to appropriate healthcare.

A spirit of self-reliance was common to all classes and most people chose to deal with minor illnesses and even childbirth themselves. Children were commonly treated using domestic remedies. Beyond that, community networks offered potential, if at times unreliable, support. In rural Gloucestershire, we saw that it might come from family, neighbours, a Lady Bountiful, the vicar, or a local midwife. There was a palpable sense that healthcare was cobbled together from a range of sources and options (the so-called 'economy of makeshifts'), the availability of which depended on financial resources, social capital and kin networks. In Gloucester itself, these networks might be weaker and as we saw in earlier chapters, the sick poor adopted new avenues through which to access healthcare. As has been seen, this might involve proprietary medicines, especially for minor ailments, but it also involved negotiating a system of charitable and public provision, and of finding other ways to access qualified medical advice.

For many, choice was based on a complex set of interacting forces – economic circumstances, religious belief and cultural norms might all feature in a decision about when and from where, to seek healthcare. Overall however there was little to support any continuation, for example, of the situation Fissell found in eighteenth-century Bristol, whereby 'patients chose from a bazaar of medical practitioners,' into the

Victorian period.[2] Most of the time people tried to access the best, not the cheapest, option available to them and seemed to have settled responses to ill-health. The balance of the evidence does not support the continued existence of Porter's medical marketplace as a place where 'the sick, given the opportunity, would shop around' and 'those who could afford it frequently called in a whole range of regular physicians, seeking second, third, and fourth opinions [and] showed no hesitation about also sampling the therapies and the drugs of empirics.'[3] By the mid-nineteenth century and likely earlier, the public had come to value the services of regular doctors and chemists and druggists over alternatives. Importantly too, customers did not seem to view healthcare in terms of the clear-cut divisions imagined by the medical establishment. It is certainly questionable as to whether they regarded chemists and druggists as 'irregulars.' More likely most regarded them as a legitimate and trustworthy component of the mainstream healthcare offering. Other sources of healthcare were resorted to only in specific circumstances. Initially, if an ailment was not perceived as being serious, this might be done to try to save money, in other cases it might be a response to the failure of regular medical treatment, but only with childbirth and the treatment of sick children was there some sense that other options were perhaps preferred to a qualified doctor. In this stratified healthcare economy, gender, age, income, education, geographical location, and the nature of one's illness, all influenced the nature of interactions and outcomes. For some people, the medical marketplace paradigm hardly offers a relevant interpretation of their experience at all. Agency for them extended only as far as finding ways to navigate the complex, cumbersome and unsympathetic bureaucratic structure of the New Poor Law, where occasionally mutual distrust and prejudice combined to produce very bad outcomes.

More widely, the value of qualified medical advice was generally recognised. Of the 'medical marketplace' in Gloucester, the evidence is that by 1850 it had already passed into history. It was not the Medical Act that signalled its demise, nor even new scientific discoveries like anaesthesia and antiseptics; the transformation occurred much earlier and had different causes. The end of the medical marketplace was not an abrupt one and it is likely only sections of the population ever experienced healthcare in the

[2] M.E. Fissell, *Patients, Power and the Poor in Eighteenth-Century Bristol* (Cambridge, 1991), p.68.
[3] R. Porter, ''Before the Fringe: Quackery and the 18th-Century Medical Market' in R. Cooter (ed.), *Studies in the History of Alternative Medicine* (London, 1988), pp.3-4.

way advocates of the model have described. Having reached a pragmatic accommodation with the chemists and druggists, doctors had eased slowly, but surely, into a position of hegemony far less troubled by plurality, diversity, choice and competition than the historiography suggests. They achieved this position before they were able to deliver truly effective treatments and before they enjoyed meaningful legal separation from their unqualified rivals. If healthcare in Gloucester in the Age of Reform can be summarised, it would not be as an anarchic *laissez-faire* jungle, but as a remarkably stable, structured and hierarchical environment over which the medical profession and the chemists and druggists presided with increasing confidence and authority.

Appendix I: Incumbents of medical posts at The Gloucester Infirmary and Gloucester Eye Institution between 1815-1870.

Title	Name	Dates	Notes
Consulting Physician	Thomas Evans	1867-1880	
Consulting Surgeon	Ralph Fletcher	1833-1851	
	William Cother	1833-1846	
	George Washbourn Charleton	1868-1881	
	John Pleydell Wilton	1874-	
	Ryves William Graves	1878-1882	
	Thomas Smith Ellis	1878-	
	Richard Mount Cole	1898-	
Acting Physician	John Baron F.R.S.	1809-1833	
	Hardwicke Shute	1815-1842	Appointed Consulting Physician 1867
	Thomas Evans	1833-1867	
	Ralph Fletcher	1842-1855	
	Thomas Buchanan Washbourn	1856-1884	
	Rayner Winterbotham Batten	1867-1899	Appointed Consulting Physician 1899
Acting Surgeon	Charles Brandon Tyre F.R.S.	1784-1811	
	Richard Nayler	1784-1816	
	Ralph Fletcher	1811-1833	Appointed Consulting Surgeon 1833
	William Cother	1816-1833	Appointed Consulting Surgeon 1833
	John William Wilton	1833-1858	
	William Henry Fletcher	1833-1852	
	George Playne	1833-1839	
	Thomas Cox Buchanan	1833-1848	
	Alfred Joshua Wood	1839-1858	
	George Hymeneus Lovegrove	1858-1861	
	John Pleydell Wilton	1858-1874	Appointed Consulting Surgeon 1874
	Caleb Barrett	1861-1868	

	Ryves William Graves	1861-1878	Appointed Consulting Surgeon 1878
	Thomas Smith Ellis	1868-1875	
	Henry Edward Waddy	1875-	
	Richard Mount Cole	1876-1898	Appointed Consulting Surgeon 1898
Assistant Physician	William B. Cooke	1868-1869	
	Henry Peacock	1869-1890	
Assistant Surgeon	Thomas Smith Ellis	1868	Elected Surgeon 1868
	William F. Keddell	1869-1872	
	Henry Edward Waddy	1872-1875	Elected Surgeon 1875
	Richard Mount Cole	1875-1876	Elected Surgeon 1876
Ophthalmic Physician	Rayner Winterbotham Batten	1873-1883	
Ophthalmic Surgeon	Thomas Smith Ellis	1878-1881	
Apothecary (title changed to House Surgeon and Apothecary 1827)	Charles Brandon Tyre	1780-1782	Elected Surgeon 1784
	Samuel Mutlow	1796-1827	Secretary also 1804-1828
House Surgeon and Apothecary	George Playne	1827-1833	Secretary also 1828-1833, elected Surgeon 1833
	George Washbourn Charleton	1833-1868	Appointed Consulting Surgeon 1868, temporary secretary 1845-1846
	Richard Mount Cole	1869-1874	Elected Assistant Surgeon 1875
	Sydney Morris	1874-1875	
	Henry Moore Sampson	1875-1877	
House Surgeon	Ernest Dykes Bower	1877-1880	Elected Ophthalmic Surgeon 1881
Dispenser	F. Charles Mumford	1864-1878	

Source: G. Whitcombe, The General Infirmary at Gloucester and The Gloucestershire Eye Institution: Its Past and Present (Gloucester, 1903), p.76. GA D3558/196

Appendix II - List of medicines stocked by J. Roberts, 1815.

For Coughs, Colds, Asthmas, Hooping Cough & Consumption.				
		s.	d.	
Essence of Coltsfoot		3	6	
Hill's Balsam of Honey		3	6	
Paregoric Lozenges		1	1	½
Asthmatic Candy		1	1	½
Tolu Lozenges		1	1	½
Balsam of Liquorice	4s. and	2	6	
Essence of Tolu		2	9	
Bath Pectoral Balsam		1	6	
Bennett's Cough Drops		2	9	
Church's Cough Drops	4s. 6d. and	2	6	
Candell's Balsam of Honey		2	9	
Dawson's Lozenges		1	1	½
Ipecacuanha Lozenges		1	1	½
For Weakness, Debility, and Nervous Disorders				
Hodson's Drops		10	6	
Huxham's Tincture of Bark	3s. 6d. and	4	6	
Oxley's Concentrated Essence of Ginger		2	9	
Cordial Balm of Gilhead		11	0	
Ditto, Family Bottle		33	0	
Diseases incident to Females				
Analeptic Pills		4	6	
Welsh's Pills		2	9	
Hooper's Female Pills		1	1	½
Golden Pills		1	1	½
For the Rheumatism				
Jones's Rheumatic Tincture		3	6	
Bateman's Drops		1	6	
Cumberland's Bituminous Fluid		2	9	
Essence of Mustard and Pills, each		2	9	
Ratcliff's Antithritic Tincture	4s. 6d. and	2	9	
For Scorbutic Complaints				
Ward's White Drop		1	1	½
Anti-Impetigines		10	6	
Ditto, Family Bottle		33	0	
Ploughman's Drops	11s. [1 1s.?] and	22	0	
Deering's Drops		2	0	
Hayman's Meredant's Drops		4	6	
Spilsbury's Drops		6	0	
Lignum's Drops		6	0	

De Velno's Syrup		13	0	
Brodum's Botanical Syrup	22s. and	6	0	
Radcliff's Elixir		1	1	½
For Cutaneous Eruptions				
Edinburgh Ointment		2	9	
Pike's Ointment		1	9	
Masson's Ointment		1	1	½
Barclay's Jackson's Ointment		1	0	
Wheatley's Ointment	1s 9d. - Ditto, Liquid	2	9	
For Eruptions on the Face				
Abstergent Lotion, Half-pints		2	9	
Gowland's Lotion, Quarts		8	6	
Gowland's Lotion, Pints		5	6	
Gowland's Lotion, Half-pints		2	9	
King's Evil				
Chamberlain's Ointment		2	9	
Ditto, Pills		2	9	
Venereal Affections				
Jesuit's Drops		2	9	
Specific Remedy		2	9	
Velno's Pills		5	6	
Velno's Syrup		13	0	
Brodum's Botanical Syrup		22	0	
Leake's Pills and Drops		2	9	
Gutta Saintaris		2	9	
Hunter's Pills		2	9	
Lignum's Pills		2	9	
Billious Complaints				
Norris's Drops		2	9	
Rymer's Tincture		4	6	
Camomile Drops		1	1	½
Rev. Mr. Barclay's Pills		5	6	
Gall's Pills	2s. 9d. and	1	1	½
Hallam's Pills		2	9	
Dixon's Pills		2	9	
Disorders of the Bowels				
Hunt's Family Pills		1	1	½
Scot's Pills, Anderson's and Inglish's		1	1	½
Oriental Cordial		4	6	
Dalby's Carminative		1	9	

Daffy's Elixir	2s. 9d. and	2	0	
Squire's Elixir		2	0	
Stoughton's Drops		1	1	1/2
Essence of Peppermint		1	1	1/2
Beaume de Vie		3	6	
Disorders of Children				
Henry's Magnesia		2	9	
Waite's Gingerbread Nuts		1	1	1/2
Ching's Lozenges	2s. 9d. and	1	1	1/2
Worm Tea		1	1	1/2
Godfrey's Cordial		1	0	
American Soothing Syrup		2	9	
Glass's Magnesia		3	6	
Tooth-ache				
The much esteemed Odontalgic		2	9	
Gray's Lozenge		1	9	
Greenough's Tincture		1	1	1/2
For Sprains, Bruises, Wounds, Chilblains, &c.				
Turlington's Balsam		1	10	
Marshal's Universal Cerate		1	1	1/2
Johnson's Family Cerate		1	1	1/2
Steer's Opodeldoc		2	9	
British Oil		2	9	
For the Teeth				
Cox's Tooth Powders		[blank]	[blank]	
Butler's ditto		2	9	
Newton's ditto		2	9	
Amboyna ditto		2	6	
Miscellaneous				
James's Fever Powders		2	9	
Ladies' Court Plaister		0	6	
Bath's Pills		1	6	
Dutch Drops		1	1	1/2
Sibley's Solar Tincture		7	6	
Sibley's Lunar Tincture		10	6	
Issne Plaister		1	0	
Seidlitz Powders		4	6	
Taylor's certain Remedy for Deafness		3 [?]	6	
James's Analeptic Pills		4	6	
Blaine's Powder for Distemper in Dogs		1	6	
Cephalic Snuff		1	1	1/2

Cheltenham Salts	2	9	
Calve's Cordial	3	0	
Norris's Fever Drops	2	9	
German Corn Salve	1	1	1/2
Heartburn Lozenges	1	1	1/2
Hickman's Pills for the Gravel	2	9	

N.B. Dealers in Patent Medicines supplied at the London Prices.

Source: *The Glocester Herald*, 25 November 1815.

Appendix III Secondary newspaper sampling frame

Title	Edition sampled
The Glocester Herald	17/12/1814
The Glocester Herald	27/8/1814
The Glocester Herald	23/7/1814
The Glocester Herald	9/7/1814
The Glocester Herald	2/4/1814
The Glocester Herald	26/3/1814
The Glocester Herald	19/2/1814
The Glocester Herald	2/4/1814
The Glocester Herald	19/3/1814
The Glocester Herald	2/12/1815
The Glocester Herald	25/11/1815
The Glocester Herald	11/11/1815
The Glocester Herald	28/10/1815
The Glocester Herald	21/10/1815
The Glocester Herald	14/10/1815
The Glocester Herald	23/9/1815
The Glocester Herald	2/9/1815
The Glocester Herald	26/8/1815
The Glocester Herald	19/8/1815
The Glocester Herald	12/8/1815
The Glocester Herald	29/7/1815
The Glocester Herald	10/6/1815
The Glocester Herald	27/5/1815
The Glocester Herald	29/4/1815
The Glocester Herald	22/4/1815
The Glocester Herald	15/4/1815
The Glocester Herald	1/4/1815
The Glocester Herald	5/8/1815
The Glocester Herald	4/2/1815
The Glocester Herald	5/8/1815
Gloucester Mercury	31/12/1828
Gloucester Mercury	17/12/1828
Gloucester Mercury	10/12/1828
Gloucester Mercury	26/11/1828
Gloucester Mercury	19/11/1828
Gloucester Mercury	6/9/1828
Gloucester Mercury	5/11/1828
Gloucester Mercury	6/9/1828
Gloucester Mercury	7/1/1829
The Gloucester Free Press and Weekly Advertiser	8/12/1855
The Gloucester Free Press and Weekly Advertiser	17/11/1855
The Gloucester Free Press and Weekly Advertiser	14/7/1855
Gloucester Mercury	13/12/1856

Title	Edition sampled
Gloucester Mercury	22/11/1856
Gloucester Mercury	8/11/1856
Gloucester Mercury	12/7/1856
Gloucester Mercury	5/7/1856
Gloucester Mercury	7/6/1856
Gloucester Mercury	31/5/1856
Gloucester Mercury	5/12/1857
Gloucester Mercury	28/11/1857
Gloucester Mercury	3/10/1857
Gloucester Mercury	26/9/1857
Gloucester Mercury	8/8/1857
Gloucester Mercury	1/8/1857
Gloucester Mercury	9/5/1857
Gloucester Mercury	2/5/1857
Gloucester Mercury	21/3/1857
Gloucester Mercury	28/2/1857
Gloucester Mercury	21/2/1857
Gloucester Mercury	20/11/1858
Gloucester Mercury	6/11/1858
Gloucester Mercury	5/6/1858
Gloucester Mercury	8/5/1858
Gloucester Mercury	1/5/1858
Gloucester Mercury	24/4/1858
Gloucester Mercury	17/4/1858
Gloucester Mercury	20/2/1858
Gloucester Mercury	1/10/1859
Gloucester Mercury	21/5/1859
Gloucester Mercury	5/3/1859
Gloucester Mercury	26/2/1859
The City of Gloucester Guardian	19/11/1859
The City of Gloucester Guardian	5/11/1859
The City of Gloucester Guardian	22/10/1859
The City of Gloucester Guardian	15/10/1859
The City of Gloucester Guardian	1/10/1859
The City of Gloucester Guardian	24/9/1859
The City of Gloucester Guardian	29/10/1859
The City of Gloucester Guardian	24/9/1859
Gloucester Mercury	4/8/1860
Gloucester City and County News	11/11/1863
Gloucester City and County News	28/10/1863
Gloucester City and County News	21/10/1863
Gloucester City and County News	7/10/1863
Gloucester City and County News	30/9/1863
Gloucester City and County News	7/10/1863

Title	Edition sampled
Gloucester City and County News	30/9/1863
Gloucester City and County News	7/10/1863
Gloucester Mercury	5/8/1865
Gloucester Mercury	6/8/1870

Appendix IV Sample of proprietary medicines listing the conditions they claimed to treat, 1850.

PRODUCT	**TREATMENT FOR:**
Kearsley's Widow Welch's Pills	Female complaints: • effectually removing obstructions • inconveniences to which the female frame is liable • create appetite • correct indigestion • remove giddiness and nervous headache • windy disorders • pains in the stomach • shortness of breath • palpitation of the heart
1. *The Cordial Balm of Syriacum* 2. *The Concentrated Detersive Essence* 3. *Perry's Purifying Specific Pills*	• nervous and sexual debility • impotence • barrenness • consumption • indigestion • female complaints • 'An anti-syphilitic remedy for purifying the blood in cases of infection, secondary symptoms, eruptions, and the abuse of mercury; and all diseases of the skin.' • Gonorrhoea • Gleet • Stricture • Chronic inflammation of the bladder.
Norton's Camomile Pills	• Indigestion • Sick Headache • Flatulent Distensions and Acidity of the Stomach • Depressed Spirits • Disturbed Sleep • Violent Palpitations • Irregular Appetite • General Debility • Spasms • Costiveness, &c.

PRODUCT	TREATMENT FOR:
Holloway's Pills	• Ague • Asthma • Bilious Complaints • Blotches on the Skin • Bowel complaints • Colics • Constipation of the Bowels • Consumption • Debility • Dropsy • Dysentery • Erysipelas • Female Irregularities • Fevers of all kinds • Fits • Gout • Head-ache • Indigestion • Inflammation • Jaundice • Liver Complaints • Lumbago • Piles • Rheumatism • Retention of Urine • Scrofula, or King's Evil • Sore Throats • Stone & Gravel • Secondary Symptoms • Tic Doloreux • Tumours • Ulcers • Venereal Affections • Worms of all kinds • Weakness from whatever cause

PRODUCT	TREATMENT FOR:
Bewley Fisher and Co.'s Concentrated Essence of Jamaica Ginger	• Gout • Nervousness • Cramps • Spasms • Flatulency • a sense of oppression after meals
Eden's Pills	• Bile • Head-ache • Looseness of the Bowels • Cramp • Spasms • Indigestion • Flatulency • Rheumatism • Gout • Lumbago. 'They act as a mild aperient, and with a continued course will thoroughly cleans the Body from all impurities of every kind and nature, and are not attended with any unpleasant feelings of nausea or sickness. If taken occasionally, they are a certain preventative against English and Asiatic Cholera.'
Eden's Hooping Cough Mixture	• Coughs • Colds • Asthma • Influenza • Bronchitis • Sore Throats • Inflammation of the Chest and Lungs.
Eden's Ointment	• Wounds • Sores • Bruises • Cuts • Ulcers • Chapped Hands • All cutaneous disorders of the skin

Source: *Gloucestershire Chronicle*, 6 July 1850 and *Gloucester Journal*, 5 January 1850.

Appendix V: Occupations of head of household in Sweetbriar Street from the 1851 census*

Name	Occupation/Occupation of Head of Household
Thomas Cleveland	Journeyman Fellmonger
Edwin Brown	Carpenter
John Steel	Whitesmith
John Phelps	Tailor
James Robinson	Pin Maker
John Mason	**Tailor**
William Griffiths	Labourer
John Read	Porter
Joseph Clayton	Wire Drawer
Joshua Webb	Labourer
John Jones	[?] Keeper
Thomas Chapman	Excavator
John G. Lane	Courier
Henry Halloway	Pin Whitener
George Baxter	Journeyman Shoemaker
Sarah Dark	Pauper
Edward Brindley	Tallow Chandler
Priscilla Kerby	Laundress
William Jackson	Bricklayer
John Coates	Labourer
James Hill	Master Green Grocer
Edwin Harvey	Labourer
Daniel L[?]	Porter
Joseph L?]	Farm Labourer
Thomas Hussing	Journeyman Nailor
John Price	Labourer
John Hall	Sawyer
Ann Gough	Not recorded
James Cleveland	Journeyman Fellmonger
Ann Pedlar	Charwoman
James de Bar	Plumber
Thomas Winney	Gardener
George Cole	Labourer
[?] Lewis	**Labourer**
James Kilminster	Plasterer
[?] Tombey	Master Coal Merchant
Sarah Powell	Shopkeeper

Name	Occupation/Occupation of Head of Household
James Cooke	Waterman
John Allen	Shoe Maker
Eliza Charlton	Charwoman
Samuel Dowers	Labourer
Robert Jones	Iron Moulder
William Jones	Gardener
John Allen	Master Earthen Ware Man
Thomas Townsend	Journeyman Pin Maker
John Gay	Labourer
John Sweetman	**Labourer**
Nicholas J. Robinson	Journeyman Pin Maker
Denis Stock	Journeyman Cord Wainer
Richard Budding	Journeyman Basket Maker
John Elliott	Sawyer
John Barton	Labourer
Richard Cullis	Labourer
Shadrack Wood	Master Milkman
James Ravenhill	Journeyman Gardener
Joseph Bard	Journeyman Parchment Maker
Harriett Cot	Laundress
George Jarman	Journeyman Ship Wright
William Tingle	Master [?]
Henry Cole	Labourer
Thomas Meadows	Farm Labourer
Thomas Plaisted	Master Coal Merchant [?]
Thomas Neale	Labourer
Thomas Nail	Labourer
Eliza Price	Dress Maker
Thomas Healey	Journeyman Cordwainer
Walter Wood	Labourer
Emma Anderson	Not recorded
William Plaisted	Labourer
Robert Carpenter	Journeyman [?]
Lewis Griffiths	Labourer
Isaac Small	Journeyman Iron Moulder
George Butt	**Journeyman Parchment Maker**
Daniel Hewitt	Labourer
Charles Wood	Labourer
James de Board	Journeyman Iron Founder

Name	Occupation/Occupation of Head of Household
Edward Berry	Carpenter
Henry Randall	**[?]**
John Graham	Journeyman Parchment Maker
Thomas Taylor	Journeyman Butcher
James Bethell	Journeyman Ship Wright
[?] Smight	Master Gardener
[?] Clarke	Labourer
John Wheeler	Labourer
John Nicholls	Farm Labourer
Sarah Vaughan	**Not recorded**
James Lewis	Taylor
Benjamin Bayer	Journeyman Stone Mason
Daniel Kent	Carpenter
Thomas Brain	Journeyman Wire Drawer
Mary Ashwin	Laundress
Josiah Chivers	Labourer
John Llewellyn	Journeyman Tailor
John Williams	Gardener
William Batley	Journeyman Shoe Maker
John Barnett	Journeyman Gardener
Joshua Meredith	Journeyman Brick Layer
Henry Ramsay	Labourer
Henry Parker	Porter
George Elliott	Dealer in Stones
John Lane	Labourer
William Smith	Clerk to Merchant
John Turk	Labourer
William Morris	Labourer
William George	**Journeyman Shoemaker**
Henry Corey	Labourer
Thomas Perry	Journeyman Wheelwright
Charles Anderson	Master Baker
John Reed	Master Brick Layer
Mark Martin	Labourer
Mary Price	Laundress
James Sharman	Labourer
Thomas Smith	Journeyman Leather Dresser

*Red **bold** font indicates a match with Stafford's prescription book.

Source: W. Stafford, Prescription books, 1849 – 1851, Gloucestershire, GA, Walwins of Gloucester collection, MSS, D2752/4/56 – D2752/4/57 and Ancestry.com, *1851 Census* [database on-line]. Provo, UT, USA: Ancestry.com Operations Inc, 2005. Original data: Kew, The National Archives, *Census Returns of England and Wales, 1851*, HO 107.

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