‘SICK, AGED AND INFIRM’
ADULTS IN THE NEW BIRMINGHAM WORKHOUSE, 1852 – 1912

by

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ABSTRACT

This study has explored the role of a large urban workhouse and its separate infirmary in Birmingham in the provision of indoor medical care for adult paupers between 1852 and 1912. Due to the difficulty in distinguishing between the medical and social care of older people, it has examined the provision for all older inmates. Birmingham guardians were forward thinking in appointing resident medical officers and paid nurses earlier than other unions, but retrograde by continuing to apply the workhouse test to sick patients longer than others. Workhouse medical officers in Birmingham worked long hours, provided care for many more patients than doctors in voluntary hospitals, and stayed in post for an average of four and a half years. Nevertheless, some strove to provide high standards of treatment. Patient narratives have been identified, showing that positive experiences of medical care did occur. Despite being the largest group of adult inmates, older people were relatively neglected compared with able-bodied inmates until the later part of the nineteenth century, when better standards of living were introduced. The development of the infirmary into an acute hospital created conflict between the two institutions and resulted in the workhouse's role being limited to the care of patients with chronic conditions.

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ABBREVIATIONS

AWMO	Assistant Workhouse Medical Officer
BBG	Birmingham Board of Guardians
BCL	Birmingham Central Library
CL	Commissioner in Lunacy
GHAR	General Hospital Annual Report
HSC	House Sub-committee
IMO	Infirmary Medical Officer
ISC	Infirmary Sub-committee
LGB	Local Government Board
LGBR	Local Government Board Returns
PLB	Poor Law Board
PLI	Poor Law Inspector
PP	Parliamentary Papers
VGPC	Visiting and General Purposes Committee
WISC	Workhouse Inquiry Sub-committee
WMC	Workhouse Management Committee
WMO	Workhouse Medical Officer

INTRODUCTION

The Poor Laws passed at the end of the sixteenth and the beginning of the seventeenth centuries introduced an organised system of poor relief in England and Wales. They differentiated between the impotent poor who were unable to work, the able-bodied unemployed for whom work was not available and vagrants who preferred not to work. The main kind of help was outdoor relief in the form of money and food. Institutions for providing indoor relief were usually small in size, often a large adapted house or cottages.[1] There was considerable variation throughout the country in the extent and type of relief administered and the acts governing relief were subject to much local interpretation. By the end of the eighteenth century, the emphasis had moved toward the greater provision of workhouses, stimulated by amalgamation of parishes, enabled by Gilbert's Act of 1782. At the beginning of the nineteenth century, social and economic changes, such as increasing unemployment in rural areas, industrialisation and social mobility, resulted in increasing difficulty in financing relief through the poor rate levy. The resulting dissatisfaction with the system resulted in the setting up of the Royal Commission on the Poor Laws in 1832, which concentrated on the problems of unemployment and vagrancy among able-bodied destitute adults.[2] Driver makes the point that the object of the resulting Poor Law Amendment Act of 1834 was the relief of indigence, not the abolition of poverty.[3] However, for the majority of those who were unable to work, the main reason was ill health or disability. As a result of what Hodgkinson calls a 'faulty

[1] Morrison, *The Workhouse*, p.3.
[2] Webb and Webb, *Minority Report*, p.3.
[3] Driver, *Power and Pauperism*, p.23. He defines indigence as that condition whereby individuals were unable to secure their survival in the labour market.

diagnosis' and Digby refers to as 'incorrect diagnoses' of the reasons for the increasing poor rates, a system was set up to tackle the wrong problem.[4]

The Poor Law of 1834 established the principles of deterrence and rigid centralisation designed for the management of pauperism, in order to control the 'unacceptably burdensome poor rates'.[5] It attempted to limit outdoor relief other than medical attention, by requiring every parish and union to provide institutions for paupers. The original intention of separate buildings for different types or classes of pauper never materialised and the general mixed workhouse gradually predominated across the country. Crowther describes this as the 'first national experiment in institutional care'.[6] The Act also established the principles of 'less eligibility' for relief and of a lower standard of living for a pauper compared to a wage-earning labourer. To achieve these, it promoted the workhouse test, namely that a pauper would only receive relief if prepared to enter the workhouse where conditions would be worse than for the poorest in the community. According to Driver, the workhouse was 'designed to be a disciplinary institution, its inmates subject to the rule of official regulations'.[7] As it became increasingly recognised that medical illness was a major cause of pauperism, workhouses began to provide 'sick wards', which in due course became specific infirmary areas for the sick. As attempts to keep the able-bodied out of workhouses became more successful, they came to care for more and more sick paupers. In addition, those who were ill and could not be cared for at home began to be admitted directly to workhouse sick wards. By 1861, over 81% of all hospital beds

[4] Hodgkinson, *The Origins of the National Health Service*, p.1; Digby, *Pauper Palaces*, p.107; Crowther, *The Workhouse System*, p.271; Digby, *The Poor Law in Nineteenth-century England and Wales*, pp.9, 13.
[5] Driver, p.3; Digby, *The Poor Law*, p.9.
[6] Crowther, p.3.
[7] Driver, p.64.

in the country were in workhouses.[8] Ten years later, they had become the first public hospitals.[9] Gradually, separate workhouse infirmaries were built, so that by 1891 over 16% of poor law beds were in infirmaries rather than workhouse sick wards.[10]

Medical Care

The main focus of this study will be the nature and role of the medical care in a large urban workhouse in Birmingham between 1852 and 1912. Because of the difficulty in differentiating between the medical and social problems of older people, the scope will be extended to include all older inmates within the institution.[11] Unless indicated otherwise, this term will refer to those aged 60 years and over. Within the literature on the workhouse, older inmates are usually mentioned incidentally. Although some texts do devote specific sections to them, these are often in association with discussion on sick inmates. The medical care of older inmates has largely been neglected.[12]

In order to receive medical attention under the poor law system, a person had to be declared a pauper and it was not envisaged that paupers should receive better medical care than the working-class poor. The New Poor Law Act had made no recommendations for a medical service and the central authority had no coherent medical policy. It was never envisaged that acute illness would be a reason for

[8] Fraser, *The Evolution of the British Welfare State*, p.100.
[9] Hodgkinson, p.451.
[10] Fraser, p.102.
[11] Thane, 'Geriatrics', in Bynum and Porter (eds) *Companion Encyclopaedia of the History of Medicine*, p.1109; Martin, 'Medical Knowledge and Medical Practice: Geriatric Medicine in the 1950s', *Social History of Medicine*, 7 (1995), pp.458-9.
[12] Specific sections devoted to older inmates are contained in Digby, *Pauper Palaces*; Morrison; Higgs, *Life in the Victorian and Edwardian Workhouse*; Longmate, *The Workhouse*; Fowler, *Workhouse* and Thane, *Old Age in English History*. Most have concentrated on the number of older inmates and their living conditions.

admission to the workhouse. Medical care was intended only for those inmates who became unwell after admission. In the late 1860s, the Poor Law Board reversed the policy of less-eligibility in relation to the sick and its president, Gathorne Hardy, stated that the deterrent principle was no longer appropriate. Despite this, many provincial unions were slow to implement the change and in Birmingham the sick were still subjected to the workhouse test in 1888.[13]

Prior to 1834, larger workhouses provided sick rooms or wards for inmates who became unwell. A few had designated infirmaries as in the Old Birmingham Workhouse. Provision for sick wards was included in the plans of the model workhouses contained in the first annual report of the Poor Law Commission (PLC). One of the models sited an infirmary in a separate building to the rear of the main workhouse building.[14] As the separate block plan became more popular, infirmaries were more often located in separate buildings. Larger ones were erected, many on separate sites from the workhouse, as was especially the case in London. In the later nineteenth century, many adopted the pavilion style based on the model of the Chorlton Union workhouse, praised by Florence Nightingale. This allowed a high degree of segregation according to the nature of the illness. As workhouses catered for the chronic sick on a long-term basis, this necessitated provision of large infirmaries and the recommended size of 500 to 600 beds was often exceeded. By 1900, some had expanded to over 1,000 beds.[15]

[13] Webb and Webb, *English Poor Law History*, pp.319-20; Flinn, *Medical Services under the New Poor Law* in Fraser (ed), *The New Poor Law in the Nineteenth Century*, p.65; Hodgkinson, p.542.
[14] Morrison, p.69.
[15] Ibid, p.171.

Ill health was a major cause of the need for relief under the poor law system. Digby estimates that in the mid-nineteenth century nearly three-quarters of the cases of pauperism in England and Wales involved sickness.[16] The numbers of sick inmates rose from 10% in 1843 to between 34% and 48% in the mid to late 1860s, with the higher figure in London and the lower in provincial workhouses.[17] The main factors behind the increase were the recognition of the benefits of institutional medical care compared with domiciliary care and the poor state of health of many of the paupers admitted. Workhouses now began to adopt the role of hospitals and, by 1870, those in large towns had been transformed into 'infirmaries for the sick'.[18] Nevertheless, patients of all ages admitted to the workhouse because of sickness or disability were subjected to the workhouse test and to the same regime within the institution as all other inmates. Their one concession was a special dietary to provide a better standard of nutrition.

A significant step in the transition into state hospitals was the passing of the Metropolitan Poor Act in 1867. This established distinct infirmaries for the sick poor under separate management in London and new asylums for lunatics. It recommended resident medical officers with one to every 150 patients. The result was that, by 1888, there was hardly one union in the capital without a separate infirmary.[19] In the same year, the principles of the act were extended to the whole country, so beginning the process of taking hospitals out of workhouses and firmly establishing the hospital branch of the poor law. These separate infirmaries began to be selective in admitting only those with acute illness, leaving the workhouses to

[16] Digby, *Pauper Palaces*, p.166.
[17] Hodgkinson, pp.147, 465-6; Lane, *A Social History of Medicine*, p.64.
[18] Ashforth, *The Urban Poor Law*, in Fraser (ed), *The New Poor Law in the Nineteenth Century*, p.148.
[19] Hodgkinson, p.521.

accept the remainder, who were predominantly the chronic sick. Hodgkinson considers this differentiation between the two types of admission was in place by 1871.[20] Although medical care within the workhouse grew piecemeal with little central planning, there is general agreement within the literature that the Poor Law Act of 1834 gave the opportunity for the sick poor to receive medical treatment which was better than in the early part of the nineteenth century. Fowler has described the development of medical care as the 'greatest success of the workhouse'.[21]

Poor Law Medical Officers

The district medical officer was the 'key figure in the medical service' after 1834, yet his position and conditions of work were 'profoundly unsatisfactory.[22] Appointed by the guardians, often on an annual contract, he provided medical care to sick paupers at home and in the workhouse, with the cost of medicines usually met from his salary. By the 1860s, appointments were being made with duties solely within the institution and some of these medical officers were required to be resident. Most workhouses had one medical officer, though in London it was often two. The *Lancet* commented in 1867 that Bethnal Green Workhouse had only one for 600 patients, while a similar sized hospital in London would have had 15 doctors.[23] Guardians also employed the services of visiting physicians and surgeons to attend to sick inmates.

There is general agreement that the medical officer was badly paid and overworked, but provided a high standard of care in most instances. However, there was always

[20] Ibid, p.545.
[21] Ibid, p.64; Longmate, p.194; Fowler, p.150.
[22] Flinn, pp.49, 53.
[23] Hodgkinson, p.356.

the temptation for him to prefer prescribing medical extras, such as food items or alcohol, rather than drugs, as the guardians would meet the cost of the extras.[24] Disputes between medical officers and guardians over terms of employment and conditions in the workhouse were numerous. This 'perpetual guerrilla warfare' achieved little, as did pressure at national level with the central authority, which remained reluctant to become involved in medical matters.[25] The formation of such organisations as the Poor Law Medical Officers Association and the Association of Metropolitan Workhouse Medical Officers gave the medical profession a stronger voice in pressing for reform. The status of medical officers within the workhouse gradually changed from a subordinate role to one of great influence. Nevertheless, Crowther maintains that they remained at the bottom of the medical hierarchy.[26]

There is extensive coverage in the literature on the movement to improve the conditions of service of poor law medical officers.[27] Areas such as how well they carried out their duties, whether they were required to pay the cost of drugs from their salaries, and to what extent they managed to improve professional standards have been extensively reviewed. In contrast, little has been documented regarding the nature of the treatments they used, the impact of these on the health of patients and the medicine practised from the point of view of the workhouse medical officers themselves.

[24] Ibid, p.169.
[25] Flinn, p.61.
[26] Crowther, p.167.
[27] Hodgkinson, *Origins,* and Crowther, *Workhouse System,* each devote a chapter to this topic. They discuss it in detail in Hodgkinson, 'Poor Law Medical Officers of England, 1834-1871', *Journal of the History of Medicine and Allied Sciences,* XI (1956), pp.299-338 and Crowther, 'Paupers or Patients? Obstacles to Professionalization in the Poor Law Medical Service Before 1914', *Journal of the History of Medicine and Allied Sciences*, 39 (1984), pp.33-54. The subject is also covered by Flinn, 'Medical Services Under the New Poor Law'.

Nursing Care

In contrast to the medical service, nursing was the weakest part of the care provided for patients and the lack of trained nurses was the greatest handicap for the developing poor law infirmaries.[28] Nursing duties were initially undertaken by untrained female paupers, who were noted for being inefficient and unreliable. They were frequently rewarded with extra rations and alcohol, which made drunkenness not uncommon. A few guardians did employ paid nurses, but this was rare before the mid 1860s when nurse training began to be available. White states that there were only 248 paid nurses in workhouses in England and Wales in 1850.[29] Their duties were mainly domestic as they gave minimal personal attention; their status was equivalent to domestic servants.

The first formal nurse training scheme in a poor law infirmary was begun in Brownlow Hill Infirmary in Liverpool. In 1865, a local benefactor, William Rathbone, with the help of Florence Nightingale, financed the introduction of trained nurses into the infirmary under the control of Agnes Jones. Following this, trained nurses began to be employed by guardians, although they always remained in short supply. Pauper nurses continued to be used until the LGB issued an order in 1897 prohibiting their use for specifically nursing duties. However, they could be employed as attendants, if supervised by a trained nurse.[30]

[28] Flinn, p.56; Digby, *Pauper Palaces*, p.171; Anon., *British Medical Journal*, 'On Nursing in Workhouse Infirmaries', 2, (1896) p.857.
[29] White, *Social Change and the Development of the Nursing Profession*, p.26.
[30] Ibid, p.87; Hodgkinson, *Origins*, p.569.

As training became more widespread, the number of poor law nurses increased, reaching 2,490 in the separate infirmaries in 1909.[31] They were responsible for nursing 40,000 patients. This represented a ratio of one nurse to around 16 patients, which had improved from one nurse for 30 to 40 patients in the 1890s.[32] Because of the type of patient admitted to the infirmaries, they developed expertise in the nursing care of those with chronic illness and incurable disease. The development of training for poor law nurses, the improvement in their conditions of service and their increasing involvement with acutely ill patients has commanded most attention in the historiography of nursing. By comparison, the nature of the nursing tasks they performed and their interaction with the patients they cared for has been relatively neglected.

Older People

The Royal Commission of 1832 did not include older people among the issues it considered and so their special needs were not recognised.[33] They were ignored in the classification system, which led to great variation in how they were accommodated within workhouses.[34] In some workhouses, they were allotted designated wards, while in others they could be placed with the able-bodied or with sick patients depending on their state of health. Wherever they were accommodated, there would have been little to occupy their time unless they were able to carry out

[31] White, p.131; Digby, *Pauper Palaces,* p.171.
[32] White, p.131.
[33] Smith, *The People's Health*, pp.382-3; Fowler, p.168; Longmate, p.137.
[34] Digby, *Pauper Palaces*, pp.162-4.

work. Longmate quotes workhouse visitors in 1857 as describing older people, sitting 'round the walls, vacant and dreary'.[35]

Paradoxically, older people were the largest single group of inmates. The percentage of the population of England and Wales aged over 60 years remained constant at around 7.3% during the second half of the nineteenth century. On 1 August 1890, 2.5% of the total population were receiving poor relief as compared with 13.4% of those aged over 60. On 1 January 1892, 0.7% of all paupers were in workhouses, compared with 4.6% of those aged over 65.[36] Within the workhouses of the Huddersfield Union, 26% of inmates were over 60 years of age in 1841, 32% in 1851 and 30% in 1861.[37] There is conflicting evidence regarding the role of the workhouse in the care of older people. In the workhouses of Hertfordshire in 1851, Goose found that 32% of inmates were older than 60 years and so was unable to accept Thomson's assertion that 'workhouses were not especially important in providing care for the aged'.[38] The age of 60 years was accepted as the lower limit of old age in terms of applying for relief and was used as a general indicator of infirmity.[39] The term 'older people' will be used here to refer to those of 60 years and above unless indicated otherwise.

Following the publication of Booth's study on *Pauperism and the Endowment of Old Age* in 1892 and the Report of the Royal Commission on the Aged Poor in 1895, older

[35] Longmate, p.141.
[36] Laslett, *Family life and illicit love in earlier generations*, p.193; Boyer and Schmidle, 'Poverty among the elderly in late Victorian England', *Economic History Review*, 62 (2009), p.251.
[37] Driver, p.150.
[38] Goose, 'Workhouse Populations in the Mid-Nineteenth Century', *Local Population Studies*, 62 (1999), pp.57, 67; Thomson, 'The Welfare of the Elderly in the Past' in Pelling and Smith (eds) *Life, Death and the Elderly*, p.207.
[39] Thane, *Old Age in English History*, p.167; Boyer and Schmidle, p.253.

people were treated more leniently, so that they could enjoy better facilities than in their own homes. They were allowed a better diet, to go out for walks and to receive visitors. Only one workhouse was built specifically with older paupers in mind, in London in 1900. [40] Nevertheless, Edwards is of the opinion that poor law medical care for older people was less generous than has been reported by historians and concludes that age-based rationing existed throughout the nineteenth century.[41]

Twentieth Century

Workhouse infirmaries took on a greater role in caring for acute illness, gradually being transformed into state hospitals. After the Local Government Act of 1929, most were taken over by local authorities as municipal hospitals. Many became prominent acute and teaching hospitals within their communities, but were selective in the patients they admitted, rejecting those with chronic disease.[42] This role was taken on by the workhouses, many of which continued after 1929 as specialist geriatric hospitals. Others became old people's homes and even in 1960, around half of local authority accommodation for older people was in old workhouse buildings.[43] As a result, they remained low in public esteem and this may account for the fact that they have received less attention from medical historians than metropolitan infirmaries and voluntary hospitals.

[40] Morrison, p.118.
[41] Edwards, 'Age-based rationing of medical care in nineteenth-century England', *Continuity and Change*, 14 (1999), p.251.
[42] Crowther, 'The Later Years of the Workhouse 1890-1929', in Thane (ed) *The Origins of British Social Policy*, p.51; Flinn, p.66; White, p.198; Abel-Smith, *The Hospitals,* pp.207-9.
[43] Crowther, *Workhouse System*, p.112; Lane, p.65.

Birmingham Workhouses

The first Birmingham Workhouse, commonly referred to as the Old Workhouse, was erected in 1733, situated in Lichfield Street. An infirmary wing with 97 beds was added in 1766. In 1783, Birmingham Parish was incorporated under a local act of Parliament, and a Board of Guardians established. After 1834, it continued as a Local Act Parish over which the central authority had much less control compared with Poor Law Unions. Additional wings were added to the Old Workhouse later in the eighteenth century, one of which served as an infirmary with 97 beds. It was then able to accommodate 600 paupers.[44] By 1835, the building was dilapidated and surrounded by other buildings, restricting the original view of the countryside from its windows. In addition, the rapid increase in the population of Birmingham from 25,000 when the workhouse was built to 170,000 in 1838 had resulted in severe overcrowding.[45]

The guardians decided to build a new workhouse on Birmingham Heath, between what is now Western Road and Dudley Road, about one and half miles from the centre of the town. It opened on 29 March 1852, designed on a corridor plan, with the central part containing an open rectangular wall to the full height of the ceiling. On each floor there was a cantilevered cast iron gallery supported by brackets and protected by railings. The arches to the two corridors, leading to male and female accommodation, were enclosed by two-leaf, wrought-iron gates. It had an innovative system of flues for ventilation and was regarded as one of the finest workhouses in the country.[46] In keeping with the principles of the workhouse system of classification, segregation and surveillance of individual conduct, the emphasis throughout was on

[44] Hutton, *History of Birmingham,* p.362.
[45] Hearn, *Dudley Road Hospital*, p 11; Dent, *Old and New Birmingham*, pp.426, 500-1.
[46] Morrison, pp.95, 88-9; Hodgkinson, *Origins,* pp.530-1, 539.

supervision. The rooms for the master and matron were placed centrally to enable them to overlook the single entrance. The workhouse was one of the largest in the country and the largest in the midlands.[47] A total of 1,610 inmates could be accommodated, comprising 602 adults, 601 children, and 80 tramps, plus an infirmary for 310 patients. [48] Langford highlights that there was 'a separate bed for each adult pauper'.[49] Almost from the beginning, additional building took place to accommodate the increasing number of inmates and a substantial building was erected in 1869. Ten years later, the children's department was moved to Marston Green Cottage Homes. By 1881, the workhouse had doubled in size and accommodated 2,291 inmates, including some children.[50] The population of Birmingham increased by 88% over the period of 1850 to 1870, from 233,000 to 437,000 inhabitants.[51]

The Workhouse Infirmary

The main infirmary was in a detached building with wards for common cases, four wards for convalescents, four for 'idiotic and epileptic cases', plus a dispensary and surgeon's room on the ground floor. In addition, there were detached buildings containing fever, infection and lying-in wards.[52] Birmingham guardians had been progressive in their policy on medical care since they had employed a resident house surgeon, two assistant dispensers and six paid nurses in the Old Workhouse by 1843.[53] In 1854, a Poor Law Board Inspector complimented the infirmary as being

[47] Higginbotham, *Workhouses of the Midlands*, p.11.
[48] Langford*, Modern Birmingham and its Institutions*, pp.381-2.
[49] Ibid.
[50] Upton, *A History of Birmingham*, p.163.
[51] Mayne, *The Imagined Slum*, Table 2.1 on p.19.
[52] Langford, p.383.
[53] Power and Weale, 'Report on the Administration of Relief to the Poor in the Parish of Birmingham', *Appendix to the Ninth Annual Report of The Poor Law Commissioners*, pp.139-140.

one of the best arranged and managed in the country with a full-time resident medical officer and with the guardians paying for all medicines.[54] The number of paid nurses employed increased as the number of patients admitted grew rapidly. Overcrowding became so persistent that the guardians decided in 1885 to erect a new separate building adjacent to the workhouse and to incorporate some of the existing buildings to form a new infirmary.

It opened four years later with a capacity of around 1,300 beds. The new building was erected on the pavilion style with nine three-storey blocks set on alternate sides of the main corridor, which was almost a quarter of a mile long.[55] A report in the *Birmingham Daily Post,* in April 1890 described how all potential admissions to the infirmary had to be seen at the workhouse entrance by the workhouse medical officer, who decided to which institution a pauper would be admitted.[56] Conflict over admissions arose between him and the medical officers of the infirmary, which employed four resident doctors, plus three visiting physicians and one visiting surgeon. The infirmary was managed by its own master and matron. Surprisingly, the guardians did not decide to appoint a medically qualified superintendent as was the usual practice at that time.[57] In contrast, the first matron, Anne Gibson, had been trained in the first poor law training scheme in Brownlow Hill Infirmary in Liverpool. She later achieved national recognition for her work in the poor law service.[58]

The infirmary gradually developed a policy of selective admissions concentrating on acute illness, with the workhouse taking patients with chronic disease. In 1912,

[54] Quoted in Hodgkinson, p.530, n 1.
[55] Richardson, *English Hospitals*, p.72.
[56] *Birmingham Daily Post,* 22 April 1890.
[57] Abel-Smith, p.96.
[58] White, p.96.

Birmingham Parish combined with the adjacent Unions of King's Norton and Aston to form an expanded Birmingham Union. Following this, the infirmary was renamed Dudley Road Hospital to reflect its new role as an acute hospital and the workhouse became Western Road House. After the Local Government Act in 1929, both institutions came under the control of Birmingham Corporation and both were incorporated into the National Health Service in 1948. Following this, the name of the workhouse was changed to Summerfield Hospital and it became a specialist geriatric hospital.

The following chapters will discuss the role of the New Birmingham Workhouse in the medical care of adults and the medical and social care of older people from 1852 until 1912. The first chapter covers the number of patients admitted during this period, the facilities provided for them and the degree to which these were inadequate. Patient experiences are recalled, in particular difficulties in moving between the workhouse and the infirmary. The development of nursing care for patients is explained and the interaction between patients and nurses recounted. The next chapter deals with the position of the workhouse medical officer in terms of the nature of the post holders, the efficiency of their practice and the conflict between those appointed to the two institutions. The medical and surgical treatments they employed are explored with particular reference to patients who remained in the workhouse. The final chapter highlights the difficulty in distinguishing between the medical and social needs of older people and their relative neglect within the records of the workhouse, despite being the largest single group of inmates. The changing attitude to the care of older people over the period is detailed along with the greater comforts it brought them.

CHAPTER 1

PATIENTS AND THEIR NURSES

Introduction

Prior to the New Poor Law, sick inmates were usually cared for in their dormitories as only the largest workhouses had separate sick wards. These were provided for use by able-bodied inmates who became sick and not for the admission of ill paupers from their homes. Even when separate facilities existed, the provision for the sick in most workhouses was considered to be inadequate.[1] Early New Poor Law workhouses incorporated separate wards for ill inmates, sometimes in a dedicated building at the rear of the main house. For example, Epping Union Workhouse had dormitories for the infirm within the main house, while Wells Union Workhouse provided a separate infirmary for the sick.[2] Because of the increasing numbers of sick paupers entering the workhouse, detached infirmaries became commonplace, often with additional discrete buildings for fever cases. The Metropolitan Poor Act of 1867 provided the stimulus for the building of new larger infirmaries, often on a site away from that of the workhouse and usually under independent management. Dedicated facilities in a separate building for the sick were officially confirmed in a central authority circular in the late 1860s.[3] As a result, guardians built or purchased 155 buildings to provide sick wards between 1867 and 1883, substantially more than the 108 in the preceding 31 years.[4] Despite this, around two-thirds of sick inmates in 1896 were still being treated in general mixed workhouses.[5] Even into the twentieth century, provision varied greatly and some rural workhouses still possessed small sick wards. Whatever

[1] Morrison, *The Workhouse*, p.155; Webb and Webb, *The State and the Doctor*, pp.86-7.
[2] Morrison, pp.63,69,157.
[3] Hodgkinson, *The Origins of the National Health Service*, p.534.
[4] Driver, *Power and Pauperism*, p.88.
[5] Abel-Smith, *The Hospitals*, pp.94-5.

was provided, the accommodation for the sick in workhouses was inferior to that in voluntary hospitals.[6]

As the number of sick inmates increased, they assumed a greater proportion of the workhouse population, from 10% in 1847 to 30% in 1867.[7] Several estimates of the extent of sickness among inmates took place throughout the late 1860s. In metropolitan workhouses, the proportion requiring medical attention was estimated at 48% in 1865 and 39% four years later. The latter survey provided a more detailed analysis, showing that 21% of all inmates were classed as ordinary sick, including lying-in cases, while 17% were old and infirm people requiring medical care[8]. For provincial workhouses, the proportion of the sick was less, estimated in several surveys at around 30%, the equivalent figure for Birmingham Workhouse in 1868 being 25%.[9] In the twentieth century, the proportion remained much the same, at 32% of inmates in either sick wards of general workhouses or separate infirmaries, until 1929, when it rose to 45%.[10]

With no provision for medical care being incorporated into the directives of the New Poor Law, it would have been surprising if there had been any guidance for the nursing of sick paupers. The central authority gave only mild encouragement to the development of a poor law nursing service and to the training of poor law nurses.[11] Until the mid 1800s, the majority of nursing was undertaken by pauper inmates, who were usually older women. They were rewarded with extra allowances in the form of

[6] Digby, *Pauper Palaces*, p.169.
[7] Ibid, pp.147, 467.
[8] Ibid, pp.465-6.
[9] Ibid, p.466; Lane, *A Social History of Medicine*, p.64; Stout and Bowen, 'Parish of Birmingham', BCL, *Miscellaneous Documents*, Vol 4, pp.l4-5.
[10] Crowther, *The Workhouse System*, p.89.
[11] White, *Social Change and the Development of the Nursing Profession*, pp.207-8.

food and alcohol. As beer was often provided early in the day, it contributed to their reputation as drunkards. The standard of nursing has been described as neglectful, cruel, harsh and inhuman at worst and ineffective at best. Medication was often not given correctly and, not infrequently, was stolen to provide remuneration. However, many older women so employed were thereby 'condemned to endless toil', with no hope of release from the workhouse.[12]

Some guardians did employ nurses for financial remuneration, but training for them was not available until schools of nursing were set up in the early 1860s, usually in association with voluntary hospitals. The first training scheme in a poor law infirmary was instigated in Liverpool by a local philanthropist, William Rathbone, in 1865. Prior to that only 6 out of 38 metropolitan infirmaries employed trained nurses, but no provincial ones did so.[13] Paid nurses were employed in the larger workhouses only, but from 1866 their numbers expanded greatly. In all the workhouses in Norwich, only four paid nurses were employed in the mid 1840s, but by 1891 this had increased to 41, with a further substantial rise five years later to 145.[14] Nationally, 3,625 paid nurses were caring for 56,628 inmates in wards for the sick in 1896, giving an average of 15.6 patients per nurse. However, this ratio was lower in London, at 11.6, and higher in the provinces at 18.5. The figure of 12.6 for Birmingham was nearer to that of London.[15] From their beginnings as pauper nurses who gave the minimum of personal attention, poor law nurses organised the care of the sick in the infirmaries and developed their role as bedside nurses.[16]

[12] Hodgkinson, pp.489, 169; Crowther, pp.165-6.
[13] White, pp.39, 71.
[14] Digby, pp.171-2.
[15] 'Workhouses, etc.' *Parliamentary Papers 1896 (371)*, pp. 2-5, 28-9.
[16] Ibid, pp.8, 198, 202.

This chapter will cover patients in the infirmary as well as those who remained in the workhouse after the new infirmary opened. It will consider their number, how they were accommodated, the degree to which they were subjected to overcrowding, the nature of their illnesses and the difficulties they encountered in transferring between the workhouse and the new infirmary. Specific groups of patients will be given special mention, in particular those with epilepsy. Attempts will be made to draw out experiences of patients from the records and recount their opinions of the care they received. The nature and quality of nursing care will be outlined and particular instances of interaction between patients and their nurses will be highlighted.

The Sick in Birmingham Workhouse

The accommodation for 1513 inmates in the New Birmingham Workhouse included an infirmary for 310 in a detached building. This was more than three times the provision in the workhouse it replaced. Wards were designated for common cases, convalescence, idiotic and epileptic cases, fever and infection, and lying-in women. However, three years later, the workhouse medical officer would report that the 'daily average of patients in the Infirmary is 318'.[17]

Thereafter, the increasing number of sick inmates necessitated the erection of additional facilities, either by adding wings to existing buildings or building new ones. In 1864, boys were transferred out of the workhouse and their accommodation converted into epileptic and imbecile wards, which, with a new extension, gave 340 places. A few years later, sheds were converted into wards for smallpox cases and six

[17] Langford, *Modern Birmingham and its Institutions*, pp.381-3; Hutton, *History of Birmingham*, p.362; BCL, BBG, GP/B/2/1/15, 28 February 1855.

further wards were erected four years after that for the same purpose. A report in the *Birmingham Daily Mail* in 1885 described the situation:

> The Infirmary is no special block of buildings, but an aggregate of wards scattered all about…there are a few wards here and a few there, some in the main building, some in added wings, and some in separate buildings standing in their own not unpleasant bit of garden.[18]

When the new infirmary was erected, the building provided for 990 beds, but buildings in the existing workhouse were incorporated, with increased cubic space per bed, to give a total of 1665 beds.[19] However, the female bedridden wards were not incorporated into the infirmary as planned, resulting in only 1511 beds being available. Not all patients were transferred to the new facility, as those with venereal disease and about half of those in the bedridden wards remained in the workhouse. The infirmary within the workhouse grounds was regarded as one of the finest in the country.[20]

The earliest available information on patients is contained in a report by the Workhouse Medical Officer (WMO) on 28 February 1855 requesting medical assistance. At the start of the year, there were 273 persons in the sick wards, being 24% of the total number of inmates of 1118. Since then, he had admitted 448 patients into the infirmary and felt he could not provide the care they required.[21] Robert Weale, a Poor Law Inspector, reported that in July 1866, there were 566 cases under the supervision of the medical officer (Table 1.1). Four months later, 514 adults were recorded as sick in the medical officer's book and 134 of these were bedridden and

[18] *Birmingham Daily Mail*, 30 July 1885.
[19] BCL, BBG, GP/B/2/1/59, 7 May 1890.
[20] Hodgkinson, p.539.
[21] BCL, BBG, GP/B/2/1/15, 28 February 1855.

122 insane or epileptic. They accounted for 38% of adults in the workhouse. An additional 268 adults were on the medical officer's book for dietary only, 80% because they acted as assistants in the house or infirmary.[22] The proportion of sick inmates to the total workhouse population of 30% was the same as the average for provincial workhouses for 1866.[23] However, there was great variability between workhouses in the proportions of sick adults, which varied in Table 1.2 from 19% to 63%.

Table 1.1: Classification of cases under supervision of the medical officer in Birmingham Workhouse on 13 July 1866.

Bedridden	147
Epileptic	64
Harmless lunatic idiots	64
Ulcered legs	38
Minor ailments	30
Syphilitic	42
Under special medical treatment	181

Source: Smith, 'Provincial Workhouses', *Parliamentary Papers, 1867-68(4)*, p. 48.

It is possible to estimate the prevalence of morbidity among younger adults, defined as those under the age of 60 years, from the official returns to the LGB. These divide those classed as not able-bodied into two categories, namely temporarily disabled and old and infirm. The former would represent sick younger adults and, as Table 1.3 shows, they represented 18% to 26% of total inmates of the workhouse in the late 1870s. The proportion of younger adult inmates who were sick fell by around 20% between 1877 and 1879, though did increase to a lesser degree after that. The total number of sick around this time was recorded as 860, which would give an estimate

[22] Smith, 'Provincial Workhouses', *Parliamentary Papers, 1867-68 (4)*, p.45; BCL, BBG, GP/B/2/1/33, 18 July 1866.
[23] Smith, p.45; Hodgkinson, p.466.

of about 40% of those classed as old and infirm who were also ill, making sick adults of all ages just under half of the total workhouse population.[24]

Table 1.2: Sick inmates in English provincial workhouses with more than 500 inmates.

Union or Parish	Total number of inmates	Number and percentage of sick adults	Percentage of all sick inmates
Liverpool	3194	741-30%	32%
Birmingham	1926	514-38%	30%
Portsea	1475	180-21%	13%
Manchester	1310	804-63%	63%
Sheffield	844	259-46%	34%
Wolverhampton	739	225-44%	32%
Norwich	730	112-22%	19%
Bath	690	237-48%	36%
Dudley	626	266-65%	46%
Leeds	542	196-42%	38%

Source: Smith, 'Provincial Workhouses', *Parliamentary Papers, 1867-68(4)*, pp.26-157.

Table 1.3: Number of temporary disabled adults not able-bodied and percentage of total inmates in Birmingham Workhouse on last day of the first week of the Lady Day and Michaelmas quarters, 1877-80.

First Week of Quarter in Year	Temporary Disabled			Percentage of Younger Adults	Percentage of Total Inmates
	Men	Women	Total		
Lady day 1877	324	235	559	68%	26%
Michaelmas 1877	271	192	463	63%	23%
Lady day 1878	400	182	582	67%	25%
Michaelmas 1878	328	118	446	58%	20%
Lady day 1879	393	61	454	49%	18%
Michaelmas 1879	368	16	384	48%	16%
Lady day 1880	486	79	565	51%	20%
Michaelmas 1880	450	78	528	57%	21%

Source: BCL, LGB Returns, GP/B/5/1/1, December 1878 to October 1880.

By the early part of the 1880s, the recorded numbers of sick of all classes had almost doubled, as is evident in Table 1.4. This also demonstrates a mild seasonal variation, with a slight reduction each summer of between 3% and 9% compared to the previous winter. When the Infirmary Sub-committee was set up in 1882 to assume

[24] BCL, LGB Returns, GP/B/5/1/1, December 1878 to October 1880; LGB Orders, GP/B/1/1/3, 10 August 1876.

responsibility for the medical administration of the workhouse, the number of those classed as sick was recorded regularly in the minutes of each meeting, but was gradually omitted after two years.[25] In February 1886, Local Government Inspectors, J. Henley and F. Mouatt, recorded that there were 1,455 inmates classed as 'sick' out of a total of around 2,000 in the workhouse.[26]

When the new infirmary opened, 817 patients were transferred from the workhouse by March 1889. Over the following year, 4,445 patients were admitted or transferred and there were 88 births. Discharged patients numbered 3,492 and with 572 patients dying, this left 1,286 remaining in the infirmary on 22 March 1890. However, the number had fallen in October that year to 1,070, a bed occupancy rate of 71%.[27] By 1900, only one ward had not yet been opened, and in the remainder only two beds were vacant.[28]

Details of the number of inmates in the infirmary and workhouse are available in the weekly returns submitted by the guardians to the LGB from 1894 to 1911. Adults are divided into able-bodied and non-able-bodied and each group is further divided between those in the infirmary and those in the workhouse. All inmates over 60 years of age were classed as non-able-bodied,[29] although this group may also have included younger individuals with chronic disability. With this proviso, the figures for the able-bodied group give an indication of the number of younger adults in the infirmary.

[25] BCL, ISC, GP/B/2/4/1/1 and 2, July 1882 to September 1884.
[26] *Parliamentary Papers, 1886 (19)*, 'Copies of Evidence', p.11.
[27] BCL, BBG, GP/B/2/1/59, 7 May 1890; *Parliamentary Papers, 1890-91 (365)*, 'Workhouses, etc.' p.12.
[28] BCL, IHSC, GP/B/2/4/5/1, 26 February 1900.
[29] Boyer and Schmidle, 'Poverty among the elderly in late Victorian England', *Economic History Review*, 62,2(2009) p.253.

Table 1.4: Average number per month of sick paupers in Birmingham Workhouse, 1881-1884.

Month	Number of sick inmates			
	1881	**1882**	**1883**	**1884**
January	-	1131	1230	1228
February	-	1106	1246	1245
March	-	1156	1262	-
April	-	1131	1153	-
May	-	1104	1087	1225
June	-	1057	1109	1110
July	-	1038	1125	-
August	-	-	-	-
September	-	1102	1063	1232
October	1049	1110	1070	-
November	1039	1150	1129	-
December	1115	1195	1198	-

Source: BCL, ISC, GP/B/2/4/1 and 2, July 1882 to September 1884

Table 1.5: Able-bodied and non able-bodied adults in the Birmingham Infirmary on the last day of the first week of the Lady Day and Michaelmas quarters for selected years between 1896 and 1910.

Month and Year	Able-bodied			Non-able-bodied			All adults
	Men	Women	Total	Men	Women	Total	Total
Jan 1896	263	228	491	175	171	346	837
July 1896	219	207	426	177	152	329	755
Jan 1897	314	230	544	184	178	362	906
July 1897	303	278	581	186	190	376	957
Jan 1898	369	260	629	185	189	374	1003
July 1898	297	231	528	162	165	327	855
Dec 1899	408	300	708	177	198	375	1083
June 1900	341	255	596	145	153	298	894
Jan 1903	393	280	673	197	172	369	1042
July 1903	328	278	606	172	171	343	949
Jan 1904	350	284	634	170	158	328	962
July 1904	291	225	566	108	143	251	817
Dec 1904	370	297	667	140	151	291	958
July 1905	267	217	484	162	188	350	834
Jan 1909	321	235	556	158	191	349	905
July 1909	293	202	495	127	126	253	748
Jan 1910	368	230	598	178	130	308	906
July 1910	306	211	517	148	133	281	798

Source: BCL, LGB Returns, GP/B/5/1/2-8, January 1896-July 1910

Details for selected years are shown in Table 1.5, which includes the total number of adults in the infirmary. There was a marked increase between 1896 and 1897 for all classes, followed by a gradual increase until 1904 when numbers reduced slightly and thereafter remained stable. The decrease in 1909 was due to transfer of epileptic women from the infirmary to the new epileptic colony at Monyhull.[30] There was a seasonal variation with fewer patients in summer compared with the previous winter, by around 10-15% in half of the summers over the period 1896 to 1911. Able-bodied men always outnumbered women, by 20-30%, but in the non-able-bodied class, numbers were similar and there were more women than men on a greater number of occasions.[31]

Table 1.6: Admissions, discharges and deaths for adults in the Birmingham Infirmary during the first week of Lady Day and Michaelmas quarters for selected years between 1897 and 1909.

Month and Year	Admissions	Discharges	Deaths
Jan 1897	**55**	**48**	**12**
July 1897	**68**	**53**	**6**
Dec 1898	**66**	**36**	**9**
July 1899	**59**	**67**	**6**
Dec 1900	**49**	**38**	**18**
June 1901	**49**	**62**	**9**
Jan 1903	**89**	**59**	**18**
July 1903	**90**	**68**	**14**
Dec 1904	**91**	**51**	**14**
July 1905	**53**	**62**	**11**
Dec 1906	**71**	**33**	**12**
June 1907	**64**	**71**	**6**
Jan 1909	**105**	**62**	**17**
July 1909	**64**	**70**	**11**

Source: BCL, LGB Returns, GP/B/5/1/3-8, January 1897 to July 1909.

[30] Male epileptic patients were also transferred to Monyhull epileptic colony, but the male epileptic wards were part of the workhouse, rather than the infirmary.
[31] BCL, LGB Returns, GP/B/5/1/3-8, May 1894 to January 1911.

Overcrowding

The increasing number of admissions over the second half of the nineteenth century resulted in the workhouse accommodation becoming insufficient. Even when the overall total of inmates was less than the total that could be accommodated, specific wards or departments could become full and inmates would be placed in inappropriate wards. The central authority placed great emphasis on the maintenance of the classification system and pressed the guardians to provide more accommodation.

Problems arose as early as November 1855 when the Clerk to the Guardians called their attention to 'the very crowded state of the workhouse', with the exception of the School Department. In particular, the two dormitories of the female epileptic wards were severely affected with 41 patients placed in wards with only 32 beds. The situation improved after a 'thorough call over of inmates', identifying those who could be discharged and supported by out relief. However, until that could be effective the master found it necessary to use an old clothing store as temporary sleeping rooms for some of the female epileptic patients.[32] The epileptic wards were originally designed to hold 32 patients of each sex, but were accommodating a total of 86 patients with several sleeping in double beds. In addition, some male epileptic patients were sleeping in the male venereal ward and eight women in the main part of the workhouse. Two convalescent wards had been converted, one as a female venereal ward and the other for women with 'malignant and offensive diseases'. Other examples of interference with proper classification were men with itch accommodated in a fever ward along with patients with fever and erysipelas. The extent of overcrowding is outlined in Table 1.7, with 322 inmates accommodated in

[32] BCL, VGPC, GP/B/2/8/1/1, 13 July 1855, GP/B/2/8/1/2, 26 October, 1855; BBG, GP/B/2/1/7, 28 November 1855, 9 January 1856.

wards approved by the Poor Law Board (PLB) to hold 254, but the situation was worse in the women's wards.[33]

Table 1.7: Number of inmates in selected wards on 13 November 1855, showing the extent of overcrowding.

Ward number	Gender of inmates	Number of inmates in ward	Number approved by PLB
1	Male	15	14
16	Male	35	30
15	Male	15	14
11	Male	14	13
6	Male	15	13
24	Female	28	14
25	Female	39	28
23	Female	21	18
22	Female	50	37
21	Female	30	22
20	Female	23	20
26	Female	20	16
27	Female	17	15
All Wards		322	254

Source: BCL, VGPC, GP/B/2/8/1/2, 30 November 1855.

Pressure on the epileptic and sick wards continued to 'materially interfere with' the classification of inmates, resulting in the erection of new epileptic wards, to accommodate 80 patients in 1865.[34] However, there were 133 epileptics in the workhouse in May that year, after the accommodation had been increased to provide for 100 patients. Only 81 were in the appropriate wards and the others lived in the main part of the workhouse. Overcrowding was also present in the female sick ward, where 102 patients were present in a ward allowed for 80, with 10 in the workhouse. Although some wards were under-occupied, the net excess of inmates in the workhouse was 83.[35] Robert Weale, Poor Law Inspector, reported that wards 19 to 22 inclusive should hold 71 inmates, but 118 women and children had slept there on the

[33] BCG, VGPC, GP/B/2/8/1/2, 9 November and 30 November 1855.
[34] BCL, BBG, GP/B/2/1/31, 18 January 1865, GP/B/2/1/32, 1 March 1865.
[35] BCL, VGPC, GP/B/2/8/1/4, 22 May 1865.

night before his visit in September 1865.[36] The problem of overcrowding in these wards had abated by the time he visited in July the following year and he confirmed that 'the certified numbers for each ward are strictly attended to'.[37] However, it did recur, as the dining hall was being used to accommodate 110 inmates by day and 70 by night in January 1868, until new wards were opened.[38] In June 1873, some wards, mainly the epileptic department and the infirmary wards, had an excessive number of patients while others, as in the fever and smallpox wards, had unoccupied beds (Table 1.8). As a result, the beds for smallpox patients were reduced from 103 to 30 and bedrooms in the able-bodied women's wards used for female epileptic patients.

Table 1.8: Number of beds and inmates in selected wards of the infirmary of Birmingham Workhouse on 6 May 1873.

Department	Number of beds	Number of inmates	Excess/shortfall of inmates compared with beds
Male Infirmary	66	69	+3
Female Infirmary	73	77	+4
Bad Leg Ward	33	30	-3
Fever Ward	38	24	-14
Smallpox	103	15	-88
Male Epileptic	102	115	+13
Female Epileptic	101	110	+9
Male Venereal	31	24	-7
Female Venereal	35	38	+3

Source: BCL, BBG, GP/B/2/3/3/3, 3 June 1873.

The epileptic department continued to have difficulty with overcrowding, as the master was required to transfer 25 inmates from the male ward to other parts of the house in August 1881.[39] However, within two years, the situation had greatly improved. At the Poor Law Conference at Malvern in 1884, several speakers praised

[36] BCL, VGPC, GP/B/2/8/1/5, 8 September 1865.
[37] BCL, BBG, GP/B/2/1/33, 18 July 1866.
[38] BCL, HSC, GP/B/2/3/3/1, 7 January 1868.
[39] BCL, HSC, GP/B/2/3/3/8, 4 August 1881.

Birmingham for its management of pauper lunatics and this resulted in a large number of requests from delegates to visit and inspect the epileptic wards at the workhouse.[40]

Overcrowding and the subsequent breakdown in the classification of inmates were the main reasons behind the decision in 1885 to build a separate infirmary. A report in the *Birmingham Daily Mail* in July 1885 described the conditions in the wards in the infirmary as 'repellently overcrowded':

> The beds are so crowded together that two ordinary-sized people could not conveniently pass between them....it was shocking to see poor people lying so close together that they could touch each other in their beds.

In the largest of the female bed-ridden wards, 81 beds were as close to one another as possible, just to allow room to pass between them. Some of the patients were asleep in bed with the clothes 'drawn over their faces', some were 'crouched up' in bed reading periodicals and a few were 'creeping about the room'. The report concludes that 'it is impossible to visit the Infirmary without seeing the necessity for additional space'.[41]

Transfers and Delays

The new infirmary provided the extra accommodation needed, but did not prevent the workhouse from becoming overcrowded. On a number of occasions it was necessary to open wards in the infirmary in order to transfer groups of inmates to relieve the workhouse. In March 1898, the infirmary agreed to the transfer of 24 bedridden

[40] BCL, BBG, GP/B/2/1/52, 14 May, 20 August 1884.
[41] *Birmingham Daily Mail*, 30 July 1885.

patients and all the women with venereal disease. A further 25 female bedridden patients were transferred three years later, following which the infirmary accommodation was fully utilised.[42] However, the separate management of the two institutions, each with its own master, gave rise to difficulties in transfer arrangements. Sick paupers were required to be admitted initially to the workhouse to be assessed by the WMO before transfer to the infirmary. Likewise, all patients were discharged from the infirmary to the workhouse before being allowed home. In 1880, the House Sub-committee had decided that it was 'not desirable, even if it were legal, for patients to be admitted to the Infirmary from the front without being taken into the body of the House'.[43] This was confirmed by the Board when it approved the Sub-committee's minutes. The Select Committee of the House of Lords on Poor Law Relief in 1888 recorded that 'The Birmingham Guardians....have determined to make all persons who come to their infirmary pass through the gate which leads to the workhouse grounds'.[44] Hodgkinson calls the system employed by the Birmingham guardians unique, as it continued after the majority of unions had accepted that the principle of deterrence no longer applied to sick paupers. [45] It was partially relaxed in 1900, when it was agreed that cases sent in by ambulance could be sent directly to the infirmary, but only when the WMO was on leave.[46]

One year after the new infirmary opened, Dr Suckling, Visiting Physician to the Infirmary, complained of the 'large number of cases of mild illness', especially suffering with bronchitis, 'being sent in daily from the House'. [47] He warned the

[42] BCL, WIMC, GP/B/2/4/4/3, 18 March 1898, 2 February 1901.
[43] BCL, HSC, GP/B/2/3/3/7, 22 June 1880.
[44] *Report on Poor Law Relief, 1888 (363)*, p.viii.
[45] Hodgkinson, *The Origins*, p.542.
[46] BCL, WIMC, GP/B/2/4/4/3, 30 July 1900.
[47] BCL, HSC, GP/B/2/3/3/12, 4 March 1890.

extra work would make it necessary to appoint additional medical and nursing staff and so the WMO was asked to contain these patients in the workhouse. In March 1893, Emma Westlake was 'being sent backwards and forwards' between the infirmary and workhouse, due to a misunderstanding on the part of one of the medical officers in the infirmary.[48] The situation had worsened by November, the master reporting a great many cases passing between the two institutions, some 'going backwards and forwards the same day'.[49] Again the question was raised of transferring trivial cases of illness, for example, diarrhoea and slight coughs. The root of the problem was the difficulty in finding beds in the workhouse to treat these patients due to overcrowding and a lack of nursing staff to provide care. The transfer of cases of mild illness was still taking place at the end of 1899.[50]

The number of transfers from the infirmary increased over the next five years and 65 cases within 10 days were recorded in January 1908, some of which were considered inappropriate or 'not strong enough for transfer' by the workhouse committee.[51] The infirmary medical officers (IMOs) denied this, but were requested to use further discretion in considering transfers, especially as the workhouse was in a crowded state**.** As there was only one medical officer for the workhouse, the resident IMOs were required to cover his duties while he was on half-day and occasional leave, though not on annual leave. However, delays occurred because of the time they took to arrive at the workhouse after being called to see new admissions or sick inmates in the wards. After the first occasion in 1899, there followed several amendments to the regulations to improve matters, but none of these solved the problem. The delay

[48] BCL, WMC, GP/B/2/3/2/2, 24 March, 14 April 1893.
[49] Ibid, 24 November 1893.
[50] Ibid, 15 December 1893; IHSC, GP/B/2/4/5/1, 11 December 1899.
[51] BCL, WMC, GP/B/2/3/2/5, 24 January, 14 February 1908; IMC, GP/B/2/4/4/5, 27 January 1908.

usually arose because the IMOs were busy with duties in the wards along with the visiting physicians.[52] On one occasion in January 1904, a man in pain arrived at the workhouse at 3.40 pm and the medical officer had not attended the receiving ward to see him by 6.00 pm, when a telephone message was sent. By this time, nine cases were waiting for admission. After several more telephone calls, Dr Cooper eventually arrived at 7.40 pm. The patient in pain had not waited, but returned the next day to be admitted to the infirmary.[53]

Epileptic Patients

There is scant information in the literature with regard to patients with epilepsy in workhouses.[54] They were usually placed on the same wards as lunatics and imbeciles and were included in the reports by the Commissioners in Lunacy (CL), but rarely given specific mention. Although the wards in the Birmingham Workhouse were labelled 'epileptic wards', they included lunatic inmates who made up around 40% to 50% of the occupants of the wards.[55] Information regarding the number of patients in the epileptic wards, obtained from reports of the CL, did not always distinguish between epileptics and lunatics. After 1890, the commissioners limited the figures given to those classed as 'of unsound mind', which would have included some

[52] BCL, IHSC, GP/B/2/4/5/3, 21 December 1903.
[53] BCL, HSC, GP/B/2/3/3/21, 26 January 1904.
[54] For instance, Higgs, *Life in the Victorian and Edwardian Workhouse* is one of the few to include a specific section on epileptics, but the coverage is short, pp. l79-81. Morrison discusses briefly the establishment of asylums and epileptic colonies, pp.165, 174'. Negrine, Medicine and Poverty: A Study of the Poor Law Medical Services of the Leicester Union 1876-1914 (unpublished PhD Thesis, 2008) includes a more extensive discussion, but the number of epileptic patients in the Leicester Workhouse was small, for example, 28 patients in 1881.
[55] BCL, BBG, GP/B/2/1/33, 18 July 1866; Letters, GP/B/1/2/1/4, 13 February 1888. It was usual to place epileptics and lunatics in the same wards, since it was considered they must be suitable for managing epileptic fits, Negrine, p.188, Railton and Barr, *Battle Workhouse and Hospital, 1867-2005*, p.68.

epileptic patients. However, many on the epileptic ward were noted to be sane.[56] Nationally, 13% of lunatics and epileptics in workhouses in 1900 were classed as 'not insane'.

The number of inmates in the epileptic wards in Birmingham increased from 86 in 1855 to 135 in 1865. Further increases took the number to 180 in 1870, to 225 in 1873 and to 311 in 1890.[57] In August 1885, 323 beds were provided in the epileptic wards, comprising 24% of the total number of beds provided for sick inmates.[58] On all occasions, there were more patients than appropriate beds available for them and this overcrowding affected the conditions in the wards.[59] In 1855, the CL, Mr Gaskell, observed that several inmates slept in double beds, some of the straw beds were scantily filled and several were wet. He recommended the practice of two patients to one bed be discontinued.[60] Conditions did improve slowly after new epileptic wards were built and, in 1888, the commissioner, Dr Williams, described the beds and bedding as 'in good order'.[61] After a further report in 1896, the guardians made arrangements for epileptic inmates to be engaged in boot making, tailoring and basket making.[62] Mrs George Allbright treated 70 epileptic women to a drive followed by a tea in July 1899, though the medical officers were concerned that the vehicles used were unsafe for these patients. Despite this, outings such as this became a regular feature for both men and women over the following decade, and by 1906,

[56] BCL, VGPC, GP/B/2/8/1/8, 27 October 1882; LGB Letters, GP/B/1/2/1/5, 10 March 1890; *Parliamentary Papers 1900 (362)*, 'Lunatics and epileptics in workhouses', pp.2-3; BCL, LGBR, GP/B/5/1/3, 30 December 1899.
[57] BCL, VGPC, GP/B/2/8/1/2, 30 November 1855; GP/B/2/8/1/4, 3 March 1865; HSC, GP/B/2/3/3/2, 25 October 1870, GP/B/2/3/3/3, 3 June 1873; LGB Letters, GP/B/1/2/1/5, 10 March 1890.
[58] BCL, LGB Letters, GP/B/1/2/1/4, 13 February 1888.
[59] The overcrowding of the epileptic wards has been discussed previously in this chapter (see Table 1.8).
[60] BCL, VGPC, GP/B/2/8/1/3, 9 November 1855.
[61] BCL, LGB Letters, GP/B/1/2/1/4, 13 February 1888.
[62] BCL, WIMC, GP/B/2/4/43, 10 July 1896.

took place three or four times per year. A concert was now being held for the epileptic patients once per week and a piano had been provided for the women.[63]

Occasionally, details of patients in the epileptic wards and their experiences appear in the records. In 1855, the WMO, William Fernie, considered that Sarah Gibbons was much improved since her admission, but was still incapable of 'lengthedly fixed attention' to any subject and irrational in many of her actions. However, she was 'harmless' and could safely be discharged to the custody of her husband.[64] Downes Ireland, aged 32, had been admitted in January 1870 and transferred to the asylum on two occasions, returning back to the workhouse for the second time in December. He was having fits about once per month, was ill tempered, used bad language, but had no delusions. Although fit to be discharged from the workhouse, he was unable to get work. Eli Ensor, a 28-year-old woman admitted in November 1867, was subject to fits about every seven days, was sometimes morose, but appeared contented. Elizabeth McGuire's fits had occurred every seven to ten days since her admission in November 1870 and, although the 32 year old was sometimes noisy, she could not be regarded as dangerous. In his report Adam Simpson, WMO, did not consider that any of them needed to be moved to the lunatic asylum.[65]

When the guardians were considering amending the number of attendants for the male epileptic wards in 1889, from two paid plus two pauper assistants to three paid ones only, they requested information on the number of fits occurring on the wards. Table 1.9 shows the figures provided by Dr Suckling, Visiting Physician, with the daily

[63] BCL, IHSC, GP/B/2/4/5/1, 24 July 1899; LGB Letters, GP/B/1/2/1/9, 12 April 1906; GP/B/1/2/1/6, 1 January 1900.
[64] BCL, BBG, GP/B/2/1/16, 20 June 1855.
[65] BCL, HSC, GP/B/2/3/3/2, 16 May 1871.

average ranging from 13 to 24, excluding the patient who had 150 fits in week eight. The result was the appointment of four paid attendants at 18 shillings per week each.[66]

Table 1.9: Average weekly number of fits over nine weeks in the male epileptic wards.

Week	Number of Patients	Number of Fits
1	36	168
2	37	157
3	37	129
4	37	97
5	38	89
6	33	127
7	36	149
8	39	307 (one patient had 150 fits)
9	39	167

Source: BCL, IMC, GP/B/2/4/4/1, 11 February 1889.

The guardians received a letter of thanks from the Vice Consul of Sweden and Norway in 1884 on behalf of F. Broderson, his countryman, who had been a patient in the epileptic ward. He wished to express his appreciation of the 'extreme kindness' with which he was treated, especially by the lady supervising the ward and his surprise at seeing what was done for the inmates.[67] In 1909, the guardians of Birmingham with those of Aston and King's Norton Unions bought Monyhull Hall and erected cottages for the care of 200 'sane epileptic and feeble minded persons'. Morrison suggests this set a pattern for the subsequent development of 'mental deficiency colonies'.[68]

[66] BCL, IMC, GP/B/2/4/4/1, 6 and 11 February 1889.
[67] BCL, VGPC, GP/B/2/8/1/9, 26 September 1884.
[68] BCL, BBG, GP/B/2/1/73, 20 July 1904; Morrison, p.174.

Patients' Experiences

Patients' narratives have assumed an important part of post-modern medical historiography, but have concentrated on hospitals and asylums.[69] Much less is known of the experience of patients in workhouses, due to the paucity of recording within poor law records. The words of inmates themselves are seldom found in official documents and only survive in fragmentary form. It is ironic that a system that gave rise to a massive archive of paperwork should contain so little of the views and experiences of paupers themselves.[70] Occasional reports relating to patients occur in the minutes of the Birmingham committees, most often relating to letters of complaint in local newspapers. One such was published in the *Birmingham Journal* in September 1857 under the title of 'A Voice from the Workhouse' and signed 'Pauvris'. This claimed that the guardians influenced the prescription of medicines by the medical officer on the basis of cost, namely 'all medicines more expensive than Epsom salts are unnecessary'. The author considered that the new WMO was more parsimonious with his medicines, basing his prescribing 'on the cheap principle'.[71] The WMO, William Fernie, denied that he had ever had any interference by the guardians in the prescription of drugs. The records show that the guardians always agreed with recommendations made by the medical officer and the difference between him and his predecessor was most likely due to each individual's prescribing habits.

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[69] For an overview of this approach, see Digby A., 'The Patient's View' in Loudon I. (ed), *Western Medicine: An Illustrated History*. Patient narratives feature in Porter R. and Porter D., *In Sickness and Health: The British Experience 1650-1850*; Porter R. (ed), *Patients and Practitioners*; Fissell M. E., *Patients, Power and the Poor in Eighteenth-Century Bristol* and Marland H., *Medicine and Society in Wakefield and Huddersfield, 1780-1870*. The patients' view has been recorded more extensively within the setting of the asylum in Porter R., *A Social History of Madness*; Peterson D. A., *A Mad People's History of Madness*; Bynum W. F., Porter R., Shepherd M. (eds), *The Anatomy of Madness*; Shepherd A., 'The Female Patient Experience in Two Late-Nineteenth-Century Surrey Asylums', *Clio Medica/The Wellcome Series in the History of Medicine.*

[70] Crowther, p.193; Driver, p.3.

[71] BCL, VGPC, GP/B/2/8/1/2, 4 September 1857.

The letter was found subsequently to have been written by George Johnson, alias Whittleworth, on charges brought by Daniel Smith, formerly an inmate.[72]

Hugh Thomas Leonard sent a letter to the LGB in 1896 complaining about the medical treatment of a fellow inmate, who appeared to other inmates as too ill to be classed as able-bodied. He was transferred to the infirmary after a few days, but died within an hour of arrival. William McDougall, WMO, explained that on initial examination, he had found only 'slight phthisis and rough breathing', for which he had prescribed cod liver oil and cough mixture. He had given the cause of death as cardiac failure. The Workhouse Management Committee found evidence of neglect on the part of McDougall in not seeing the patient again when requested by the labour master.[73]

A letter of gratitude was received in December 1902 from Henry Yarwood, who had been in the infirmary for 16 weeks suffering from Bright's disease. He had received 'every care and kindness from doctor and nurses, who pulled me through my long and dangerous illness'. In return, he offered to play his organette free in the workhouse on Christmas Day.[74] There is evidence that inmates were able to procure their own medicaments while in the workhouse, as a pauper messenger was found to be in possession of four ounces of opium on returning to the workhouse in 1893. It had been purchased for a female inmate who had been a long-standing opium user. The

[72] BCL, BBG, GP/B/2/1/20, 21 October 1857.
[73] BCL, WMC, GP/B/2/3/2/2, 28 February 1896.
[74] BCL, WIMC, GP/B/2/4/4/4, 15 December 1902. Bright's disease is a group of diseases characterised by inflammation of the kidneys and oedema of the lower body.

guardians requested an explanation from the chemist who had been supplying it to her.[75]

Nursing in the Workhouse

When the new workhouse opened in 1852, eight paid nurses were being employed, including one night nurse. Three paid nurses came with the children when they were moved into the workhouse from the Infant Poor Asylum. At that time, only 248 paid nurses were employed in workhouses in England and Wales.[76] It is uncertain when Birmingham guardians started to employ non-pauper nurses, but information on nurse employment is included in the *Ninth Annual Report of the Poor Law Commissioners* in 1842. A nurse was employed in the men's infirmary, one in the women's infirmary and one in the women's insane ward, each at an annual salary of £10. The three nurses in the women's bedridden, venereal and aged and infirm wards were paid £8 annually. There were also an assistant keeper in the men's insane ward and seven paupers paid as nurses, receiving between £1.5.01 and £1.10.0 per quarter. In addition, three paupers were paid to act as attendants, two as wardsmen and one as keeper in the men's insane ward. Because this system was 'unknown elsewhere', Hodgkinson claims that Birmingham guardians were 'more progressive than those of the Poor Law Unions'.[77] From returns received from workhouses with over 1,000 beds in respect of nursing staff in 1856, only Greenwich and Manchester had comparable staffing levels. Manchester, with 2,000 beds, employed 12 nurses

[75] BCL, HSC, GP/B/2/3/3/4, 10 January 1893.
[76] BCL, BBG. GP/B/2/1/11, 16 June and 22 September 1852; White, p.26.
[77] Power and Weale, 'Report on the Administration of Relief to the Poor in the Parish of Birmingham', *Appendix to Ninth Annual Report of the Poor Law Commissioners*, pp.139-140; Hodgkinson, pp.190-1.

although this number may have included paupers and Greenwich had 18 for 1,044 inmates. The Birmingham figures were 12 nurses and one attendant for 1,663 beds.[78]

Ten years later, in the mid 1860s, the number of nurses had increased to 17, but the number of sick patients had risen by the same proportion to 566. Eleven were paid £15 *per annum* plus rations, 4 received £20 *per annum*, while two male nurses were paid £33 16s. These were similar to the salaries paid in metropolitan workhouses, where the average wage was £20 18s.[79] The report by Dr Edward Smith, Medical Inspector of the PLB, later that year states there were 22 paid nurses, which included attendants, a wardsman and two night nurses for the infirmary. The nurses had the help of inmates so that they did not do 'any rough cleaning'.[80] Of the large workhouses Smith visited, Birmingham had the lowest ratio of 1 nurse to 26 patients, the next lowest being Liverpool at 1 to 38.[81] Further details on the number of paid nurses can be found in the list of quarterly salaries in the minute books of the Board of Guardians, though they may not have included all nursing staff. From these records, only 10 to 16 nurses were employed until a review of medical and nursing requirements took place in 1877. The sub-committee appointed for the purpose recommended the appointment of a superintendent nurse, who should be 'well qualified by training and education' and of two paid assistant nurses for the female venereal, female bedridden, male and female epileptic wards and male infirmary.[82]

[78] BCL, Returns, GP/B/18/2/1, 15 October 1856. Some workhouses employed many fewer, such as Liverpool and Marylebone Street, which both had over 2,000 beds but had only four and two paid nurses respectively.
[79] BCL, BBG, GP/B/2/1/33, 18 July 1866; Abel-Smith, *A History of the Nursing Profession*, p.14.
[80] Smith, pp.44-5.
[81] Ibid, pp.26-157.
[82] BCL, VGPC, GP/B/2/8/1/7, 3 May 1878.

One of the first tasks of the newly formed Infirmary Sub-committee in 1882 was to request the Superintendent Nurse, Kate Nicholson, to report on deficiencies in nurse staffing, with the result that four additional nurses were appointed for the female surgical, male and female epileptic, and male surgical and venereal wards. This brought the number of nurses and attendants to 29 to care for 1,173 patients.[83] There had been an increase in nurses and attendants to 37 by the end of the following year, although the number of patients had remained the same.[84] In 1885, three probationer nurses were appointed to compensate for the abolition of pauper nursing and within two years, 20 probationers were being trained.[85] The nursing department in the new infirmary was managed by a matron with nursing qualifications, and 19 charge nurses, six assistant nurses, seven male epileptic nurses, one female epileptic nurse and 40 probationers were initially employed in 1889.[86] Tables 1.10 and 1.11 reveal that Birmingham compared well with other large urban workhouses in the number of paid nurses employed in 1890 and 1896. By contrast, a large London teaching hospital at the end of the nineteenth century would have had one nurse to two or three patients.[87] Nursing duties are described in Appendix A. In 1893, Murray Browne, LGB Inspector, complimented the management of the infirmary, as he was certain that patients could not have 'better nursing in sickness'.[88]

[83] BCL, ISC, GP/B/2/4/1/1, 28 July and 1 December 1882; BBG, GP/B/2/1/50, 13 December 1882.
[84] BCL, BBG, GP/B/2/1/51, 12 December 1883.
[85] BCL, BBG, GP/B/2/1/53, 18 March 1885; ISC, GP/B/2/4/1/4, 4 November 1887.
[86] BCL, BBG, GP/B/2/1/59, 7 May 1890.
[87] Abel-Smith, *Nursing Profession*, pp.51-2.
[88] BCL, BBG, GP/B/2/1/61, 1 February 1893.

Table 1.10: Number of beds and nurses in selected urban workhouses in 1890.

Union or Parish	Number of beds in wards for the sick	Number of paid nurses	Number of beds per nurse
St Pancras	1554	860	19
Holborn	1249	56	22
Birmingham	1820	79	23
Liverpool	1720	84	21
West Derby	1230	36	34
Manchester	1440	82	18

Source: 'Workhouses, etc.', *Parliamentary Papers 1890-91 (365)*, pp.1, 12, 14.

Table 1.11: Number of patients and paid nurses in selected urban workhouses, and for England and Provincial England, 1896.

Union or Parish	Number of sick inmates	Number of paid nurses	Number of patients per nurse
St Pancras	1686	98	17
Holborn	917	69	13
Birmingham	917	73	13
Liverpool	1202	100	12
West Derby	1237	110	11
Manchester	981	95	10
All England	56,628	3,625	16
Provincial England	39,083	2,111	19

Source: 'Workhouses, etc.', *Parliamentary Papers 1896 (371)*, pp.2-4, 6-7, 28-29, 32-3

This chapter has shown how the numbers of patients at the New Birmingham Workhouse increased steadily after it opened in 1852. It expanded with the addition of new wards, but when the number of patients had increased five fold, it became necessary to erect a new larger infirmary. Because the two institutions were managed separately under different masters, patients suffered difficulties in being transferred between them appropriately. Overcrowding, especially in the epileptic wards, took place in the infirmary, affecting living conditions and standards of care, although improvements gradually took place. Epileptic patients in the workhouse have been neglected compared with other groups, such as venereal patients and lunatics. This study has been able to give more insight into how these patients fared within the institution. The guardians employed paid nurses in the workhouse from the date it opened, in addition to pauper nursing assistants. The institution was one of the few in

the country where non-pauper nurses were in paid employment. Quality of nursing care was variable, but improved once trained nursing supervisors were appointed. By the late 1890s, the infirmary and its matron had gained a national reputation for the high standard of nursing care. Although the recorded experiences of patients were few in number, they demonstrate that some patients did receive benefit from the care they received in the infirmary throughout the second half of the nineteenth and early twentieth centuries. Such positive opinions support the more balanced view of medical care recorded in other studies of sick indoor paupers.[89]

[89] Particularly notable in this respect are Digby, Higgs and Negrine.

CHAPTER 2

MEDICAL OFFICERS AND THEIR TREATMENTS

Introduction

Numerous studies of the poor law medical service have been carried out, but few concentrate on the medical treatment practised in the workhouse.[1] This chapter will include descriptions of how medical officers of the Birmingham Workhouse attempted to introduce and provide medical care which was at the forefront of medical treatment at the time in which they practised. Neither the central authority nor local boards of guardians published medical reports of their work. Sidney and Beatrice Webb, in their survey of the state medical service, quote a comment from a witness to the Poor Law Commission in the first decade of the twentieth century: 'The Poor Law statistics have steered very clear of medical statistics'.[2] The couple, who were social reformers and historians of the poor laws, were critical of both the Poor Law Board (PLB) and the Commission for the deliberate neglect of the treatment of sick paupers, despite attempts of several publications at the time to draw the attention of the central authorities to the imperfection of medical provision.[3]

More importance was attached, both centrally and locally, to the administrative aspects of the duties of the medical officer. He was required to compile a monthly report on defects in diet, drainage, accommodation, overcrowding, ventilation, heating, nursing, and to designate the classification and fitness for punishment of

[1] The most extensive is that of Hodgkinson, *The Origins of the National Health Service,* although it only covers the period of 1834-1871. Others include Crowther, *The Workhouse System*, 1834-1929; Flinn, 'Medical Services under the New Poor Law' in Fraser (ed) *The New Poor Law in the Nineteenth Century*; Higgs, *Life in the Victorian and Edwardian Workhouse*; Lane, *A Social History of Medicine*; Webb and Webb, *The State and the Doctor*.
[2] Webb and Webb, *The State and the Doctor*, p.110.
[3] Webb and Webb, *Poor Law History*, pp.315-6.

paupers. Several historians have recorded that his reports were often disregarded by the guardians.[4] Clinical duties included the examination of all new inmates, the certification of those who were mentally ill and punctual attendance to all those who required medical attention. He was required to keep a detailed account of any 'extras' in the way of food or beverages that he prescribed, but was not expected to keep records of the medical condition and treatment of patients.[5]

In Victorian England, the status of poor law medical officers was low, both within the profession and the poor law administration. Although attempts by the Poor Law Medical Officers' Association at bringing about reform, both to employment conditions for medical officers and standards of medical care for patients, did not come to fruition, individual doctors gradually brought about piecemeal improvements within their local union by 'perpetual guerrilla warfare'.[6] Eventually, they became one of the most influential of officers within the poor law service so that, by the early twentieth century, guardians were unlikely to ignore the recommendations of their medical officer, with regard to patient care. Even if, as in Crowther's view, poor law medical officers remained at the bottom of the medical hierarchy, they did benefit from the rise in prestige of doctors and upheld the standards of their profession. Hodgkinson points out that 'even those workhouse doctors whose whole time was engaged in public service remained aloof in spirit from its [the Poor Law administration's] cramping and restrictive influence'. Poor law medical officers

[4] Abel Smith, *The Hospitals*, 1800-1948, pp.60-1; Crowther, p.163-4; Higgs, p.119; Hodgkinson, *The Origins*, p.458; Hodgkinson, 'Poor Law Medical Officers of England, 1834-1871', *Journal of History of Medicine and Allied Sciences*, XI (1956), p.321.
[5] Abel Smith, p.60; Crowther, p.163; Hodgkinson, *The Origins*, p.458.
[6] Flinn, p.61.

played a major role in separating medical care for the poor from relief of destitution, turning 'paupers into patients'.[7]

The most usual arrangement for medical care for inmates of the workhouse was for guardians to engage a private practitioner under contract. In some instances, it was included in the duties of District Medical Officers.[8] Less commonly, a whole-time medical officer was appointed specifically for the workhouse, and may have been required to reside within it. By the end of the 1860s, whole-time contracts were becoming more common, especially in large urban workhouses, such as Liverpool, Nottingham and Manchester.[9] In the metropolitan unions in 1871, only 8% of 142 medical appointments were described as workhouse medical officers with less than half resident.[10] In 1900, 93% of 625 unions in England and Wales reported having no resident medical officer in the workhouse.[11]

This chapter will concentrate on the medical officers employed within the workhouse, to the exclusion of the resident medical officers in the later separate infirmary. Their terms and length of service, the extent of their workload, and opinions over their ability to perform their duties satisfactorily will be discussed in the light of the increasing number of sick inmates. Difficulties arose later in the allocation of duties between the medical officers of the workhouse and infirmary. Details will be provided of the steps taken by the guardians to resolve them and to provide adequate arrangements for the medical care that was still required in the workhouse. Medical

[7] Crowther, *The Workhouse System*, p.167; Hodgkinson, *The Origins*, p 683; Crowther, 'Paupers or Patients? Obstacles to Professionalization in the Poor Law Medical Service Before 1914', *Journal of History of Medicine and Allied Sciences*, 39 (1984), p.53; Lees, *The Solidarities of Strangers*, p.279.
[8] Crowther, *The Workhouse System*, pp.157-8.
[9] Hodgkinson, *The Origins*, p.349; ibid, 'Poor Law Medical Officers', p.320.
[10] Hodgkinson, *The Origins*, p.399-401.
[11] Webb and Webb, *State and Doctor*, p.100 n. 1.

treatments prescribed and surgical operation performed will be described, along with disagreements with the guardians over some of these medical practices. These issues will be examined in order to show that the medical role of the workhouse was substantial and that the medical practice within it was carried out to a high standard.

Medical Officers in the New Birmingham Workhouse

Birmingham guardians appointed medical officers to full-time duties in the workhouse where they were required to reside. In addition to their salary, they were provided with furnished apartments, fuel and the services of a servant. The guardians paid for all medicines dispensed to inmates. Private practice was not permitted. Workhouse Medical Officers (WMOs) were subject to the same restrictions on leaving the institution, such as recording their times out of the house, as all other officers.

John Humphrey transferred from the Old Birmingham Workhouse, where he had been WMO for the previous two years. From then until the outbreak of the First World War, fourteen medical officers were in post, serving for periods varying from one month to 16 years, with an average of 4 years and 7 months (Table 2.1). The resulting lack of continuity of medical care meant that the quality of care very much depended on the individual WMO's practice. This contrasts with the position at Leicester Workhouse, which employed only three WMOs over the same period. As it was less than half the size of Birmingham, the WMOs worked part-time for the guardians and

had private practices in the town, which explains the longer periods of service.[12] The dependence on one person lessened after 1876, when Assistant Workhouse Medical Officers (AWMOs) were appointed. Voluntary hospitals ensured greater continuity of care by appointing local medical practitioners as honorary visiting doctors, who might stay in post throughout their working life. For instance, of 21 physicians and surgeons at Birmingham General Hospital between 1848 and 1909, ten served between 10 and 20 years, five between 20 and 30 years and four more than 30 years.[13] Birmingham guardians adopted this approach by appointing a salaried visiting physician in 1882 and a visiting surgeon five years later.[14] AWMOs served for short periods that were rarely more than two years (Tables 2.2 and 2.3). The only exceptions were Charles Mitchell, who was an assistant for almost ten years before becoming WMO, and James Bennett who had served for just over two years before becoming a resident surgeon at the new infirmary.[15] The resident medical officers at the General Hospital between 1857 and 1875 served similar short periods, averaging between two and a half and three years.[16] The WMOs over this period also served for an average of three and a half years (Table 2.1). It would appear these posts were being used to gain more experience early in a medical career.

WMOs resigned for a variety of reasons although they were not always recorded in the Board's minutes. One resigned because of ill health; another as he felt unable 'to continue the necessary performance'; and another to return to Australia. Several took

[12] Negrine, Medicine and Poverty: A Study of the Poor Law Medical Services of the Leicester Union, 1876-1914, (unpublished PhD Thesis, 2008), p.53.
[13] BCL, GHAR, HC/GH/1/3//2-22, 1857-1909. The information from the Annual Reports is difficult to analyse precisely as only 21 reports are available over these years.
[14] BCL, BBG. GP/B/2/1/49-76, January 1882 to June 1908.
[15] Interestingly, Mitchell's brother was assistant master of the workhouse at the same time and the guardians allocated accommodation for them to live together on site, BCL, HSC, GP/B/2/3/3/10, 2 November 1886.
[16] BCL, GHAR, HC/GH/1/3/2-15, 1857-1875.

up other appointments, for example, at the Borough Lunatic Asylum and as Public Vaccinator for the Parish and in the 1890s, two became District Medical Officers. The guardians requested the resignation of Redfern Davies following frequent unauthorised leaves of absence, and the LGB removed the longest serving officer after an enquiry found that he had disobeyed an order of the guardians not to attend the lying-in wards during an outbreak of puerperal fever. William Sturrock, the last WMO, was called up for active service in 1914, having joined the Territorial Army six years before. [17]

Table 2.1: Workhouse Medical Officers in Birmingham Workhouse, 1850-1914.

Name	Date appointed	Annual salary	Date terminated	Reason for termination
John Humphrey	March 1850	£150-£175	April 1855	Appointed to civil hospital
William Fernie	May 1855	£150	April 1857	Resigned
John Wilmshurst	May 1857	£150	May 1858	Resigned
John Redfern Davies	June 1858	£150-£200	Oct 1861	Resigned at request of guardians
Edmund Robinson	Oct 1861	£200-£350	Jan 1869	Appointed public vaccinator
Edmund Whitcombe	Feb 1869	£200	July 1870	Appointed to Borough Lunatic Asylum
Adam Simpson	Aug 1870	£200-£350	Aug 1886	Removed from office by LGB
Charles Mitchell	Aug 1886 (acting) Jan 1889	£207	Jan 1890	Resigned
Edmund Corder	Feb 1890	£150-£200	Feb 1890	Resigned
E Teichelmann	Feb 1890	£150-£200	Sept 1891	Resigned
George Ferraby	Oct 1891	£150	Oct 1894	Appointed DMO
George Barber	Nov 1894		May 1895	Resigned
Alexander McDougall	May 1895	£150-£200	March 1899	Appointed DMO
William Sturrock	May 1899	£150-£200	Sept 1914	Active service

Source: BCL, BBG, GP/B/2/1/6-76, January 1850 to June 1908;
BCL, GPC, GP/B/2/8/2/1, September 1913.

[17] Ibid; BCL, GPC, GP/B/2/8/2/1, 23 September 1914.

Table 2.2: Senior Assistant Workhouse Medical Officers, 1876-86.

Name	Date appointed	Annual salary	Date terminated	Reason for termination
Cuthbert Fitzsimon	Jan 1876	£100	March 1876	Resigned
Aird Jolly	May 1876	£150	March 1877	Resigned
Charles Mitchell	May 1877	£150	Aug 1886	Acting WMO

Source: BCL, BBG, GP/B/2/1/44-55, January 1876 to July 1887.

Table 2.3: Junior Assistant Workhouse Medical Officers, 1878-88.

Name	Date appointed	Annual salary	Date terminated	Reason for termination
Robert McVittie	Aug 1878	£130	Nov 1879	MO to Marston Green Children's Home
Alex Suffern	March 1880	£130	Sept 1881	Temporary appointment
Richard Cowan	Jan 1882	£150	May 1883	Resigned
Walter Williams	May 1883	£130	Jan 1885	Resigned
Walter Dandy	Feb 1885	£130	May 1885	Resigned
Henry Cook	June 1885	£130	July 1886	Resigned
James Bennett	Aug 1886	£107	Nov 1888	Resident Surgeon at new infirmary

Source: BCL, BBG. GP/B/2/1/46-57, May 1878 to May 1889;ISC, GP/B/2/4/1/2,3, Nov 1883 to September 1887.

'Overworked'

It is generally agreed that WMOs were poorly paid and overworked, but strove to provide as high a standard of medical treatment to patients as found in voluntary hospitals.[18] The ratio of medical staff to patients was usually less than in the voluntary hospitals. An article in the *Lancet* in 1867 commented that Bethnal Green Workhouse had only one medical officer for 600 patients, whereas a similar sized London Hospital would have had 15 doctors.[19] In 1865, the General Hospital in Birmingham had two resident medical officers and an average daily number of patients of 162. They were supported by 8 honorary physicians and surgeons, whereas, the WMO had no support and 582 patients under his care. At the same ratio as the General Hospital for resident medical staff to patients, the workhouse would have required 6 medical

[18] Peterson, *The Medical Profession in Mid-Victorian London*, p.111; Crowther, 'Paupers or Patients?', pp.37, 47-8.
[19] Quoted in Hodgkinson, p.356.

officers.[20] The employment of only one medical officer was severely criticised by a local doctor in 1865 as unbelievable that 'a rich and progressive town like Birmingham' would permit 'an infirmary containing 599 beds to be officered by one medical man'.[21]

In 1856, the Birmingham guardians decided to compare their staffing levels and salaries with those workhouses in England and Wales built for the accommodation of 1,000 inmates and upwards (Table 2.4**).** The guardians took no action on the basis of the returns.

Table 2.4: Number of medical officers with remuneration, in workhouses in England built to accommodate 1,000 inmates or more, 1856.

Union or Parish	Number of Inmates	Number of Medical Officers	Annual Salaries	Extra Remuneration
Birmingham	1663	1	£150	Board
City of London	1016	1	£175	Rations
Clifton	1186	1	£70	-
Greenwich	1044	1	£175	-
Lambeth	1100	1	£250	Board, rations
Liverpool	2345	4	£100, £100, £80, £80	Rations for two juniors
Manchester	2000	2	£130, £85	-
Marylebone Street	2000	2	£150, £80	Rations
Nottingham	1150	2	£120, £120	-
Portsea Island	1150	1	£150	-

Source: BCL, Returns, GP/B/18/2/1, 15 October 1856.

The annual salary of John Humphrey at Birmingham at this time was £175, having been increased by £25 when the children in the Infant Poor Asylum were transferred to the New Workhouse.[22] Within a few months, he was complaining of an 'extensive increase in duties', having attended 1048 patients over the past year, with 706 coming under his care in the last six months. He felt in need of help as 'the continuous strain

[20] BCL, GHAR, HC/GH/1/3/8, 1864-5l; Smith, *Provincial Workhouses, 1867-68(4)*, p.45.
[21] Heslop, 'The Medical Aspects of Birmingham' in Timmins (ed), *Birmingham and the Midland Hardware District*, pp.701-2.
[22] BCL, BBG, GP/B/2/1/11, 6 October 1852.

presses hard on physical and mental energy when only a single acting individual'.[23] His suggestion of being allowed an articled pupil, as was the case with District Medical Officers, was agreed by the guardians but refused by the PLB on the grounds that they had 'no legal authority' to allow anyone to reside in the workhouse who was not directly responsible to the guardians through the master.[24] Two years later, he again appealed for help:

> The continued and regular increase in the number of sick persons admitted into Birmingham Workhouse renders it absolutely necessary to apply to you for some assistance. Since the commencement of this year I have admitted into the Infirmary 448 patients, making with 273 persons in the sick wards on the 1st of January, a total of 721. Besides the patients in the Infirmary, I have a large number to attend to in the Workhouse and my duties....become so great as at times completely exhaust me. The daily average of patients in the Infirmary is 318 and this number prevents me from giving that attention to some of them, which their cases require.[25]

Although a non-resident dispenser was appointed at an annual salary of £75, John Humphrey resigned a few months later to take up an appointment at a new civil hospital near Constantinople.[26]

His replacement, William Fernie, resigned within two years because he felt unable to 'continue the necessary performance of my unremitting duties with no reasonable opportunity for recreation of body or relaxation of mind'.[27] In his testimonial, the guardians referred to his 'onerous duties under circumstances of trial and difficulty arising from the crowded state of Workhouse'.[28] One of the two candidates selected

[23] BCL, VGPC, GP/2/8/1/1, 31 December 1852.
[24] Ibid, BCL, BBG, GP/B/2/1/12, 5 January to 5 February 1853.
[25] BCL, BBG, GP/B/2/1/15, 28 February 1855.
[26] Ibid, 4 April 1855.
[27] BCL, BBG, GP/B/2/1/19, 8 April 1857; the words were underlined in the record of his letter to the guardians in the Board minutes.
[28] Ibid, 15 April 1857.

for interview for the vacant post was an Assistant Surgeon at St Pancras Workhouse, but he withdrew his candidacy when he discovered the extent of the duties at Birmingham.[29] Despite this, the guardians made no attempt to provide assistance, even when requested by the WMO, John Wilmshurst, in February 1858. They gave the comparison with other workhouses carried out two years before as providing 'no sufficient grounds for further aid' (Table 2.4).[30] Wilmshurst resigned three months later, though no reason for this was recorded in the minutes.[31] After two years in office in 1864, Edmund Robinson, WMO, recorded that the number of inmates on the sick list over that period had increased from 486 to 608.[32] As a result of the general increase in the size of the workhouse, he complained of his 'labours greatly increased, his duties occupying him all day and some portion of the night'.[33] His request for an increase in salary, rather than for assistance, was granted and it was put up from £200 to £250 *per annum*. A report by the Medical Officer for the PLB in 1866 recorded that the medical officer had charge of 606 to 700 sick inmates and was satisfied with his position and emoluments, could do the whole work, and did not at that time need an assistant. His salary was reported as £350 yearly in addition to 'house, servants, fire, light and washing'.[34]

Following a report by the Local Government Inspector in March 1874 stating that medical staff was totally insufficient for the requirements of the workhouse, an assistant medical officer to act under the direction of the WMO was recommended for

[29] BCL, BBG, GP/B/2/1/19, 6 May 1857.
[30] BCL, VGPC, GP/B/2/8/1/2, 12 February 1858.
[31] BCL, BBG, GP/B/2/1/21, 19 May 1858.
[32] BCL, VGPC, GP/B/2/8/1/4, 1 January 1864.
[33] Ibid.
[34] Ibid; Smith, p.43.

appointment at an annual salary of £100. However, it took 18 months before the Board finally gave its approval.[35]

'Totally Insufficient' Medical Staffing

A subcommittee was set up in October 1877 to consider medical and nursing arrangements and duties and the efficiency of all the officers of the workhouse. The WMO, Adam Simpson, was questioned about his duties and workload. He considered that he had had no particular difficulty in performing his duties without assistance but had an 'uncomfortableness of leaving the place'.[36] He had worked hard but had 'broke down two to three times' and felt there was more work with the patients than he could perform.[37] It was not the patients who had suffered, but himself. Now that there was an AWMO, he takes one side of the house and the assistant takes the other; they alternate daily. With a second assistant, the AWMOs would share the house between them, visit their patients daily and he would provide supervision and be available for consultation over difficult cases. Simpson estimated that three medical officers were needed to provide sufficient care to the number of patients, which he put at 900 to 1,000.[38]

The AWMO, Charles Mitchell, agreed with the need for an additional medical officer. Although patients did not suffer, they were liable to be overlooked and with more time, could be more carefully examined. He spent from 9.00 am to 12 noon going round the wards and seeing people in the body of the house and saw admissions in the

[35] BCL, VGPC, GP/B/2/8/1/6, 13 March 1874, 2 July and 29 November 1875.
[36] BCL, WIMC, GP/B/2/3/11/1, 24 January 1878.
[37] Ibid.
[38] Ibid.

afternoon. He was called up at night about twice per week. After considering their evidence, the subcommittee's recommendation was to appoint a third medical officer in order to give 'complete and careful medical attendance'. They were impressed by the large number of acutely ill patients, which had turned the workhouse into 'a large Hospital containing cases of so many various kinds of disease'.[39] The guardians had recognised in their own institution the national trend toward the increasing involvement of workhouses in medical care.

A further review of the medical department was carried in 1882, following criticism by LGB Inspectors. To aid this process, a deputation was sent to assess the medical administration of the workhouse at Liverpool. It reported that Liverpool housed around 3,000 compared with about 2,500 in Birmingham and that around six capital operations were carried out there each week. A comparison was made of the cost of the medical departments at the two workhouses (Table 2.5). Birmingham appears generous in its payment to medical staff as it was very unusual for poor law medical salaries to rise above £250 *per annum*.[40]

Table 2.5: Annual cost of medical administration in Liverpool and Birmingham Workhouses in 1882.

Liverpool		Birmingham	
Medical officer	£150	Medical officer	£350
Surgical officer	£150	Assistant MO	£200
3 Assistant MOs	£240	Assistant MO	£150
Dispenser	£80	Dispenser	£130
Assistant dispenser	£78	Assistant dispenser	£18
Total annual cost	£698	Total annual cost	£858

Source: BCL, HSC, GP/B/2/3/3/8, 4 July 1882.

[39] Ibid, 22 March 1878; VGPC, GP/B/2/8/1/7, 3 May 1878.
[40] Peterson, pp.211, 214.

The medical and surgical officers in Liverpool were non-resident, visited the workhouse daily and supervised the assistants. The Birmingham deputation queried the 'smallness' of medical staff relative to the nature of the cases. The Liverpool guardians considered that by allowing them to have private practices, they were able to appoint a 'high class' of medical officer.[41] The result was the appointment of Dr C. W. Suckling as Visiting Physician at an annual salary of £150. He also held an appointment as honorary physician to the Queen's Hospital He was required to make daily visits to the workhouse and take charge of the medical wards, leaving Simpson to cover the surgical wards. The two AWMOs would be divided between each side of the house attached to either the WMO or the visiting physician.[42] Five years later, Dr George Jordan Lloyd was appointed Visiting Surgeon at the workhouse at an annual salary of £150, to make a daily visit and take charge of, and be responsible for, the surgical wards of the infirmary.[43] At that time, he held the appointment of Honorary Surgeon to Queen's Hospital and later became Professor of Surgery in the University of Birmingham

When the new infirmary opened in 1889, the AWMOs were transferred as resident surgeons and Charles Mitchell, the acting WMO, was appointed to the post on a substantive basis. The Visiting Physician and Surgeon had their duties apportioned between the two institutions, with the majority of their time spent at the new infirmary. The following year, the Workhouse Management Committee considered the arrangements for dispensing at the workhouse and suggested it be carried out by the WMO. He felt unable to comply as he was fully occupied with his duties of

[41] BCL, HSC/GP/B/2/3/3/8, 4 July 1882.
[42] BCL, BBG, GP/B/2/1/49, 14 June 1882; GP/B/2/1/50, 26 June and 1 November 1882.
[43] BCL, BBG.GP/B/2/1/55, 5 January 1887.

examining and prescribing for patients in the workhouse.[44] From 9 to 11.30am, he examined all tramps and outpatients and then he visited the wards. Following that, he examined every case before being sent to the new infirmary and 'saw all discharges'. He admitted 30 to 40 inmates daily, taking up to 15 minutes with each one and was occupied in 'seeing admissions till 11.00pm'. He spent considerable time in the bedridden and venereal wards and wrote 30 prescriptions daily, which he felt would take two hours to make up.[45]

Medical Treatment

Despite the low status of poor law medical officers, there is evidence from the Birmingham records that some of those employed as WMOs were conscientious, provided care of a high quality and utilised recently introduced treatments and procedures. John Wilmshurst in 1857 wrote to the guardians detailing his new mode of treatment for itch, imported from Belgium. This consisted of washing and drying the body of the infected person and applying a dressing of lime and sulphur, which was then washed off. He pointed out that only one application was necessary and so the treatment would create more space in the infirmary for urgent cases.[46] This treatment with a solution of sulphur and lime was used in preference to the previous treatment by sulphur ointment as it did not contaminate bedding and allowed patients to be dressed while being treated. However, it was not in general use in workhouses

[44] BCL, WMC, GP/B/2/3/21, 11 April 1890.
[45] Ibid.
[46] BCL. BBG. GP/B/2/1/19, 24 June 1857. Sulphur is an effective topical remedy for scabies and continues to be recommended in current medical textbooks.

ten years after Wilmshurst introduced it to Birmingham.[47] It is likely he was aware of the need for the extra wards that had been recommended by the Poor Law Inspector 19 months previously because of overcrowding in certain wards. The additional beds included 40 for itch cases, but the advice was not accepted by the guardians.[48]

The following month, the guardians became concerned about the large increase in syphilitic cases and whether it was due to more liberal treatment being extended to 'that unfortunate class'.[49] Wilmshurst's view was that they were 'neglected in many Unions and the surgeon never examined them' and they were 'simply dosed with salt and senna and discharged cured'. He felt it was not surprising that they came 'where they can get some specific medical treatment in wards set apart for the cure of these complaints'.[50] Despite this comment, the number of those with venereal disease had fallen from 64 patients at the time of his appointment to 23 twelve weeks later.[51] His opinion was substantiated by a statement from Emma Rose, a 23 year-old inmate, in November 1857:

> I belong to Kidderminster – I have been in the workhouse there about three months and suffered from venereal disease all the time I was in that workhouse. I was in bed all the time – I often asked the Medical Attendant for Medicine but during the last 2 months, I could not obtain any. Mrs Priddy, the Nurse of the Sick Wards examined me one morning in the early part of last week and said I was worse than when I went into the workhouse and was in a very bad state indeed. She said that if I came to the Birmingham Workhouse, I should be sure to get cured and she advised me to come to the Birmingham Workhouse. I arrived in Birmingham last Thursday evening….and on Friday morning I (in

[47] Smith, p.8; most cases of itch were the result of scabies and the acarus mite was demonstrated to be the causal agent by Renucci in 1834, Parish, 'History of Scabies' in Orkin and Maibach (eds) *Cutaneous infestations and insect bites*, p.7.
[48] BCL, VGPC, GP/B/2/8/1/2, 30 November 1855 and 25 January 1856.
[49] BCL, VGPC, GP/B/2/8/1/2, 31 July 1857.
[50] Ibid, 7 August 1857.
[51] Ibid.

company with Emma Bayliss) went to the parish offices to ask for a Note of Admission into the workhouse.[52]

An enquiry by the guardians to Kidderminster Union elicited a denial by Mrs Priddy of the statement she was alleged to have made and attributed the comment to Elizabeth Edwards, an inmate at Kidderminster, who was suffering from venereal disease. Edwards had said 'she had had more good done to her in six weeks' in the Birmingham Workhouse than in two years in Kidderminster.[53] The medical officer there reported that Emma Rose was treated with nitrate of silver almost daily for the removal of condylomata, having refused to have 'the better and quicker remedy, nitric acid'.[54]

Surgery in the Workhouse

From the start, Birmingham guardians preferred to send inmates requiring surgery to a local voluntary hospital and consent of the Board was required in each individual case. The guardians, also, had to agree before any operation could be carried out within the workhouse and frequently, delays occurred. For instance, in 1854, a man called Trafford had 'intensive disease of right arm and elbow joint'. He had been seen by a District Medical Officer and a surgeon, who recommended immediate amputation of the limb to give any chance of recovery. However, the guardians requested a further surgical opinion.[55]

[52] BCL, BBG GP/2/1/20, 18 November 1857.
[53] Ibid, 2 December 1857.
[54] Ibid. Condylomata are wart-like excrescences near the anus or vulva, which occur in the secondary stage of syphilis. Wilmshurst did not detail the treatment he provided to patients with venereal disease. The main form of treatment at that time was mercury, although local applications of nitric acid were also in use, Wyke, 'Hospital facilities for, and diagnosis and treatment of, venereal disease in England 1800-1870', *British Journal of Venereal Disease*, (1973), 49, pp.81-2.
[55] BCL, BBG, GP/B/2/1/14, 24 February 1854.

This position was challenged by Redfern Davies, appointed WMO in June 1858. Eight months later, he wrote to the PLB requesting the right to perform amputations and capital operations in the workhouse. The PLB referred it back to the guardians who confirmed their objections to this and their preference for such operations to be carried out in hospital because of 'the ample and neat accommodation and the practised skill and combined judgement of medical men in these establishments'.[56]

By this time, he had already published accounts in the *British Medical Journal* of procedures he had carried out in the workhouse, though no record of permission by the guardians appears in the records. The first was the removal of glandular enlargements in the neck, pressing on the trachea, in an eight-year-old boy, Henry Baggotts, under the administration of chloroform. Within two weeks the wound had healed and the boy's respiration had become normal.[57] The other involved a novel technique for the radical cure of hydrocele using metallic wires instead of vegetable ligatures. Patrick Coyne, aged 32 years, was admitted with a recurrent hydrocele, which had accumulated to the size of 'a small cocoa-nut'. According to the 'plan suggested by Professor Simpson', two iron wires were introduced and withdrawn seven days later after all the fluid had drained and hot fomentations applied. According to Davies, within two weeks, 'the case would seem to be radically cured'.[58] He had carried out a large number of operations for the repair of inguinal hernia using a new technique and been the first to use it for curing femoral and ventral hernia.[59]

[56] BCL, BBG, GP/B/2/1/22, 9 February 1859.
[57] Davies, 'Birmingham Workhouse Infirmary', *British Medical Journal,* 1 (1858), p.677.
[58] Ibid, 1 (1859), p.284.
[59] Pemberton, 'Contributions to Clinical Surgery', *British Medical Journal*, 1 (1859), pp.520-1.

In June 1859, he was questioned by the Visiting and General Purposes Committee regarding the case of Edward Waite whose leg had been amputated by him with the assistance of Mr Oliver Pemberton, surgeon to the General Hospital. The patient had died the day after the operation. The committee wished to know if it was his intention to perform 'amputation and capital operations' in the workhouse. He defended his actions stoutly, saying 'It is not illegal for the surgeon of the workhouse to operate on capital cases' and he considered it was 'his duty to do so and would do the same as in the case of Edward Waite'. The decision of the committee was to ask him to resign because he had acted improperly in contravening resolutions of the Board. Davies was forced to retract his statement and, in a letter to the Board, explained he had meant to act only in cases of emergency, where removal to hospital would not be possible. The Board accepted the situation as 'a misunderstanding'.[60]

Three months later, he reported to the committee that Thomas Carey and William Slaney needed amputations and it was agreed they should be transferred to the General Hospital. Thomas Ferris wished to have his leg amputated because of an enormous leg ulcer of 25 years standing, but the committee deferred making a decision and the matter was never raised subsequently.[61] At this time, Redfern Davies was on leave recovering after an accident. Although he did return to work, the guardians requested his resignation because of frequent, unauthorised periods of absence from the workhouse.

The requests for surgery appear to have declined after this. Edmund Robinson, the WMO in 1866, informed Edward Smith, Medical Officer to the PLB on one of his

[60] BCL, BBG. GP/B/2/1/23, 8 June and 22 June 1859; VGPC, GP/B/2/8/1/3, 3 June and 24 June 1859.
[61] BCL, VGPC, GP/B/2/8/1/3, 2 September 1857; 11 January 1861.

visits, that there were 'scarcely any surgical cases in the workhouse, and capital operations are not performed there'.[62] Nevertheless, in the next year, the guardians had to agree to allow John Walsh to have his right leg amputated in the workhouse, despite wishing him to be transferred to hospital. He was suffering from malignant disease of the knee joint with displacement of the bones, which would be fatal if not removed. The surgical advice was that the operation would be hazardous and uncertain, but his only chance of life, while each day of delay was adding to the risks. He was in too much pain to be transferred to hospital. He was reported to be doing well a few days after surgery.[63]

In 1887, two years before the new infirmary opened, the guardians were concerned at the rising cost of expenditure on drugs. One of the reasons given by the dispenser was that surgical operations, which were previously performed at one of the voluntary hospitals in the town, were now being done in the workhouse.[64] Once it was functioning, all surgery took place in the new infirmary, but few details of the nature of that surgery are recorded.

Summary

Crowther quotes the Chairman of the Infirmary Sub-committee, who was a doctor in Birmingham in the early 1880s, on the subject of the type of doctor who was employed as a medical officer in the workhouse:

[62] Smith, 1867-68, p.45.
[63] BCL, VGPC, GP/B/2/8/1/5, 18 and 25 January 1867.
[64] BCL, ISC, GP/B/2/4/1/4, 25 November 1887.

> The ranks are filled chiefly from two classes: first, the young and needy practitioner, who is glad of the stipend until he has established himself in practice…. the other, the middle-aged or old man who has never been able to make an income sufficiently large to enable him to do so….[65]

Birmingham workhouse appears to have employed mostly the first kind, as the majority only stayed a short period in office, despite being relatively well remunerated. Of those who resigned of their own accord and for whom a reason was recorded, almost half took up posts in the public health service locally, where private practice would also be possible. The calibre of many of the workhouse medical officers is difficult to judge though the available evidence shows several practised to a high standard and adopted new medical techniques and treatment. Only Adam Simpson, the longest serving medical officer, had complaints against him of maltreatment of patients upheld including one of confining an inmate in the padded room as a form of punishment. His eventual dismissal, however, had more to do with him disobeying an order of the guardians than with his medical practice. Medical details regarding the workhouse became sparse after the opening of the new infirmary, although a considerable amount of medical activity continued within its walls, particularly dealing with chronic disease.

The reviews of medical staffing in Birmingham confirm that the WMO worked long hours, often till late at night, and had a large number of inmates under his care. A number of medical officers resigned because of the extent of their duties. This problem recurred after the medical staff transferred to the new infirmary, leaving one doctor to manage sick inmates in the workhouse and to examine all admissions. His decisions as to which patients should be admitted to the infirmary were a source of

[65] Crowther, *Workhouse System*, p.174.

conflict between himself and the infirmary medical officers. As a result, the guardians gradually allowed patients to be admitted to the infirmary directly. Disputes took place between the surgeons over operating procedures and one example of this is given in Appendix B.

Although the mainstay of medical care was the provision of hygienic conditions and satisfactory nutrition, new treatments were introduced. In the late 1850s, Redfern Davies attempted to establish surgery in the workhouse and carried out a number of innovative operations. The evidence points to the fact that WMOs employed in the Birmingham workhouse showed initiative in the care they provided for patients. The standard of care in the infirmary was of a sufficiently high standard to be acceptable to doctors themselves. The WMO in 1903 thanked the guardians for allowing him to be treated as an inpatient in the infirmary.[66] In 1887, the Birmingham guardians felt able to 'confidently assert that the Sick Inmates are made most comfortable, that their lives are prolonged, and that they are fully treated up to the scientific attainments of the present day'.[67]

[66] BCL, WMC, GP/B/2/3/2/3, 10 December 1903.
[67] BCL, ISC, GP/B/2/4/1/4, 25 November 1887.

CHAPTER 3

AGED AND INFIRM MEN AND WOMEN AND THEIR COMFORTS

Introduction

Older people constituted a large and important group of inmates in workhouses, but one that has been relatively neglected within workhouse records. Crowther has pointed out that no regular census by age group of inmates took place prior to 1913, though she cites the finding of the Royal Commission on the Aged Poor that 46.5% receiving poor law relief were over 60 years of age and nearly half were in workhouses.[1] Beatrice and Sidney Webb put it more graphically: 'The Aged and Infirm constitute more than one-third of the entire pauper host', though this would have included those receiving outdoor relief.[2] Thomson has calculated the percentages of the population of England and Wales aged 65 and over in poor law institutions, using the ten yearly census figures. These show a steady increase from about 13% in 1851 to about 23% in 1901, although the proportion declines to 20% in 1911, similar to the level found in 1891.[3] He also draws attention to the difference between London workhouses, where 33% of inmates were aged over 65 years in 1851, and those in the rest of the country, where the corresponding figure was about 15%. In his opinion, many workhouses contained few or no older people at all for long periods of time in the mid-nineteenth century. However, he does admit that in

[1] Crowther, 'The Later Years of the Workhouse', in Thane, (ed) *The Origins of British Social Policy*, pp.44-5.
[2] Webb and Webb, *English Poor Law History*, p.49.
[3] Thomson, 'Workhouse to Nursing Home. Residential care of elderly people in England since 1840', *Ageing and Society*, 3 (1983), p.49.

time the workhouse became 'the institution of the aged', but more by default than design. By 1891, one-third of workhouse inmates were aged 65 and over, although only a small proportion of the population over the age of 65 entered workhouses.[4] Nevertheless, they formed the second largest group of inmates after children in workhouse populations in the mid-nineteenth century. In his study of workhouses in Hertfordshire in 1851, Goose found 32% of inmates to be over 60 years of age.[5] The proportions of older paupers were 20% in 1851 and 27% in 1861 within the workhouses in Winchester and Basingstoke, as reported in the investigation of Hinde and Turnbull.[6]

The increase in the number of older inmates occurred despite the proportions of older people and of indoor paupers of all ages within the population of England and Wales remaining stable at around 7% and 0.6% respectively, during the second half of the nineteenth century.[7] Between 1851 and 1901, indoor paupers ranged between only 3% and 5% of the older population.[8] On a one-day count in January 1892, 4.6% of those who were 65 years and over were indoor paupers, compared with 0.5% of those aged between 16 and 64 years. For those who had received relief at some time in the year ending Lady Day, 1892, 8.3% of those 65 years and over had been in the workhouse, compared with 1.4% in the younger age group.[9]

[4] Ibid, pp.46-47.
[5] Goose, 'Workhouse populations in the mid-nineteenth century: the case of Hertfordshire', *Local Population Studies*, 62 (1999), p.57.
[6] Hinde and Turnbull, 'The populations of two Hampshire workhouses, 1851-1861', *Local Population Studies*, 61 (1998), p.42.
[7] Laslett, *Family life and illicit love in earlier generations*, pp.192-3; Boyer and Schmidle, 'Poverty among the elderly in late Victorian England', *Economic History Review* 62 (2009), p.250.
[8] Williams, *From Pauperism to Poverty*, p.205.
[9] *Royal Commission on the Aged Poor, 1895 (C7684)*, p.ix.

Although the percentage of the population aged 65 and over receiving poor relief was similar, at between 25% and 30%, for all types of provincial union in the early 1890s, the proportion of older people admitted to different workhouses varied greatly. In general, it was higher in urban unions, with a rate of 11% compared with 4% in rural areas. Nationally, the proportion of older people relieved in workhouses increased from 23.6% in 1892 to 28.3% in 1906.[10] This may have resulted from a stricter policy by guardians, restricting outdoor relief, especially in urban conurbations. A possible alternative explanation is the willingness of older people to utilise the expanding medical facilities within workhouses.[11]

Classification of Inmates

The major difficulty in identifying and counting older people within the workhouse is the lack of clear identification of this group within the classification of paupers by the Poor Law Board (PLB). This is surprising since the workhouse system relied so heavily on the separation of different classes of pauper for its effectiveness as a deterrent. The Royal Commission of 1834 simply designated all adult non-able-bodied inmates as 'the aged and really impotent'. This was modified by the PLB in 1842 to men infirm through age or any other cause and women infirm through age or any other cause.[12] However, no definition of infirmity was ever given and no boundary for old age set. The hope expressed in the Royal Commission report that

[10] Boyer and Schmidle, pp.260, 264, 273; *Royal Commission on the Aged Poor*, p.cvi.
[11] Boyer and Schmidle, p.272; Williams, p.101.
[12] Quoted in Webb and Webb, *Poor Law History*, pp.122, 134. Different texts quote only one classification or the other, giving the impression that the greater subdivision was present from 1834. See Higgs, *Life in the Victorian and Edwardian Workhouse*, p.15; Crowther, *The Workhouse System*, p.42; Driver, *Power and Pauperism*, pp.64-65; Morrison, *The Workhouse*, p.43; Longmate, *The Workhouse*, p.55. Some texts state the later division as aged and infirm men and aged and infirm women, which is not the same as men and women infirm by age or any other cause as the latter excludes healthy older people.

'the old might enjoy their indulgencies without torment from the boisterous' was difficult to implement subsequently.[13]

The classification of older people with those suffering from infirmity makes it difficult to identify as separate groups those who were merely old and those who were both old and sick. Digby has drawn attention to this problem within the workhouses of Norfolk. In some of these institutions, paupers over the age of 60 years were given discrete facilities, often with their own day rooms, while in others inmates of the same age would be categorised according to their state of health and placed in the infirmary or with the able-bodied paupers.[14] Thus those placed in the infirmary, who were old and sick, would not be able to be identified, as they would be categorised according to the nature of the wards in which they lived. No directions were ever issued by the central authority regarding the placing of 'the aged' within the workhouse and, indeed, few circulars of any kind relating to older people were issued until the end of the nineteenth century.[15] The Minority Report of the Poor Law Commission recognised the need to break up the category of 'the aged and infirm' into distinct classes based on 'the mental and physical characteristics of the individuals concerned', as well as age.[16]

Table 3.1: Accommodation for different classes of pauper, 1852.

Infirm and aged men	74 beds
Ditto, of better character	40 beds
Infirm and aged women	80 beds
Ditto, of better character	60 beds
Aged couples	16 beds

Source: Langford, *Modern Birmingham and its Institutions*, p.382.

[13] Webb and Webb, *Poor Law History*, p.122.
[14] Digby, *Pauper Palaces*, p.163.
[15] Townsend, *The Last Refuge*, p.23.
[16] Webb and Webb, *The Minority Report of the Poor Law Commission*, p.361.

When the New Birmingham Workhouse opened in 1852, the accommodation in the adult department of the house consisted of 270 beds (Table 3.1).[17] There is no reference subsequently in the minutes of the Board of Guardians or its committees to this separation of older people by character. Within two months, the Workhouse Medical Officer (WMO), John Humphrey, reported on the admissions to the new building. Of the 90 patients seen, two to three were 'disabled by age and were removed to the bedridden wards', though it is not clear if these wards were part of the infirmary as opposed to the house.[18] The WMO's comments reflected views prevailing at that time, that ageing *per se* was responsible for infirmity. It was not until the middle of the twentieth century that the medical understanding of older people improved sufficiently to begin to meet their health needs.[19] From their study of the development of welfare services for elderly people, Means and Smith have concluded that, from the enactment of the poor laws to the time of their study, it had not been possible to distinguish between 'what is health' and 'what is welfare'.[20]

By 1865, the wards were clearly divided between men and women who were old and infirm, with accommodation for 258 and 107 respectively, and those who were bedridden, with accommodation for 51 and 70 respectively. These departments were set apart from infirmary accommodation, but in a list of wards in the infirmary eight years later, the aged men's and women's wards and the bedridden wards are included, with 98 male and 114 female beds for those who are bedridden, plus 351 for aged

[17] Langford, *Modern Birmingham and its Institutions*, p.382.
[18] BCL, BBG. GP/B/2/1/11, 5 May 1852.
[19] Conrad, 'Old Age and the health care system in the nineteenth and twentieth centuries', in Johnson and Thane (eds), *Old Age: From Antiquity to Post-modernity*, p.132; Thane, Old Age in English History, pp.436, 440; Thane, 'Geriatrics', in Bynum and Porter (eds), *Companion Encyclopaedia of the History of Medicine*, p.1109.
[20] Means and Smith, *From Poor Law to Community Care*, p.320.

men and 184 for aged women.[21] Those who were classified as bedridden may have included some individuals who were younger than 65 years of age and did include some who were not completely immobile. As Edward Smith, Medical Officer to the PLB, noted in his visit to the workhouse on 13 July 1866, 'in even the bedridden wards, one-third of patients leave their beds and their rooms'. The bedridden wards were included in his 'Return of Sick Wards' and the patients in them were receiving regular medical supervision by the medical officer. The level of dependency in these wards appears to have increased in the early twentieth century as an LGB inspector describes all but three patients in the female wards as 'actually bedridden'. [22]

Older People in the Workhouse

There is general agreement that older people formed an important large single group of inmates within the workhouse.[23] So it is all the more surprising that so little is known about them. The central authority's preoccupation with able-bodied paupers led to official neglect of adults classed as non-able-bodied, with the result that the special needs of the latter were rarely recognised until the last decade of the century.

Older people are rarely mentioned in the minutes of the Birmingham Board and its various committees unless problems arise related to them. The most frequent of these concerned overcrowding in the wards and the first instance of this occurred in January 1860, when the WMO reported insufficient accommodation for the sick and infirm. The master's recommendation to use some of the unoccupied children's dormitories for bedridden cases was accepted as a temporary measure. The following year,

[21] BCL VGPC, GP/B/2/1/4, 22 May 1865; HSC, GP/B/2/3/3/3, 3 June 1873.
[22] BCL, BBG, GP/B/2/1/73, 18 July 1866; WMC, GP/B/2/3/2/6, 16 June 1911.
[23] Crowther, in Thane, p.44; Longmate, p.137; Smith, *The People's Health*, p.382: Goose, p.54.

overcrowding continued to affect mainly the men's wards. For instance, two wards for infirm men of 20 and 22 beds, each had two extra occupants on the night of 13 June 1861. The ward of 30 beds for bedridden and infirm men contained 36 inmates. A storeroom being used for infirm men had two extra occupants. All the other men's sleeping rooms were quite full and the 'stench' in them was described as very offensive at night. As a result, the guardians sought to hire 'a commodious building for the aged and infirm poor', but, failing to find one, hired premises so that the boys could be moved out of the workhouse.[24] The bedridden wards were subsequently moved to the previous boys' school.

Despite this, the pressure on the wards for aged and infirm inmates continued to increase. A Poor Law Inspector, following a visit in January 1865, suggested an increase in accommodation for them. In a detailed report four months later, the master set out the 'state of the workhouse' with regard to overcrowding. Because of an excess of 55 old and infirm men, only 239 were in appropriate wards, which could accommodate 258, with 63 in other parts of the house. The position for old and infirm women was similar, with an excess of 20, but only 99 in appropriate wards that could accommodate 127, leaving eight in other parts of the house. Eleven men and 20 women were in the infirmary, although it is not clear if this was because of illness or overflow to available beds. All 83 bedridden men were inappropriately placed in other parts of the house. In contrast, all the 63 bedridden women were in the appropriate wards, which were under-occupied as they had room for 70. Within the year, new wards for men had been erected.[25]

[24] BCL, VGPC, GP/B/2/8/1/3, 27 January 1860, 14 June and 22 November 1861; BBG, GP/B/2/1/26, 12 June and 7 August 1861; VGPC, GP/B/2/8/1/4, 3 March 1865.
[25] BCL, BBG, GP/B/2/1/31, 18 January 1865; VGPC, GP/B/2/8/1/4, 22 May 1865; BBG, GP/B/2/1/33, 28 March 1866.

Inspections of the workhouse in July and November 1866 revealed the day rooms for the aged men and women to be overcrowded, plus 17 more beds than allowed by the central authority in the male bedridden wards and 11 in the female wards. However, the WMO, Edmund Robinson, was of the opinion that 'the wards occupied by the bedridden….and infirm inmates are not over-crowded having regard to the health of the occupants'. He had reported in June that year that the number of old and infirm inmates had nearly doubled compared with the number in the workhouse in 1859. The proportion of old and infirm inmates fell slightly in the early 1860s, but returned almost to the 1859 level in 1866, showing that the increase in the actual number reflected the general increase in admissions to the workhouse (Table 3.2). The guardians decided to build a ward for the old, infirm and bedridden women.[26]

Table 3.2: Number, and proportion of total inmates, of old and infirm inmates in the Birmingham Workhouse, 1859-1866.

Year	Number of inmates on 25 March	Old and infirm during the quarter ending 25 March	Percentage of old and infirm to total inmates
1859	1177	377	32%
1860	1178	371	31%
1861	1476	377	26%
1862	1763	453	26%
1863	1710	483	28%
1864	1885	466	25%
1865	2127	550	26%
1866	2065	614	30%

Source: Smith, 'Provincial Workhouses', *Workhouse, etc. 1867-68 (4).*

The data for older inmates were included in a letter from the WMO, contained within Smith's report on provincial workhouses in 1867.[27] No comparable information was collected for other workhouses for his report, but some is available from other studies. In Leicester Workhouse, there was a doubling of the number of disabled women

[26] BCL, BBG, GP/B/2/1/33, 18 July and 10 October 1866; Smith, 'Report on Existing Arrangements for the Treatment of the Sick Poor in Provincial Workhouses', *Workhouses, etc. 1867-68 (4)*, pp.48-9.
[27] Smith, 'Provincial Workhouses', p.49.

between 1868 and 1872, most of whom would have been in the older age range.[28] The proportion of older people in the five workhouses of Huddersfield had been stable at 30% between 1851 and 1861.[29] In contrast, there had been an increase from 20% to 27% in older inmates of two Hampshire workhouses in the same years.[30] More striking is the increase of older inmates in the infirmary of Shoreditch Workhouse from 15% to 33% between 1824 and 1874.[31] The percentages in these workhouses were very similar to those in Birmingham.

Concern over increasing admissions of older people in Birmingham workhouse continued, especially between 1867 and the following year. However, those who were both old and infirm had in fact fallen, both in absolute numbers (487 and 440 respectively) and as a proportion of all inmates (24% and 22%).[32] By 1873, there was an absolute increase to 669, but the overall bed occupancy for the relevant wards was only 90%.[33] The weekly statistical returns required by the central authority are available for 1877 to 1880 and provide information on those classed as 'Old and Infirm' within the non-able-bodied category in terms of numbers compared with the previous year and the weekly activity. Table 3.3 reveals that, although the actual number of admissions per week of older people increased by about 50%, this was accompanied by a doubling of the number of those discharged. The number of deaths was small and on average around 40% of total deaths in the workhouse. Overall, the percentage of older people in the workhouse remained the same and their greater

[28] Negrine, Medicine and Poverty: A Study of the Poor Law Medical Services of the Leicester Union, 1867-1914, (unpublished PhD Thesis, 2008), p.127; Borsay points out that older people formed a majority within the disabled population, *Disability and Social Policy in Britain since 1750*, p.8.
[29] Driver, p.150.
[30] Hinde and Turnbull, p.42.
[31] Edwards, 'Age-based rationing of medical care in nineteenth-century England', *Continuity and Change*, (1999), 14, p.255.
[32] BCL, HSC, GP/B/2/3/3/1, 4 September 1868.
[33] Ibid, GP/B/2/3/3/3, 3 June 1873.

numbers were a reflection of the increase in total inmates. The ratio of older women to men was usually around 1 to 1.7, similar to that in Leicester Workhouse in 1910.[34] There was a greater proportion of older men in the workhouses of Hertfordshire in 1851, with a ratio of 1 woman to 2.4 men.[35] Nationally, the ratio of women to men was 1 to 1.5 for indoor relief, compared with 1 to 0.4 for outdoor relief for those aged over 60 years.[36] One possible reason for this was that older men on their own may have been less capable of surviving with outdoor relief.

Table 3.3: Admissions, discharges, deaths and number of 'Old and Infirm' inmates and their proportion to total inmates in Birmingham Workhouse for first week of each quarter of the year, 1887-1880.

Quarter and year	Number (%) of inmates on last day of the week	Number (%) of inmates on last day of same week in previous year	Admissions	Discharges	Deaths
Lady Day 1877	880 (38%)	771 (36%)	13	6	3
Midsummer 1878	894 (37%)	771 (36%)	12	7	6
Michaelmas 1878	873 (39%)	772 (38%)	18	20	0
Christmas 1878	904 (39%)	795 (37%)	19	8	3
Lady Day 1878	975 (39%)	866 (38%)	13	4	8
Midsummer 1879	927 (38%)	894 (37%)	9	14	10
Michaelmas 1879	969 (41%)	873 (39%)	14	10	2
Christmas 1879	1007 (40%)	904 (39%)	16	12	2
Lady Day 1880	1099 (38%)	978 (39%)	22	11	3
Midsummer 1880	1045 (38%)	953 (39%)	17	14	3
Michaelmas 1880	906 (36%)	957 (40%)	22	21	4
Christmas 1880	953 (38%)	1007 (40%)	19	12	0

Source: BCL, LGB Returns, GP/5/5/1/1, 1887-1880.

Similar weekly returns are available for the years 1894 to 1911. However, those classed as non-able-bodied are subdivided between those in the workhouse and those in the infirmary. The former are most likely to include aged and infirm inmates since the bedridden wards were not transferred to the new infirmary. The proportion of this class fell to between 31% and 33% of all inmates in the last decade of the century and

[34] BCL, LGBR, GP/B/5/1/1, 29 December 1887 to 23 October 1880; Negrine states that there were 201 men and 134 women aged over 70, giving a ratio of 1.5, p.137.
[35] Goose, p.57.
[36] Booth, *The Aged Poor in England and Wales*, p.43.

remained stable until the middle of the 1990s when it increased to 4.2% (Table 3.4). Birmingham appears to have had a lower proportion of aged and infirm inmates than other provincial workhouses.[37] In June 1904, a sub-committee of guardians was appointed to investigate the overcrowded state of the workhouse, which had been caused by an increase in admissions of between 75 to 80 inmates annually over the previous ten years. The increase had been most marked in the departments for aged men and women. For instance, in 1904, there were 74 more aged men than the 464 present in the previous year and 33 more aged women than the 319 previously. The House Sub-committee requested assistance from the Infirmary Management Committee, but they were unable to take any transfers to the infirmary due to a lack of nursing staff and the increased cost of caring for any transferred inmates who would then be 'on the infirmary diet'. A further sudden increase took place the following year due largely to a 33% increase in non-able-bodied men, although women also increased in number by 29% (Table 3.4).[38]

Table 3.4: Admissions, discharges, deaths and number of non-able-bodied inmates in the Birmingham Workhouse and the proportion of total inmates, for the first week of the Lady Day quarter for 1901-1910.

Lady Day Quarter in Year	Number of men	Number of women	Number (%) men plus women	Admissions	Discharges	Deaths
1901	588	427	1015 (32)	14	21	0
1902	618	412	1030 (32)	26	20	4
1903	639	404	1043 (32)	34	16	1
1904	683	422	1105 (33)	24	23	1
1905	681	431	1112 (32)	14	25	1
1906	910	555	1465 (42)	24	34	0
1907	875	552	1427 (41)	21	19	2
1908	984	504	1488 (42)	29	26	0
1909	1010	508	1518 (41)	27	32	0
1910	871	470	1287 (35)	15	20	0

Source: BCL/LGB Returns/GP/B/5/1/3-8, November 1896 to January 1911.

[37] Smith, *People's Health*, p.385.
[38] BCL, HSC, GP/B/2/3/3/21, 21 June and 12 July 1904, 25 July 1905.

Transfer of Inmates

Because of overcrowding in the workhouse in July 1904, the guardians advertised in the *Local Government Chronicle* and *Poor Law Officers Journal* for the possibility of other unions being able to accommodate up to 100 aged men from Birmingham. They received four replies and chose Risbridge Union in Suffolk. Its cost at 7/- per head per week was the lowest and it was able to take all the men for at least two years. The inmates were transferred by railway to Kedington Workhouse, which was around 120 miles from Birmingham. They consisted of 80 men who had volunteered, as they had no living friends or relatives, and 20 chosen by the Revision Committee. Two weeks after their transfer, a letter from Risbridge guardians stated that they had 'expressed great pleasure at everything' and were taking long walks in their new semi-rural environment.[39]

However, by April 1905, some men had returned to Birmingham and 10 were transferred to Risbridge to make up the required number. The accompanying guardians took the opportunity to interview at Kedington Workhouse a further eight men who had expressed complaints. Of these, three wished to return to Birmingham to find work. One of them was Michael Hussey who was aged 70 years and 'had a wooden leg'. The guardians agreed to their request and to that of two others to transfer back to Birmingham because they were unable to attend Roman Catholic services. All the men returned from Risbridge in May 1907 as the number of older men admitted to Birmingham Workhouse had declined.[40]

[39] BCL, HSC, GP/B/2/3/3/21, 12 July 1904; WMC, GP/B/2/3/2/4, 20 July, 16 September, 14 October 1904.
[40] BCL, WMC, GP/B/2/3/2/4, 14 April 1905; HSC, GP/B/2/3/3/22, 7 May 1907.

Although there are no reports in the literature of such transfers between workhouses, it appears to have been not uncommon, as Kedington Workhouse accommodated inmates from several other unions. In July 1904, there were 57 older people from the Parish of St Mary, Lambeth and 81 from Mile End, Old Town, both in London. Also, many from St Olaves Union in London had been accommodated until 1902, until their own union had built a new facility.[41] In 1889, Reading guardians approached three adjoining unions to see if they could receive paupers from Reading union, but they did not have sufficient accommodation. They were more successful 10 years later when Wallingford Workhouse accepted several at a cost of 7/- per week.[42] However, it is not clear whether this was by transfer of inmates or by admission of new paupers.

Health of Older People

The records contain very little on the health of older people in the workhouse, even for those classed as bedridden. This is not surprising since medical conditions, prevalent in old age, were not seen as being of interest and were considered incurable. Denham considers that elderly patients in hospital with chronic illness and disability were medically neglected before the 1930s.[43] It is likely that many in the wards for aged men and women suffered from chronic disease such as arthritis, but the dividing line between inmates in these wards and the bedridden wards is unclear. Dementia would have been prevalent among the older inmates and occasional comments regarding senility confirm this. Some were placed in the bedridden wards while others were admitted to the epileptic and 'imbecile' wards.

[41] BCL, HSC, GP/B/2/3/3/21, 12 July 1904.
[42] Railton & Barr, *Battle Workhouse and Hospital*, pp.79, 136.
[43] Edwards, p.238; Denham, The History of Geriatric Medicine and Hospital Care of the Elderly between 1929 and 1970s (unpublished PhD Thesis, 2004), p.2.

In August 1885, when the guardians were considering the construction of a new separate infirmary, they discussed which inmates should be transferred to it from the workhouse. With regard to those in the bedridden wards, they considered that most of them were 'not classed under head of sick, many are simply cases of senility and require mainly good nursing'. It was felt, therefore, that they should remain in the 'workhouse proper', but the WMO's opinion was sought. His decision was that half required only nursing care, but the others were acute cases requiring medical treatment and would be appropriate for the new infirmary. Provision was made in the new infirmary for these 144 patients.[44] By comparison, statistics collected by the PLB for metropolitan workhouses in January 1869 revealed about 10,500 healthy old inmates, plus 5,000 old and infirm requiring medical care. The total number of old and infirm inmates constituted 54% of the total workhouse population.[45] In Leicester in 1900, 55% of the 423 inmates aged 65 years and above were in the infirmary.[46]

Edward Smith, Medical Officer to the LGB, divided the ordinary class of the sick into those who were sick and the aged and infirm. The latter were placed on the books of the medical officer 'chiefly that they may have the advantage of a nurse or for the permanent or recurring ailments of old age'. He considered that at least five-sixths of the sick were aged and infirm, 'who require no special skill to be bestowed upon them' in terms of nursing care.[47] In 1906, Mr Herbert, the LGB Inspector, suggested to the Birmingham guardians that the bedridden inmates should be transferred to the infirmary. He 'regretted very much to see bedridden persons kept at the workhouse. If any class of people required skilful nursing, it was the bedridden'. He did not claim

[44] BCL, VGPC, GP/B/2/8/1/9, 14 August 1885.
[45] Hodgkinson,*The Origins of the National Health Service*, p.466.
[46] Negrine, p.137.
[47] Smith, *Provincial workhouses*, pp.5, 11.

that the improved nursing attention would help them to live longer, but felt that 'they only existed in the workhouse, whereas they would live in the infirmary'. A year later, they were still in the workhouse, where all patients were given breakfast in bed, but some were able to get up for dinner. By 1911, the convalescent wards were 'really for chronic cases of paralysis, blind, deaf and dumb, bronchitis', most of whom had been transferred from the infirmary as they were no longer acutely ill. Some of those in the bedridden wards required the attention of two nurses and would have been more appropriately placed in the infirmary.[48]

Changing Attitudes to Older People

Sidney and Beatrice Webb have described how the policy of the central authority toward the 'aged and infirm' can be divided into three discrete parts**.** From 1834 to 1871, outdoor relief was freely given to all older people who wished to remain out of the workhouse, though the amount given was usually barely sufficient for survival**.** Around 1870, the workhouse test began to be applied more strictly to older people. The main reason for this was to put pressure on non-legally liable relatives to provide older members of their family with support. This policy remained in force for about 20 years, although it was never formally stated in official documents. Neither was it fully implemented in all unions, and some appeared to ignore it. The final policy, developed in the 1890s, was based on the concept of the 'deserving' and 'undeserving' among old people in relation to the past or present character of the

[48] BCL, HSC, GP/B/2/3/3/22, 27 February and 19 April 1906; WMC, GP/B/2/3/2/6, 28 April 1911.

individual. Outdoor relief was only available to 'the deserving' and, if they entered the workhouse, they were to receive more generous treatment.[49]

The Birmingham guardians showed consideration for older inmates soon after the New Workhouse opened. In November 1852, with winter approaching, they considered it expedient to promoting the comfort of the 'aged infirm poor attending divine service that the chapel be warmed' and consulted the architect as to the best method of heating. The dining room was used instead of the chapel pending the work being carried out.[50] Two years later, they warned the master to be careful not to employ any aged or infirm inmates in work or labour not suited to their capacity and ability and, if in doubt, to consult the medical officer. [51]

In 1861, the Chairman of the Board of Guardians raised the issue of the 'very large number of aged poor' admitted to the workhouse. It was his opinion that they could be kept at home if their circumstances were more fully investigated and a 'trifle more' outdoor relief was provided. The Board agreed to instruct the relieving officers to provide temporary relief, including lodgings, until each case was brought before the Board. There was a continuing emphasis throughout the 1860s on relieving as many old people out of the house as possible.[52]

However, this policy was to change dramatically, as Birmingham has been described as one of the most enthusiastic supporters of the crusade against outdoor relief in the 1870s. It was one of 34 urban unions where less than 30% of all paupers received

[49] These policies are discussed in detail in Webb and Webb, *Poor Law History* pp.349-364 and *The Minority Report*, pp.310-320.
[50] BCL, BBG. GP/B/2/1/11, 3 November 1852; GP/B/2/1/12, 2 February 1853.
[51] BCL, VGPC, GP/B/2/8/1/1, 1 December 1854.
[52] BCL, BBG, GP/B/2/1/26, 8 May 1861; GP/B/2/1/30, 11 November 1863.

outdoor relief. At 14%, it recorded the third lowest proportion of all the provincial unions. Birmingham and 40 other supporters achieved an average reduction of 68% in outdoor relief.[53] The figures showing the proportion of old and infirm inmates presented earlier demonstrate how the stricter policy in offering only indoor relief resulted in an increase in inmates from between 25% and 31% in the 1860s to between 36% and 40% in the following two decades (Tables 3.2,3.3,3.4). However, the increasing number of 'sick poor in large towns', as reported by a LGB Inspector, may also have contributed to the increase, as many older people would have fallen into this category. Thane has pointed out that, when statistics became available at the end of the century, it became clear that the vast majority of non-able-bodied paupers were aged 65 years and above.[54] Table 3.5 shows the proportion ranged between 58% and 72%. Despite the more lenient policy at the turn of the century, the proportion of non able-bodied inmates in the workhouse in Birmingham remained between 32% and 42%, as shown in Table 3.4.

Table 3.5: Indoor paupers aged 65 years and over, England and Wales, 1851-1911.

Year	Number	As % of adult non-able-bodied paupers
1851	25,100	72%
1861	29,400	58%
1871	38,500	56%
1891	59,600	61%
1901	76,100	69%
1911	82,700	59%

Source: Williams, pp.204-5.

[53] Williams, p.105; Booth, relevant data extracted from pp.27, 58-98; Thane, *Old Age*, p.175: the other 40 'enthusiastic' unions included 24 in London and those in the cities of Liverpool, Manchester and Salford. Lees, in *The Solidarities of Strangers*, p.365, describes this institutionalization as an urban strategy, only used extensively in the largest cities.
[54] BCL, VGPC, GP/B/2/8/1/9, 14 August 1885; Thane, pp.171-2.

The Deserving Aged Poor

The Royal Commission on the Aged Poor was set up in 1893 to consider whether any alterations in the system of poor relief were desirable for those whose destitution was due to incapacity for work as a result of old age. While it was still deliberating, the President of the LBG issued a circular recommending that outdoor relief should be granted readily to older people and that those who did enter the workhouse should have greater 'comforts' and freedom. Thane considers that his advice was taken up slowly and unevenly by guardians across the country.[55] This was certainly the case in Birmingham where the Board of Guardians was unsympathetic. A motion to implement 'further steps to increase comfort and improve the condition of the deserving poor under their care' was defeated by twelve votes to eight in June 1897. Two years later, another motion proposing that in light of 'that strong current of public opinion in reference to the treatment of the aged deserving poor, make special arrangements desirable' and that 'all cases over 65….dealt with as a separate class' was lost by 20 votes to six, with one abstention.[56] The guardians, by that time, had indeed made provision for 'the better class of inmate'. By 1898, an unused building had been modified to provide accommodation for 100 'deserving' aged women.[57]

A further circular from the President of the LGB was issued in September 1900 in which he stated:

> I have prepared a series of new regulations affecting the classification with a view to securing separate accommodation for the aged and deserving poor….that persons who have led decent and deserving lives should, if requiring relief in old age, receive different treatment from

[55] Thane, *Old Age*, p.192.
[56] BCL, BBG, GP/B/2/1/65, 2 June 1897; GP/B/2/1/68, 15 November 1899.
[57] BCL, HSC, GP/B/2/3/3/19, 13 September 1898.

> those with unsatisfactory habit....[and] be granted certain privileges, not accorded to every inmate.[58]

It was suggested that a special class was formed to include those of 65 years and upwards vetted by moral character and that they be given extra dayrooms, possibly available for both sexes. The guardians' general response was that they had:

> ....for upwards of two years formed this special group of Inmates. The Females have a Block entirely to themselves….known as 'The Merit Department'. The total number of women of this class is 80 at least. The men are also between 60 and 65 years of age. They are kept in the Male Convalescent Department and have a portion of it for themselves. These men and women have respective day rooms. They dine in them. There is no provision for these inmates (men and women) to dine together. The women are quite away from the body of the House where the men are living.[59]

Several specific recommendations were made by the LGB, to which the guardians responded. They disagreed with the LGB that separate cubicles should be provided within the sleeping accommodation. With regard to granting privileges in respect of going to bed and rising, they considered that they interpreted these regulations liberally. Their response to granting increased liberty and extended time for visiting was that the 'better class' go out once a fortnight rather than once a month and are visited frequently. Further details of leave of absence for inmates are provided in Appendix C. They did not consider it necessary to provide a locker with a key for each inmate. The orders of the LGB regarding the supply of tobacco, dry tea and sugar were now to be compulsory. The guardians confirmed that all men over 65 years were allocated one ounce of tobacco and women in the merit ward were given tea and sugar daily.[60] In addition the guardians had decided two years previously to

[58] BCL, Orders, GP/B/1/1/6, 4 August 1900.
[59] BCL, VGPC, GP/B/2/8/1/10, 25 September 1900.
[60] Ibid.

supply all inmates with clothes 'of a non distinctive colour in lieu of the uniform clothing hitherto supplied', but only when an inmate required new clothing.[61] *The Minority Report of the Poor Law Commission*, published in 1909, praised Birmingham and seven other unions for their 'admirable provision for the aged deserving poor'. Special privileges in these unions included inmates preparing some meals for themselves, the provision of comfortably furnished apartments, tea, sugar, tobacco and snuff weekly, and of comfortable, non-distinctive clothing and they could come and go during the day time at will. Interestingly, Birmingham now provided separate cubicles and had installed a gas stove for making tea in the aged women's department.[62]

Summary

Despite forming one of the largest groups in the workhouse, there is a paucity of information about older and disabled inmates. This study in Birmingham has exemplified the difficulty in obtaining details of older people in the workhouse, as none of the statistics were age-related. One of the reasons for this was the system of classification, which grouped together those who were old with those who were disabled. Within this grouping, some inmates were placed on wards described as being for those who were 'bedridden'. However, not all who were admitted to those wards were totally confined to bed. The increasing number of admissions of older people remained a continuing concern throughout the period covered by this study, although this was usually in proportion to the increase in inmates of all ages.

[61] BCL, BBG, GP/B/2/1/63, 3 April 1895.
[62] Webb and Webb, *The Minority Report*, pp.329-330. The other unions praised in the report were Bradford, Sheffield, Eccleshall Bierlow, Hunslet, Dewsbury and Sculcoates; BCL, HSC, GP/B/2/3/3/23, 12 May 1908.

Nevertheless, overcrowding was a recurrent problem in the wards for older people, made worse by the Birmingham guardians' policy of severely restricting outdoor relief in the 1870s. One solution for this, which has not previously been recorded in the literature, was the transfer of older inmates to a workhouse in a distant union. As the attitude to older inmates changed in the last decade of the century, those designated as 'deserving' were provided with greater comforts, improved accommodation and more leave to enjoy time outside the workhouse.

The identification of ill older people within the Birmingham records has been even more difficult. The wards for older people and those for bedridden inmates are categorised at times within the infirmary and at others within the main part of the workhouse. After the new infirmary opened in 1889, information on adults was divided between those in the workhouse and those in the infirmary. The assumption has been made that non-able-bodied adults in the infirmary were mainly older people. All inmates classed as 'sick' were deemed to be in the infirmary. The medical condition of older people was now subsumed within the adult sick population and their special health needs, particularly for those with chronic illness, were never considered.

CONCLUSION

This micro-study of the medical role of Birmingham Workhouse is one of the few that has examined a large urban poor law institution. One possible reason for the surprisingly scant literature on urban workhouses lies in Rose's contention that recent historiography of the nineteenth-century poor law had a rural bias.[1] Moreover, where histories of medical institutions have been written, they have mostly been 'celebratory rather than analytical'.[2] Despite the limited information recorded in the minute books of the guardians in relation to medical care, a number of conclusions can be drawn. These provide greater insight into medical practice in the infirmary and its impact on patients in the workhouse.

From the early 1840s, Birmingham guardians had recognised the importance of providing for sick paupers by appointing a resident medical officer and paid nurses for the workhouse. However, their decisions with regard to medical care appear contradictory. They were reluctant to appoint assistant medical officers initially and debated on a number of occasions the necessity of retaining them. They had accepted that the workhouse infirmary was in reality an acute hospital in 1878, but continued to see it as providing only for those who were destitute, rather than all who were poor. Ten years later, they continued to insist that all patients admitted to the infirmary were subjected to the workhouse test.[3] Their appointment of a visiting physician to the workhouse in 1882 was unusual, since such appointments were still a rarity almost 20 years later.[4] Yet they installed a master to take charge of the new infirmary in 1889,

[1] Rose (ed), *The poor and the city*, p.4.
[2] Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, p.231.
[3] Hodgkinson, *The Origins of the National Health Service*, p.542; Webb and Webb, *The State and the Doctor*, p.103.
[4] Webb and Webb, p.110.

when the majority of separate infirmaries were managed by a medical superintendent.[5] It was not until 1913, after the creation of the enlarged Birmingham Union, that a medical superintendent was appointed. A nursing superintendent, with training in nursing, was appointed in 1877 at the guardians' instigation and with the reluctant acquiescence of the medical staff. The infirmary had one of the best nurse staffing levels in the country and achieved national recognition for the quality of nursing care under the direction of the matron, Anne Gibson. Conversely, the guardians attempted to replace nurses in the workhouse with attendants after 1889, despite the fact that not all patients were transferred to the infirmary. It was not until 1906 that they saw the need for the matron of the workhouse to have nursing qualifications.

The study has confirmed that workhouse medical officers worked long hours and had under their care a greater number of patients than the medical officers in the voluntary hospitals. Several resigned because of this. Most were recently qualified, staying in post for a few years before leaving to advance their careers. In contrast, the guardians were able to appoint doctors of high calibre as visiting physicians and surgeons to the workhouse and the infirmary. All had honorary contracts with local voluntary hospitals and some had academic appointments. It remains uncertain why a few medical officers continued in the workhouse for substantial periods of time. Simpson, 1870-1886, had gained assistance from junior medical officers, but Sturrock, 1899-1914, was the sole medical officer for the workhouse after the new infirmary opened.

[5] Abel-Smith, *The Hospitals, 1800-1948*, p.96.

Despite their workload, several introduced innovative medical and surgical therapy and improved standards of patient care. Wilmshurst's claim that patients with venereal disease sought out treatment in Birmingham is borne out by the experience of Emma Rose, who deliberately moved from the workhouse in Kidderminster in order to gain admission to the one in Birmingham. Redfern Davies attempted in the late 1850s to persuade the guardians to allow major surgery to be performed in the workhouse, rather than transfer the inmates to one of the local voluntary hospitals. Although he was unsuccessful, this did gradually occur over the following twenty years. The majority of the information on medical treatment is contained in the records of the workhouse prior to the opening of the new infirmary in 1889. It is both unfortunate and ironic that considerably fewer details are available about medical practice in the separate infirmary, an institution dedicated to caring for the sick.

The number of inmates in the workhouse increased by over three times and patients in the infirmary by over twice during the second half of the nineteenth century. The reason for such a large increase is unclear although the restriction on outdoor relief in the 1870s was one factor. The population of the parish rose by only 37% and the pauperism rate decreased slightly from 2.5% to 2.0% over the same period.[6] The mortality rate for the town also fell from 25.2 to 22.1 per thousand between 1871-1875 and 1901-1910.[7] The resultant overcrowding caused the guardians considerable concern. They responded by erecting extra wards and eventually by building the new infirmary, as well as by acquiring additional facilities outside the workhouse. One of these measures involved transferring 100 older men to Kedington workhouse in a

[6] *Poor Law (Birmingham and Aston) 1856 (128)*, pp.5, 6; BCL, BBG, GP/B/2/1/72, 17 June 1903; ibid, GP/B/2/1/73, 21 September 1904.
[7] Woods 'Mortality and sanitary conditions in late nineteenth-century Birmingham', in Woods and Woodward (eds), *Urban Disease and Mortality in Nineteenth-Century England*, pp.179, 181.

distant union for a period of three years. The guardians took considerable care to choose suitable inmates and readily agreed to requests for transfer back to Birmingham. This arrangement appears to have been not uncommon as Kedington workhouse had taken inmates from a number of London unions and Birmingham had had offers for accommodating the men from several unions. This study has provided an in-depth account of a practice that has not previously been reported in the literature.

The lack of sufficient accommodation affected the living conditions of the inmates, although some groups were affected more than others. When patients were admitted to inappropriate wards alongside those with infectious disease, they were at risk of cross-infection. Epileptic patients, as well as lunatics, were subjected to considerable overcrowding and this study has provided insight into a relatively neglected group within workhouse historiography. The early deplorable conditions in the epileptic wards did improve toward the end of the century. Even then, life in the male ward must have been unpleasant, with patients having an average of nine to ten fits every day. Despite this, a letter of appreciation was received from an official of the Swedish government, suggesting a high standard of care. Complaints from inmates over the lack of treatment and letters of appreciation were rare, but give voice to patients' experiences. It is interesting to note that an inmate was able to continue her long-standing use of opium by obtaining supplies from outside the workhouse.

Another group of inmates who suffered from the effects of overcrowding throughout the period of study was the one labelled 'aged and infirm'. This was not surprising as they formed the largest category of adult inmates in Birmingham, as in workhouses

throughout England. Their number increased, but was commensurate with that for all adult inmates. Only in the latter part of the first decade of the twentieth century did older inmates increase in proportion to all adults. The data confirm the findings of other studies that more older men than women entered the workhouse.[8]

Despite being the largest group of adult inmates, older people were not easily identified within workhouse populations, since there was no specific classification category allocated to them. Several proxies have been used in this study, namely the aged and infirm group, those in the wards for the bedridden and from 1894, those termed not able-bodied. Older people, defined as those aged over 60 years, would have formed the majority in these groups, which were not exclusive to those in this age group. It was more difficult to identify older people with either acute illness or chronic disability. It was almost impossible to determine whether older people were present within the data recorded after 1894 for non-able-bodied adults in the new infirmary. As this group formed around one-third of patients in the infirmary, it is difficult to believe that older patients were excluded. However, Birmingham's entry in the return to the LGB, in respect of the number of those in the wards for the sick on 1 June 1896, states no patients had been admitted on the grounds of being 'aged and infirm only'.[9] These findings confirm the absence of a distinction between the health and social care of older people in the nineteenth century.

The change in the attitude of the public toward poverty in old age during the latter part of the nineteenth century resulted in greater benefits for older inmates. However,

[8] See Goose, 'Workhouse populations in the mid-nineteenth century', *Local Population Studies*, 62 (1999), pp.60-61; Hinde and Turnbull, 'The populations of two Hampshire workhouses', *Local Population Studies*, 61 (1998), pp.41, 49; Negrine, Medicine and Poverty: A Study of the Poor Law Medical Services of the Leicester Union, 1867-1914, (unpublished PhD Thesis, 2008), p.127.
[9] *Workhouses etc., 1896 (371)*, p.28.

these were restricted to those who were felt by the guardians to be 'deserving' and Birmingham created its 'Merit Class' along with many other unions. The guardians did not implement the changes suggested by the LGB whole-heartedly, but by 1909, the conditions for older people in the workhouse were among the best in the country.

By arranging for the workhouse and the separate infirmary to be under the control of their own master and matron, the guardians set up a situation in which conflict between the two institutions could flourish. There were continual complaints from medical officers over the transfers of patients. The infirmary physicians accused the workhouse medical officer of sending patients with mild illnesses to the infirmary and in return, he complained that patients were transferred to the workhouse before they had recovered sufficiently. Patients also suffered when the infirmary medical officers did not see them promptly at the workhouse. This was usually due to insufficient medical staff to cover the work required when the workhouse medical officer was on leave. 'The ever-present conflict as to cases' was not resolved until 1913, when a medical superintendent responsible for both institutions was appointed.[10]

It had become obvious by the 1910s that the wards in the workhouse had become occupied by more and more inmates who were disabled by chronic illness, most of whom had been transferred from the infirmary. The workhouse was now taking on the role of a chronic hospital. The infirmary had become the institution for acute medical care and had begun accepting patients involved in accidents.[11] In 1913, the medical superintendent recommended that patients with long-term conditions should

[10] BCL, BBG, GP/B/2/1/81, 18 December 1912.
[11] BCL, IMC, GP/B/2/4/4/5, 8 April 1907; Hearn, *Dudley Road Hospital, 1887-1987*, p.24.

be transferred to the workhouse after an initial brief stay in the infirmary.[12] In doing so, he was following a national trend, emulating the policies of the voluntary hospitals by giving preference to acute illness and excluding older and disabled patients. By early in the twentieth century, two distinct institutions had evolved, summed up by Abel-Smith as:

> In urban areas, where there were separate infirmaries, patients were divided into the acute sick who went to the infirmary and the chronic sick who went to the workhouse.[13]

This process continued through the next two decades with increasing reluctance of the infirmaries to admit patients with chronic illness.[14] Concern has been expressed that in the early 1900s acute medicine 'was subordinating the needs of the aged and chronically ill patients' and that it hampered the later development of care for a number of disadvantaged groups, including 'the chronically sick, the elderly, the poor, the disabled'.[15]

Medical care in the workhouse and its infirmary has been examined in this study from three aspects. From the experiences of patients and the nurses caring for them, it improved steadily from 1852 to 1912. However, this is not to say that patients did not suffer from poor quality care at times throughout this period. From the point of view of the medical officers, most of the treatments they could employ were palliative, but this did not inhibit many of them from attempting to improve medical practice in the institution. Older inmates, whether they were healthy, sick or disabled, suffered due

[12] Hearn, p.35.
[13] Abel-Smith, p.209.
[14] Means and Smith, *From Poor Law to Community Care*, p.19.
[15] White, *Social Change and the Development of the Nursing Profession*, p.120; Lawrence*, Medicine in the Making of Modern Britain, 1700-1920*, p.87.

to lack of identification as a group and neglect of their special medical needs. However, by the 1900s, their standard of living had improved through the provision of better accommodation and 'comforts'. This study has explored the relationship between the workhouse and its separate infirmary, which stood adjacent to it, but was managed as its own institution. The consequence of this was to relegate the medical role of the workhouse to that of a chronic hospital, which had a lower status within public opinion. These hospitals, of which Summerfield Hospital was an example, continued to carry the stigma of the workhouse until well into the second half of the twentieth century.

APPENDIX A

NURSING DUTIES IN BIRMINGHAM WORKHOUSE

Nurses were recruited in the early years of the New Birmingham Workhouse from those employed previously as nurses or from domestic servants. In 1852, the seven applicants for the post of nurse in the female infirmary wards included Elizabeth Manton and Mary Minshall, who worked as night nurses, Margaret Morris, a private nurse for some years, Ann Jones, a domestic servant, and Mary Larkin, a cook and housekeeper. White considers domestic service as appropriate training for nursing, as the duties of a nurse were 'still that of a ward maid' as late as 1857. The only non-domestic tasks were giving medication and applying bandages.[1]

In the infirmary in 1866, 11 day nurses and one night nurse supervised 60 pauper nurses in caring for 571 patients (Table A.1).[2] It is interesting to note the high staffing level required on the smallpox and fever ward and that the male wards under the charge of Edward Shubotham had no pauper help at night. However, he did have much more assistance during the day in the male bedridden ward compared with Jane Smith for the female bedridden ward, with only a slightly smaller number of patients. Six years later, he applied for an increase in salary, as the number of patients he cared for had gone up from 88 in 1865 to 162. The duties of the pauper nurses at night were mainly attending to the fires and patients' needs, such as providing ordinary drinks, but not giving medication.[3]

[1] BCL, VGPC, GP/B/2/8/1/1, 17 December 1852; White, pp.23, 8.
[2] BCL, VGPC, GP/B/2/8/1/5, 23 March 1866.
[3] BCL, ISC, GP/B/2/4/1/2, 3 October 1884; HSC, GP/B/2/3/3/3, 16 January 1872.

Table A.1: Day Nurses, Attendants, Pauper Nurses and Patients in Birmingham Infirmary on 21 March 1866.

Name of Wards	Nurses and Attendants	Pauper Assistants		Number of Patients
		Day	Night	
Male epileptic	Thomas Bevan	3	2	57
Female epileptic No 1	Ann Giles	2	1	39
Female epileptic No 2	Bridget Driscoll	2	1	24
Male infirmary	Fanny Giles	3	2	51
Female infirmary	Catherine Latouche	4	1	63
Smallpox and fever	Jane South	5	1	21
Female venereal	Amelia Orgill	2	-	28
Women & children's infirmary	Mary Barber	4	1	49
Lying-in ward	Ann Latouche	3	-	24
Female bedridden	Jane Smith	3	1	64
Male bedridden	Edward Shubotham	8	-	77
Male bad leg & venereal	" "	4	-	43
Male convalescent	" "	1	-	15
Boys' sick room	None	1	-	16
Total	11	45	15	571

Source: BCL, VGPC, GP/B/2/8/1/5, 23 March 1866.

The Workhouse Management Committee considered that four nurses and one attendant could be dispensed with after the opening of the new infirmary in 1889.[4] However, there was a need for nursing provision in the house, as it was now called to distinguish it from the infirmary. This was necessary because some patients, such as those with venereal disease and those in the bedridden wards, had not been transferred to the infirmary. The master was adamant that trained nurses needed to be employed to fill four vacancies in 1891.[5]

However, it was not until 1906 that the guardians required the assistant matron of the house to be a qualified nurse, when Emma King, who had been assistant matron at West Ham Workhouse for six years, was appointed. Within a year, she had produced

[4] BCL, WMC, GP/B/2/3/2/1, 30 August 1889.
[5] BCL, HSC, GP/B/2/3/2/12, 23 June 1891; WMC, GP/B/2/3/21, 10 July 1891; HSC, GP/B/2/3/3/13, 8 September 1891.

a report on the duties of the female officers. They included Miss Anson, the attendant on the probationary ward, who saw all the women on admission and on transfer between the house and infirmary and was responsible for bathing new admissions She had the help of three pauper attendants. Miss Rafthner usually had around 20 male and female patients on the cutaneous ward and had the help of one man and one woman. Most of the cases would be undergoing treatment and her work was described as of a 'very objectionable character'. The two nurses on the bedridden wards, with between 36 and 48 patients each, had the help of three and five inmates respectively.[6]

[6] BCL, HSC, GP/B/2/3/3/22, 26 June 1906 and 9 April 1907.

APPENDIX B

CONTROVERSY OVER OPHTHALMIC SURGERY

A joint subcommittee, formed in 1902 between the workhouse and infirmary management committees, recommended the appointment of an oculist for the parish to treat paupers requiring regular attention to their eyes. This replaced the practice of purchasing tickets for the Eye Hospital. In his report at the end of his first year of appointment as oculist, Dr Jameson Evans, MD, FRCS, had identified 30 inmates of the workhouse with cataract out of a total of 106 cases seen. The very high percentage with cataracts, he put down to the advanced age of nearly all the patients. While he accepted that most would benefit from operation, he considered that treatment would need to be carried out gradually, either at the new infirmary or the Eye Hospital. In addition he had ordered spectacles for 65 inmates.[7]

In his second annual report, he recorded seeing a total of 504 patients including 94 new cases, had ordered 56 pairs of glasses and performed 14 minor operations at the workhouse. Also, he enquired into the position regarding the inmates requiring cataract surgery.[8] The Workhouse Management Committee had requested that these patients have their surgery performed at the new infirmary by the oculist, but the Workhouse Infirmary Management Committee could not see their way to setting up special wards for their treatment. The infirmary committee, also, suggested continuing to send urgent cases as previously at a rate of six of seven at a time or find a room in the workhouse in which the oculist could operate. The Workhouse Committee was unable to find a suitable room and regarded the carrying out of the

[7] BCL, WIMC, GP/B/2/4/4/4, 17 February 1902; WMC, GP/B/2/3/2/3, 30 January 1903.
[8] BCL, HSC, GP/B/2/3/3/21, 26 July 1904.

operation by the visiting surgeon at the infirmary as 'unfair to the Oculist'. As a result of the stalemate, no inmates were transferred to the infirmary for cataract surgery after the appointment of Dr Evans.[9]

The other major factor preventing a resolution of the controversy was the outspoken opinion of Jordan Lloyd, Visiting Surgeon to the infirmary, against medical specialisation. He regarded this trend as 'sentimental ' and considered it 'absurd that any general practitioner was not as competent to treat ordinary eye cases as an oculist' and 'utter rubbish that the best person to deal with eye cases was the person who had been specially educated for it'. He welcomed the appointment of an oculist if it were to 'gratify public opinion' and not as a 'reflection on his professional reputation'. But he did make it clear that if the oculist were to operate at the infirmary, he would need two special wards, an additional resident medical officer and specially trained nursing staff. This necessary extra expense ensured no action would follow.[10]

Nothing further was mentioned until five years later, when the Workhouse Management Committee asked the Medical Officer to inform them of the arrangement for surgery in those cases that the Oculist recommended for treatment. When he was unable to give a satisfactory explanation, he was requested to report these cases at each meeting of the committee. Subsequently, a series of patients were transferred to the Eye Hospital for operative treatment over the next few years; 4 in 1910, 11 in 1911 and 14 in 1912. Of the first four, one 75-year-old man was found to

[9] BCL, WMC, GP/B/2/3/2/4, 13 May 1904, 10 March and 15 December, 1905; WIMC, GP/B/2/4/4/4, 19 September 1904 and 4 December 1905; HSC, GP/B/2/3/3/21, 7 March 1905.
[10] BCL, WMC, GP/B/2/3/2/4, 16 December 1904; IHSC, GP/B/2/4/5/3, 10 October 1904.

be inoperable. In addition to cataract surgery, one inmate was transferred to the infirmary for treatment for a detached retina.[11]

[11] BCL, WMC, GP/B/2/3/2/5, 10 December 1909, 11 March 1910; GP/B/2/3/2/6, 14 July 1911.

APPENDIX C

LIBERTY DAYS

Most of the letters and memorials contained in the Board of Guardians' minutes from the inmates of the workhouse are concerned with their allowance for leave of absence. This is hardly surprising since the worst aspects of institutionalisation have been described as the confinement within the building and the monotony of the regime.[12] The frequency of permitted leave varied considerably throughout the country at any one time and over time within the same institution. For instance, in 1872, Dudley Union allowed elderly inmates leave of absence once a week to visit friends or relatives, but 23 years later, in the King's Norton Union Workhouse, only inmates of over 60 and of good conduct were allowed regular leave of absence and, then, only once a month.[13]

In Reading workhouse, leave was allowed only one afternoon per month in the 1870s. By 1900, the 'aged deserving poor' were allowed to go out one day a week and this had increased to each weekday by 1911. However, other older inmates were restricted to twice weekly or once a month, depending on their behaviour.[14] The men who had been transferred to Risbridge Union in 1904 enjoyed greater freedom there than they had in Birmingham, as they were allowed leave on the afternoons of Sunday, Monday and Thursday.[15]

[12] Fowler, p.169; Higgs, p.61.
[13] Higgs, p.61.
[14] Railton and Barr, pp.68, 116, 140-1.
[15] BCL, HSC, GP/B/2/3/3/21, 12 July 1904.

In May 1853, Birmingham guardians confirmed that 'periodical liberty' was not allowed for those under 60 years and permission to go out of the workhouse was at the master's discretion. They changed the fixed liberty day for the aged from Sunday to Tuesday, but allowed all well-behaved adults out on Friday and Saturday of Whitsun week, men on one day and women on the other. Four years later, this had changed and older inmates could go out on alternate Thursdays, men on one and women on the other.[16] The aged men wrote to the guardians in November 1864 requesting the recent restriction of their liberty to be restored. However, this was not agreed until August the following year, although no reason for the restriction or its removal was recorded in the minutes.[17] Limitation of leave throughout the next two decades was very definitely linked to epidemics of infectious disease. During a smallpox outbreak in April 1872, 260 inmates signed a memorial requesting the restriction on both leave and being visited by friends be lifted. This was done four months later but imposed again two years later for a further six months.[18]

There were more frequent periods of stoppage of leave in the early 1880s. A request from the aged men and women in October 1881 asking for leave to be restored to one day per month was rejected as the guardians did not wish to make any alterations during the winter months, but did allow it again, along with ordinary visiting, the following January. The restriction must have been re-imposed later that year since it was in force in October as a result of a scarlet fever outbreak in the town and a further request from the aged women to visit their friends was turned down. Although scarlet fever, along with smallpox, was still prevalent in the town in January 1884, older inmates in the 'body of the House' were allowed visits from their friends, fortnightly.

[16] BCL, BBG, GP/B/2/1/13, 11 and 25 May 1853; VGPC, GP/B/2/8/1/2, 4 September 1857.
[17] BCL, VGPC, GP/B/2/8/1/4, 11 November 1864; GP/B/2/8/1/5, 11 August 1865.
[18] BCL, VGPC, GP/B/2/8/1/6, 12 April and 2 August 1872, 28 August 1874, 12 February 1875.

The request from the aged women a few months later for 'their usual liberty' was agreed by the medical officer, and the guardians allowed the men the same privilege.[19]

In their response to the question on increased liberty in the LBG Circular of 1900, the guardians stated that ordinary inmates were allowed out and to have visits once per month, while, for the 'better class', it was once per fortnight. The following year, however, a letter signed by a large number of aged women requested the 'usual liberty days and visiting be allowed'. Although leave for one day only was agreed at that time, full restoration took place a few months later.[20] The only change over fifty years was a slight improvement from once a month to once a fortnight for older people in the merit class.

[19] BCL, VGPC, GP/B/2/8/1/8, 28 October 1881; 20 January 1882; ISC, GP/B/2/4/1/1, 17 January and 18 April 1884.
[20] BCL, VGPC, GP/B/2/8/1/10, 25 September 1900; WMC, GP/B/2/3/2/3, 15 November 1901, 14 March 1902.

APPENDIX D

ILLUSTRATIONS

Figure 1: Location of Birmingham Workhouse.[1]

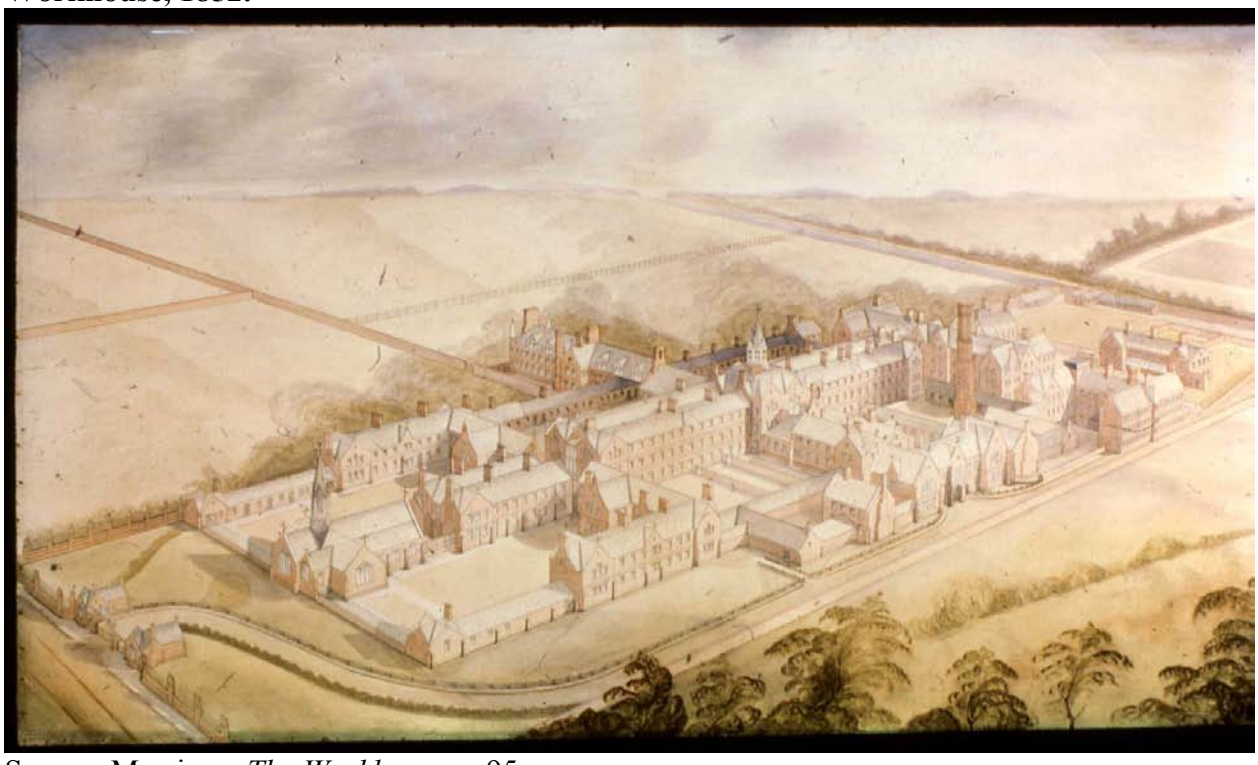
Source: Detail from Map of Birmingham, divided into half- mile squares and circles, *circa* 1890.

[1] The centre of the city (New Street) is at the bottom right hand corner of the figure. Note the proximity of the workhouse to other institutions on the former Birmingham Heath, which 'constituted the under-belly of Victorian life: prison, fever hospital, asylum and workhouse'. Upton, *A History of Birmingham*, p.136.

Figure 2: Entrance to Birmingham Workhouse.[2]

Source: Personal photograph taken in the 1980s.

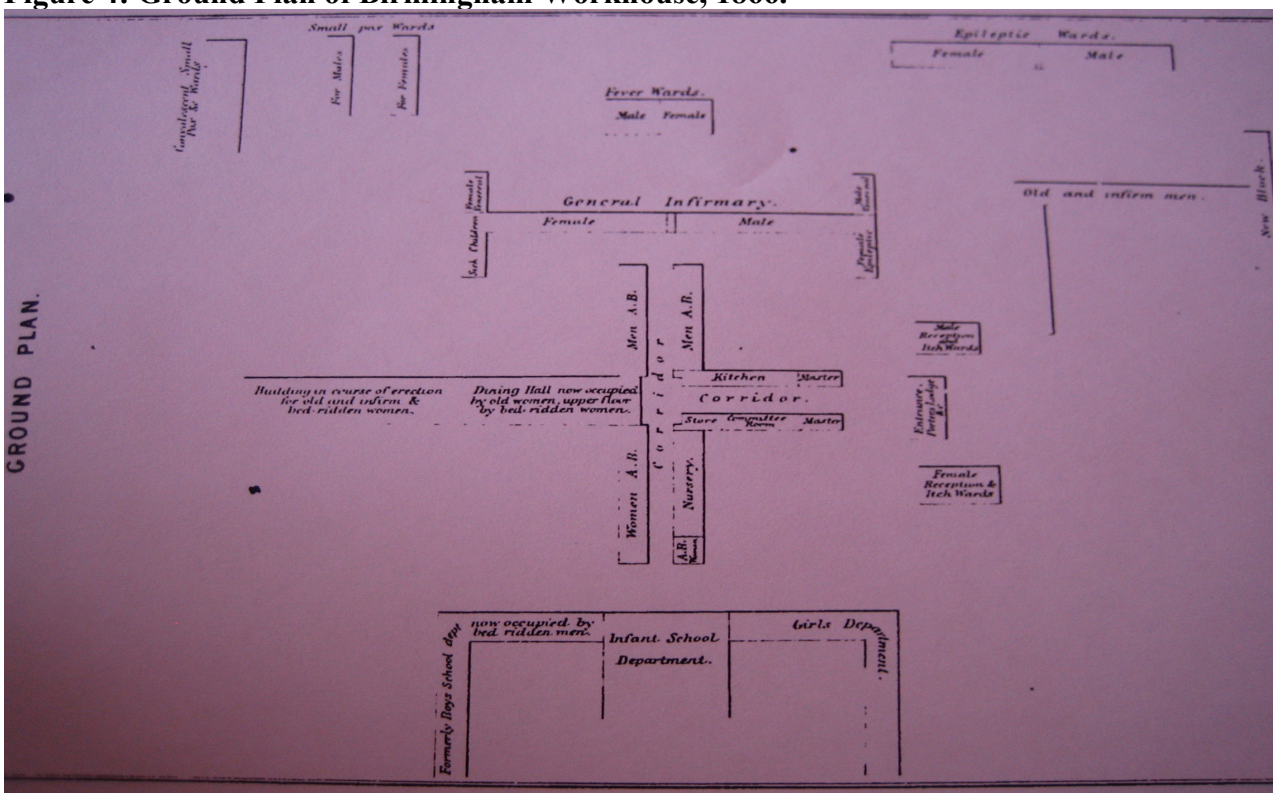
Figure 3: Perspective view, drawn by the architect, of the New Birmingham Workhouse, 1852.



Source: Morrison, *The Workhouse*, p.95.

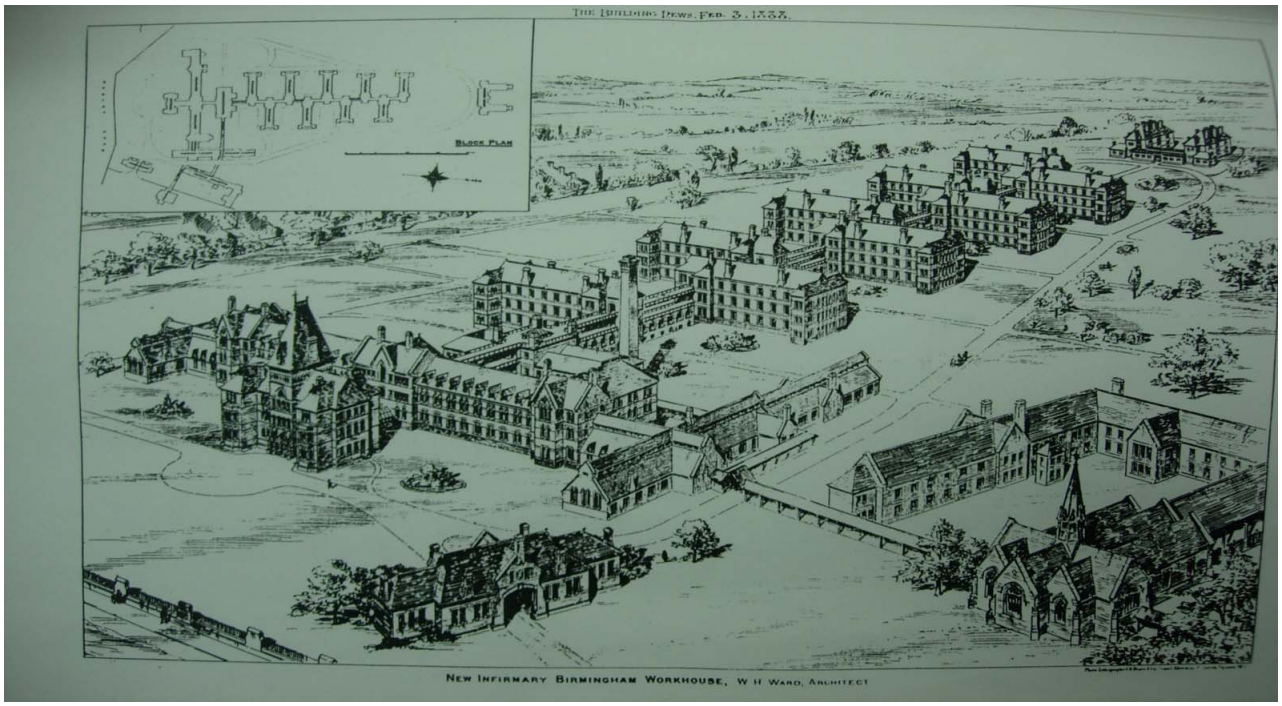
[2] This was the entrance through which all prospective patients were required to pass to gain admission to the infirmary. It became known locally as the 'Arch of Tears'. Higginbotham, *Workhouses of the Midlands*, p.105.

Figure 4: Ground Plan of Birmingham Workhouse, 1866.



Source: Smith*, Provincial workhouses, 1867-68(4),* facing p.46.

Figure 5: Perspective view, drawn by the architect, of the New Infirmary at Birmingham Workhouse, 1888.

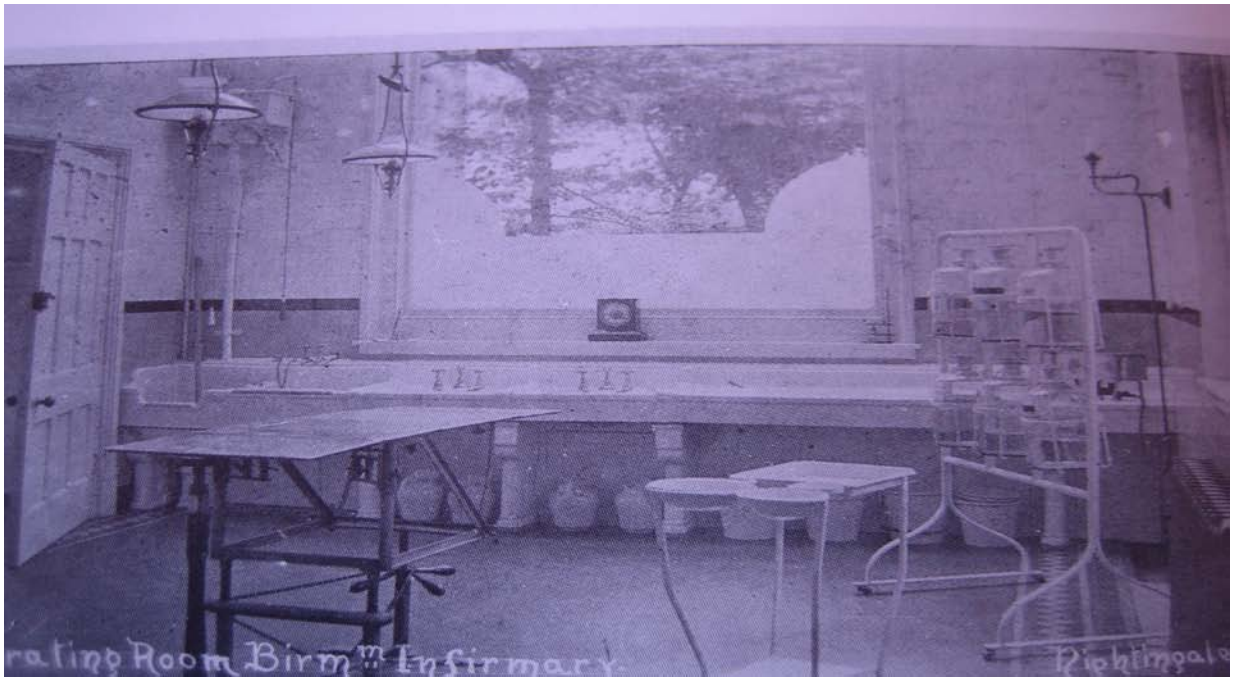


Source: Hearn, *Dudley Road Hospital, 1887-1987*, figure 3.

Figure 6: Ward in the New Infirmary at Birmingham Workhouse, *circa* 1900.

Source: Hearn, figure 17.

Figure 7: Operating room in the New Infirmary at Birmingham Workhouse, *circa* 1908.



Source: Harding, *Birmingham Hospitals on old picture postcards*, figure 24.

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GP/B/2/3/3/1	Minutes of House Sub Committee, 1867-1910
GP/B/2/3/11/1	Minutes of Workhouse Inquiry, 1877-1878
GP/B/2/3/14/1-2	Minutes of House Sub Committee, 1912-1917
GP/B/2/3/15/1-3	Minutes of Western Road House Sub Committee, 1912-1915
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GP/B/2/4/4/5-6	Minutes of Infirmary Management Committee, 1906-1912
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