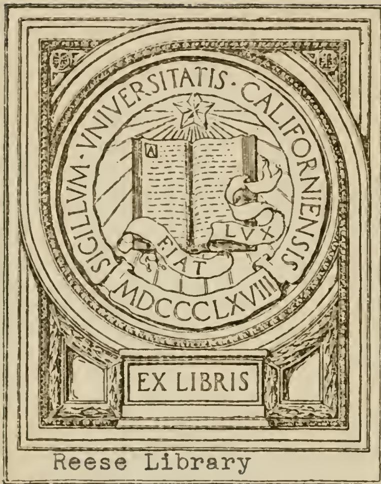

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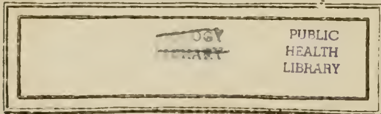

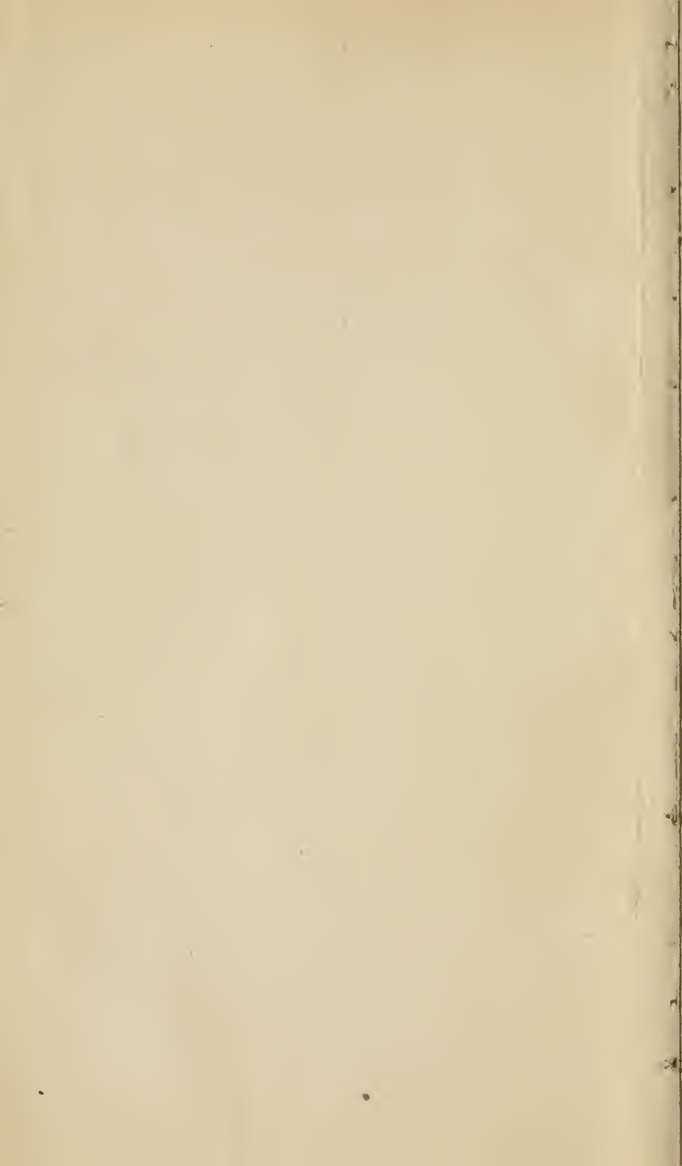

THE STATE AND THE DOCTOR: BY SIDNEY AND BEATRICE WEBB

LONGMANS, GREEN AND CO., 39 PATERNOSTER ROW, LONDON, NEW YORK, BOMBAY AND CALCUTTA.
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PREFACE

We do a great deal of State Doctoring in England —more than is commonly realised—and our arrangements have got into a tangle, which urgently needs straightening out. Everywhere there is a duplication of authorities and more or less overlapping of work. We are spending out of the rates and taxes, in one way or another, directly on sickness and Public Health, a vast sum of money annually—no man knows how much, but it certainly amounts to six or seven millions sterling. The greater part of this sum goes for the maintenance and treatment of the patients after we have let them become sick; some more is absorbed in what is but a skimpy remuneration for the large number of doctors employed in the State Medical Service; whilst relatively little is devoted to the most economical method of dealing with the problem, namely, prevention. For the most part, just as in early Victorian times, instead of preventing the occurrence of disease, we choose to let it happen, and then find ourselves driven to try expensively to cure it. Even when it has happened, we do our best (except with regard to three or four selected kinds) to avoid treating the case at the

beginning of the trouble. In the Poor Law branch of our State Medical Service, we spend, it is said, something like two millions a year as the direct result of one disease alone (tuberculosis). It seems that we know now that most of the consumptive patients who die in our workhouses could have been cured if they had been taken thoroughly in hand in time, instead of too late. Nevertheless we deliberately go on trying, by the very rules by which we fetter the State Medical organisation that deals with these patients, to prevent them from coming to us until they are so far gone in the disease as to have become technically "destitute." Incidentally also, until they have become actually incurable! Meanwhile, as is now being revealed to us, a vast amount of sickness goes altogether untreated, with the result of grave damage to our population, and unnecessary loss of productive capacity to the community as a whole.

Now, we put up with this waste, and we allow our statesmen to postpone the task of straightening out the tangle, very largely because we are not aware of the facts. There is no popular description of our existing State Doctoring. Many worthy people, thinking themselves educated, don't even know of its existence. There is not even an official report setting forth exactly what is being done and left undone for sickness and the Public Health in the different towns and rural districts. There are no medical statistics as to our success or failure with regard to this disease

or to that—we don't even know how many patients are under treatment by the State Doctors, let alone how many are restored to health. There is no systematic inspection of this not inconsiderable part of the nation's collective activities. It is actually impossible to ascertain how many municipal hospitals there are in existence in the United Kingdom, or how many patients they treat annually, or which particular diseases. What is only too painfully obvious is that, whilst much of our money is being wasted, the gaps are large.

In the absence of any more exhaustive survey of our State Doctoring, made by some more highly qualified observer, we think that our imperfect sketch may be of use, if only as demonstrating the need for something better. The sketch was made, in the first place, at the instance of the Royal Commission on the Poor Law, to whom it was submitted as a Memorandum in 1907. We have enlarged and extended it, as far as possible bringing it up to date; and we have added some explanation of the conclusions to which we have been led, and of the proposals that seem to us best calculated to stop the waste and to straighten out the tangle.

We gratefully acknowledge the assistance afforded to us in this inquiry by many hundreds of medical practitioners in all branches of the profession. We have, wherever practicable, given references to their evidence before the Poor Law Commission. But to large numbers of them, whether private practitioners

or "State Doctors," in the Poor Law Medical Service or in the Public Health Department, from the youngest recruit to those of highest official rank, we owe much more than their formal evidence; and for what they have so courteously done for us, we must content ourselves with these general thanks. We must, however, specially acknowledge the expert help afforded in the earlier part of the inquiry by Miss Louisa Woodcock (Somerville College, Oxford), M.A. (Trinity College, Dublin), M.D., B.S. (London), Physician to Out-patients' Department (late Pathologist), New Hospital for Women, and Physician to the Canning Town Medical Mission. In another way, the book owes much to the labours of Miss M. E. Bulkley, B.Sc. (Econ.), of the London School of Economics and Political Science.

We cannot refrain from adding, at the risk of seeming impertinence, that, from one end of the Kingdom to the other, we have been impressed with the vast amount of laborious, unrecognised, and very ill-paid service that, out of the dictates of humanity which form so honourable a tradition of the medical profession, is being rendered to the poor by the D.M.O. and the M.O.H., as well as by the private practitioner himself, who is often in many ways as much of a public servant as his brethren bearing official titles. Such ungrudging and devoted service to the community merits a less invidious method of remuneration and a more adequate reward. But it deserves more than this. We owe it to the doctors

not to hamper their beneficent work by clumsy administrative organisation. We can, at any rate, stand out of their way; and this at present we are not doing. We owe it to them, at least to let them intervene in time, and not, by refusing to deal with cases at the incipient stage, to foredoom so much of their work to futility. They may even fairly ask us, as a "business" people, not, by the neglect of obvious preventive and hygienic measures, and by the failure to enforce even a minimum standard in the conditions of civilized existence, to condemn a whole profession to something very like the labours of Sisyphus.

SIDNEY AND BEATRICE WEBB.

41 Grosvenor Road,
Westminster Embankment,
June 1910.

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CHAPTER I

HISTORICAL INTRODUCTION

It is interesting to notice that the Public Health medical service and the Poor Law medical service sprang historically from the same source, namely the prevalence of disease among the pauper class, and the economy of diminishing it. No statute had, prior to 1834, specifically authorised the supply of medical attendance and medicine at the expense of the poor rates, any more than any statute had specifically authorised the supply of food; but the Act of 1601 had required the "necessary relief of the lame, impotent, old, blind, and such other among them being poor and not able to work." Under this general provision the 1834 Commissioners found that a system of medical relief had everywhere grown up, under which the sick were attended and supplied with physic by the "parish doctor." No alteration of this system was recommended in the 1834 Report; and the Poor Law Commissioners, from 1835 to 1847, did little more than reform and regularise the method of remuneration of the Poor Law Medical Officers. It was the fond hope of some of the most ardent of the reformers of 1834 that the universal adoption of the "workhouse test" would eventually

lead to the complete disappearance of the pauper class. But experience and actual observation forced upon the Poor Law Commissioners the fact that a vast amount of pauperism was the direct and immediate result of ill-health. In 1838, only four years after their establishment, the Poor Law Commissioners had set Dr. Neil Arnott and Dr. J. Phillips Kay to investigate the causes of the "fever" in the Metropolis that was creating so much destitution; and Dr. Southwood Smith to explore the circumstances which made Bethnal Green and Whitechapel so unhealthy, and therefore so poor.[1] In the following year Dr. Southwood Smith was employed by the Poor Law Commissioners to prepare an elaborate report on the causes and effects of "fever" in twenty Metropolitan parishes or Unions.[2] The Poor Law Commissioners, in pointing out to the Government the amendments of the Poor Law that were required, expressly gave the first place to the measures to be taken to prevent the pauperism of ill-health. "The most prominent and pressing" were "the means of averting the charges on the poor rates which are caused by nuisances by which contagion is generated, and persons are reduced to destitution. . . . All epidemics, and all infectious diseases, are attended with charges, immediate and ultimate, on the poor rates. Labourers are suddenly thrown, by infectious diseases, into a state of destitution, for which immediate relief must be given. In the case of death the widow and the children are thrown as paupers on the parish. The amount of burdens thus produced is frequently so great as to

[1] Fourth Annual Report of the Poor Law Commissioners, 1838.

[2] Fifth Annual Report of the Poor Law Commissioners, 1839.

render it good economy on the part of the administrators of the Poor Law to incur the charges for preventing the evils where they are ascribable to physical causes." And the Poor Law Commissioners then specifically recommended that the Boards of Guardians, with their District Medical Officers, should be given what we should now call Public Health powers; that they should be authorised, at the expense of the poor rate, to suppress nuisances, and to remove causes of disease, as well as to continue their practice of supplying medical attendance and medicine freely to all the poor who applied for it.[1]

From this time forth the energetic secretary to the Poor Law Commissioners (Chadwick) never ceased to agitate for Public Health measures, as the most effectual means of reducing pauperism. In 1839 he put up Bishop Blomfield to move in the House of Lords for an inquiry into the causes of the ill-health to which the Poor Law Commissioners had called attention. It is characteristic that when Lord John Russell agreed to this inquiry, it was to the Poor Law Commissioners that it was entrusted; the matter was regarded entirely as one of Poor Law concern; and the whole of the work was done by the Assistant Poor Law Commissioners, the new Boards of Guardians, and the Poor Law staff. The general reports, avowedly drawn up by Chadwick himself,[2]

[1] Poor Law Commissioners to Lord John Russell, 14th May 1838; Fourth Annual Report of the Poor Law Commissioners, 1838, pp. 94-8; *English Sanitary Institutions*, by Sir John Simon, 1890, pp. 180-84.

[2] "Chadwick," wrote Sir G. C. Lewis, "has been writing a long report on the means of preventing disease by drainage, cleansing, etc. It contains a good deal of good matter, and on the whole, I prefer it to anything else he has written. We shall present it as his report, without making ourselves responsible." (Lewis to Head, 13th March 1842; in *Letters of Sir G. C. Lewis*, p. 119.)

and presented by the three Poor Law Commissioners in 1842,[1] constitute the starting-point of Public Health organisation in this country. It was inevitable, in the then condition of things and the contemporary state of sanitary science, that attention should have been directed, primarily and almost exclusively, to what may be called the physical or mechanical side—to the accumulations of dirt and filth, to stenches and putrefaction, to water supply and drainage, and, generally speaking, to the non-human environment.

It is unnecessary to pursue in detail the subsequent history of Public Health Legislation. It was expressly at the instance of the Poor Law Commissioners that the first Act was passed (in 1840) for the general vaccination of the population; the service being entrusted to the Poor Law Authorities, who were to carry it out gratuitously for all who applied for it, without it being deemed parochial relief.[2]

Meanwhile an abortive House of Commons Committee on the Health of Towns, and another on Interment in Large Towns, had prepared the public for the disclosures of the above-mentioned Poor Law Commissioners' reports, which were not issued until 1842.[3] These led to the appointment of the Royal Commission on the Health of Large Towns, which was throughout assisted and inspired by Chadwick.

[1] General Report on the Sanitary Condition of the Labouring Population of Great Britain, 1842; Local Reports on the Sanitary Condition of the Labouring Population of England and Wales, 1842; Local Reports on the Sanitary Condition of the Labouring Population of Scotland, 1842.

[2] 3 & 4 Vict. c. 29 (1840); 4 & 5 Vict. c. 32 (1841).

[3] To them the energy of Chadwick added another, on the System of Interment in Large Towns (Ninth Annual Report of the Poor Law Commissioners, 1843).

The resulting reports of 1844 and 1845 led to the first Public Health Legislation. The Removal of Nuisances Act, 1846,[1] made the Board of Guardians the Public Health Authority wherever no Municipality or Improvement Commissioners existed, but began, so far as the towns were concerned, the separation of the Public Health from the Poor Law work, which has since continued. This separation was permanently established by the Public Health Act of 1848, and the Nuisances Removal and Diseases Prevention Act of the same year.[2] Chadwick had, in fact, by this time fallen out with his nominal superiors, the Poor Law Commissioners, and had transferred all his interest and enthusiasm to the sanitary side of the work. He was accordingly glad to break this off from the unpopular Poor Law Commissioners, and to become, in 1848, the leading personage in a new Government department, the General Board of Health. Though this came to an end in 1854, when the too energetic Chadwick was retired on a pension, the two services remained distinct, and the Privy Council, which had always dealt with quarantine and the cattle plague, eventually assumed charge of the Public Health work, which was, meanwhile, being developed by the Town Councils. The principles on which all this work was carried out were those of the universal provision of the necessary public services, the compulsory enforcement of the sanitary measures deemed requisite, and (in the isolation hospitals that were gradually established) the curative treatment of those unable to provide for themselves. These principles, in sharp contrast with those of the Poor

[1] 9 & 10 Vict. c. 96 (1846).

[2] 11 & 12 Vict. c. 123, and 11 & 12 Vict. c. 63.

Law, received explicit Parliamentary sanction in the great Sanitary Act of 1866,[1] promoted and passed by the Privy Council, partly under Lord Russell's Cabinet and partly under Lord Derby's.

Meanwhile the Poor Law Board, which had retained the characteristic policy of the Poor Law Amendment Act of 1834, with its idea of deterring people as much as possible from applying for relief, gradually found, against its intention, that the "hospital branch" of the Poor Law assumed ever larger dimensions. The crusade against preventable disease, which occupied so much of the attention of social reformers between 1844 and 1871, led to the formation of a considerable body of opinion in favour, not only of combining "the sanitary care of the population" with the "medical aid" afforded by the Poor Law, but also the entire separation of these functions from the relief of the able-bodied, and their administration by Local Boards of Health, under a Central Health Department.[2] The public exposures of 1865-6 led the Poor Law Board to take up the policy of providing, at first in the Metropolis only, well-equipped hospitals for the destitute sick at the expense of the poor rate. The outdoor medical service was at the same time steadily improved, especially by the establishment in the Metropolis of Poor Law dispensaries. Though these new departures were criticised as involving an abandonment of "the principles of 1834," so far as the sick were concerned, the argument of the Poor

[1] 29 & 30 Vict. c. 90 (1866).

[2] See, for instance, the evidence before the House of Commons Committee on Medical Poor Relief, 1844; and the various works of Dr. Rumsey; also the evidence before the House of Commons Committee on Medical Relief, 1854, especially that of Dr. Wallas, who advocated a system of free public dispensaries all over the kingdom, complete medical inspection, and the separation of the Central Medical Department from the Poor Law Board.

Law Board was that the amount of pauperism produced by ill-health (as Chadwick had discovered thirty years previously) made it of importance to the Poor Law Authorities to secure the best and promptest medical attendance of all the sick poor. This had been sought in Ireland by the establishment of a universal dispensary system, freely available for the whole wage-earning class, without deterrent conditions or any stigma of pauperism. The success of this system in Ireland profoundly impressed the Poor Law Board, as it had the medical and other witnesses who had studied it; and the establishment of an analogous system of free medical advice to the whole of the wage-earners in England and Wales was in 1870, as the Annual Report of that Board shows, seriously under consideration. "The economical and social advantages of free medicine to the poorer classes generally," said Mr. Goschen, "as distinguished from actual paupers, and perfect accessibility to medical advice at all times under thorough organisation, may be considered as so important in themselves as to render it necessary to weigh with the greatest care all the reasons which may be adduced in their favour."[1]

The complication of statutes and authorities in England and Wales had by this time become unendurable. Besides the confusion caused by the division of the Public Health powers between the Town Councils and the Boards of Guardians, under the Privy Council and the Poor Law Board respectively, a third series of Nuisance Authorities had been created at the instance of the Home Office in the ancient parishes, so that, from 1868, in some rural parishes,

[1] Twenty-second Annual Report of the Poor Law Board, 1869-70, p. lii.

"the privies were under one authority and the pigsties under another."[1] The Boards of Guardians, moreover, distracted between the two conflicting principles, and, swayed chiefly by motives of parsimony, had failed, in most cases, to put in force their Public Health powers. The result was a Royal Commission of 1869-71, usually called the Royal Sanitary Commission, which recommended the union, for Public Health purposes, of all the conflicting organisations, and the establishment, all over the country, of a Public Health service as nearly as possible on a uniform basis. It was contemplated in that report that the network of 3000 District Medical Officers, with which the Poor Law Board had by this time covered the land, should for the most part become the Medical Officers of Health for their respective districts,[2] and thus unite both services into a single rate-supported medical service with sanitary and preventive objects.

The union proposed by the Royal Sanitary Commission was only imperfectly carried out. It is true that the Public Health Branch of the Privy Council and the Local Government Act Branch of the Home Office were added to the swollen Poor Law Board, to constitute a new central authority, the Local Government Board.[3] This creation of a new and consolidated department, it might have been supposed, would have brought together and harmonised the growing sanitary and preventive service, which had arisen between 1848 and 1871, with the new develop-

[1] *English Sanitary Institutions*, by Sir John Simon, 1890, p. 323.

[2] The question of the area or possible combinations of areas to be placed under a full-time salaried officer was left undetermined.

[3] For this partial amalgamation see *English Sanitary Institutions*, pp. 332-4, 345-7, 354-8.

ments of the Poor Law in the transformation of workhouses into hospitals, and in the provision of medical attendance and medicine to the poor generally, as distinguished from actual paupers, which the Poor Law Board under Mr. Goschen had been considering. But the union of the separate streams of work in the new department seems to have been little more than nominal. Each determined to go on according to its own set of principles, content to be free individually to progress without caring to affect the other. Objections were raised, from the Public Health side, to the appointment as Medical Officers of Health of the crowd of private practitioners, ignorant of and not interested in the new sanitation, to whom the Poor Law Board had entrusted the duties of District Medical Officers.[1] It was pointed out that the appointment of "whole time" and adequately salaried Medical Officers of Health for large districts would be neither economical nor efficient unless the District Medical Officers were made their assistants.[2] From the Poor Law side, objections of quite another character were made to any development of "outdoor medical relief," as it was called, in the direction of Public Health. The Poor Law Officials, who took the lead in the new department, had, in fact, come, after Mr. Goschen's transfer to another office, under influences hostile to the forward movement which had been in view. The

[1] *English Sanitary Institutions*, pp. 339-40, 363-5.

[2] Mr. Hedley, the Local Government Board Inspector, is reported later to have laid it down that "the appointment of one Medical Officer of Health over a large area, over the districts of several sanitary authorities, at a large salary, and to devote his whole time to sanitary matters and preventive medicine, will not be found to work well unless the Poor Law Medical Officers are also appointed to act as his assistants." (Quoted at South Eastern Poor Law Conference, 1876, p. 490.)

crusade against outdoor relief, carried on by the inspectorate between 1871 and 1885—though aimed primarily at money doles—made no exception for domiciliary medical attendance and the supply of medicine. Whether or not this crusade against outdoor relief may properly be said to have been part of the policy of the Local Government Board, it is clear that it knocked on the head the projected system of free medical attendance, of which, on the Poor Law side, we hear no more. On the other hand, the desire to encourage indoor relief, as against outdoor relief, coincided with the other part of the medical policy to which the Poor Law Board had, by 1870, been driven; and we see a continuance, and even a steady development, of the transformation of the deterrent workhouse into the well-provided general hospital or asylum. The Public Health branch of the office, dealing mainly with its own set of Local Authorities (the Town Councils and Improvement Commissioners), went on with its own principles, undisturbed by those of the Poor Law branch. These principles of universal provision, curative treatment and compulsion, so greatly strengthened by the Royal Sanitary Commission, received further sanction by the Public Health Act of 1872, under which what became a distinct Public Health service was created, which was connected with the Poor Law medical service only through the heads of the Local Government Board, and by the accidental conjunction, here and there, of the separate appointments, proceeding on different principles, over areas invariably non-coincident with each other, of Medical Officer of Health and District Medical Officer in one and the same local practitioner. This separation between the

two services has ever since been maintained. For Public Health purposes England and Wales is, in 1910, divided into something like 1800 areas, and is served by approximately 1380 separate Medical Officers of Health, who are all qualified medical practitioners, having under them several thousand sanitary inspectors and other officers, with nearly a thousand isolation hospitals and other institutions. On the other hand, for the provision of domiciliary medical attendance and medicine to the destitute sick, it is divided into 646 areas, almost invariably non-coincident with those of the Medical Officers of Health, served by 3713 District Medical Officers, working in connection with a distinct set of institutions in the shape of Poor Law workhouses, infirmaries, dispensaries, and, in some places, even hospitals for special classes of diseases.

For many years the two rate-supported medical services went on their several ways, without seriously infringing one on the other, and without raising any question as to the divergence of the principles on which they were respectively acting. So long as the Medical Officer of Health was occupied principally with the external environment—with dirt and filth, with stenches and putrefaction, with water supply and drainage, with the provision of open spaces and improved housing—his activities brought him little into contact with the half-a-dozen respectable private practitioners, who were, in the Public Health district for which he was responsible, contentedly going their rounds and dispensing bottles of physic as District Medical Officers. Gradually, however, the sphere of sanitation and Public Health has become enlarged. From the non-human environment it has proceeded

to the human being himself. The first great task of cleaning up the streets and houses, of providing for the prompt removal of excreta, and of securing purity of water supply has been to a large extent accomplished. Guided by the illuminating reports of the Registrar-General, and even more influenced by the teaching of bacteriology, the Medical Officers of Health, and the expert advisers of the Local Government Board on its Public Health side, have, during the last two decades, turned more and more, for the reduction of the death-rate and the sickness-rate, to the treatment of the human being who forms, after all, so large and so influential a part of the environment of his neighbours. The discovery that disease is, in a great number of cases, due to a microbic agent, has, in fact, inevitably led to the recognition that the tissues of the individual human being are even more important (as a soil for the microbic agent) than anything else.

The outcome is, in 1910, an admitted overlapping of work, a chaos of authorities, a startling lack of uniformity between district and district, an absence of any generally accepted principle by which the action of the Local Authorities should be guided, and, in our judgment, a consequent failure to secure, for the enormous expenditure that has grown up on the various branches of the public medical service, anything like the utmost possible return in the prevention and cure of disease. Not only are the two authorities, who spend the public money and are both acting with reference to the same locality, acting independently and without co-operation, but the Town Councils and the Boards of Guardians have absolutely conflicting policies. While the Guardians

deter persons from applying for medical relief for themselves or their children, the Town Council Medical Officers issue notices or leaflets urging parents to call in the doctor as soon as the baby begins to be ill or ceases to thrive, and try by every means in their power to obtain the earliest possible information of cases of any infectious disease in schools or of serious infectious disease throughout their jurisdiction. Meanwhile one set of Inspectors of the Local Government Board encourages the Guardians to take steps which are known to deter persons from applying for medical relief, while another group of its officials insists most earnestly on the importance of the "unrecognised case" and of the earliest possible diagnosis. The different rate-supported organisations for combating disease have, as a whole, so far as we are aware, not been made the subject of any systematic description, or even of any official report.[1] We propose to describe, first the outdoor and indoor medical service of the Poor Law, then the provision made by Voluntary Agencies for the treatment of the sick, and lastly the medical service of the Public Health Authorities.

[1] A detailed analysis of the evolution of Poor Law administration between 1834 and 1909, in regard to the treatment of the sick, so far embodied in utterances of the Central Authority, will be found in our *English Poor Law Policy*, 1910.

CHAPTER II

THE DOMICILIARY TREATMENT OF THE SICK UNDER THE ENGLISH POOR LAW

THE public provision for the medical attendance of the sick poor[1] is, in Great Britain (though not in Ireland,[2] and, we believe, not in any other country of Europe), primarily a branch of the Poor Law—

[1] We estimate, though no statistics are available, that the pauper sick in England and Wales numbered on 31st March 1906 probably 120,000; in Scotland, probably 16,000; and in Ireland, possibly 24,000, apart from the merely infirm, aged, and the mentally defective. Including "chronic" cases, the number would be much greater. A return obtained by the Poor Law Commission from 128 Unions, comprising 31 per cent of the population of England and Wales, showed that on a given day, 31·4 per cent of all the paupers, indoor and outdoor (excluding lunatics in asylums), were actually receiving medical treatment. (Report of the Poor Law Commission, 1909, Appendix, vol. xxv.) These statistics indicate that throughout the United Kingdom there are probably 300,000 paupers under treatment. But half of these are merely "chronic" or "senile" cases.

[2] In Ireland, since the passing of the Medical Relief Charities Act, 1851, any sick "poor person," not necessarily a pauper, has a right to free medical advice and medicine, such medical attendance not being deemed poor relief. Each Union is divided into Dispensary districts. The Dispensaries are managed by the Boards of Guardians, tickets being issued to any sick "poor person" who applies for medical relief by any of the Guardians, the Relieving Officers, or the Local Wardens. The Dispensary Medical Officers, who are appointed by the Guardians, act also ex-officio as Medical Officers of Health under the Sanitary Authorities. (See Report of the Poor Law Commission, 1909, *Qs.* 99822-72, 99959-77; "Some Notes on Public Health and its Relations to the Poor Law in Ireland," by Dr. T. J. Stafford, Medical Member of the Local Government Board for Ireland; "Poor Law Dispensary Medical Relief in Ireland," by the same (*ibid.* Appendix, vol. x.).

that is, of the public relief of destitution. Whatever may be the advantages of this arrangement, it has the result of compelling a classification of the subject, not based on medical considerations, and corresponding to no pathological divisions. As a merely subordinate branch of Poor Law administration, the Poor Law medical service follows the fundamental classification of the Poor Law Amendment Act of 1834, of indoor relief and outdoor relief; and the cases treated fall into two entirely distinct medical administrations according to whether they are treated inside the Workhouse (including the Workhouse infirmary) or outside it.

A.—The District Medical Officer

The domiciliary treatment of the sick poor is conducted under the orders of the Board of Guardians of each of the 646 Unions into which England and Wales is divided. Each of these Boards of Guardians is required by the Local Government Board to appoint a number of "District Medical Officers," who must be qualified practitioners residing in their several districts.[1] Each Union has, for this purpose, to be divided into geographical districts, which, according to the Local Government Board instructions, should never exceed either 15,000 acres in extent—equivalent to a radius of nearly 2¾ miles from a central point —or 15,000 in population. The districts, the con-

[1] Non-resident Medical Officers may be appointed, with the sanction of the Local Government Board, but if there is a resident medical man in the district there must be a special minute of the Guardians stating the reasons why a non-resident should be appointed, and the appointment is only made for a limited time. (Report of the Poor Law Commission, 1909, *Qs.* 39110-16.)

ditions of appointment, and the appointments themselves are subject in each case to the express approval of the Local Government Board. The Local Government Board insists on a separate medical practitioner being independently appointed for each district—not one for several, with assistants under him. There is an additional and usually separate Medical Officer for the Workhouse itself. But the appointment of the District Medical Officer may be, and usually is, held in combination with that of public vaccinator,[1] and, in rural districts, often with that of Medical Officer of Health for one, or even for several, sanitary districts. The policy of the Local Government Board has apparently been to secure the presence, within at most 4 or 5 miles of every possible patient, of a qualified medical practitioner who should be bound to give, in person and not by any assistant, at the patient's own home, whatever medical attendance and medicine was required;[2] and, nevertheless, to have this provision made under arrangements which should not encourage it to be made use of more than was indispensably necessary. The outcome is that there are, to-day, in the 646 Unions of England and Wales, no fewer than 3713 District Medical Officers, or one-sixth of the estimated total of doctors actually practising in the kingdom, all (with one or two

[1] In 218 Unions investigated, 138 officers held post of District Medical Officer and public vaccinator, 80 officers held post of District Medical Officer only.

[2] The Local Government Board have expressed their opinion that it is preferable that the sick poor should be attended by a medical man having a general practice in the neighbourhood, rather than by an officer appointed to devote all his time to the treatment of pauper cases. The Board, therefore, do not consider it advisable that the whole of a Poor Law Union should be formed into one medical relief district under the charge of a Medical Officer devoting his whole time to the duties of the office. (*Decisions of the Local Government Board*, by W. A. Casson, 1904, p. 3.)

exceptions, *e.g.* in the Oxford Union) retained for life or during good behaviour, for the domiciliary treatment of the sick poor, each holding a separate personal appointment, and each resident within a specified district.

The districts for which the District Medical Officers are severally responsible vary considerably in size and population. The prescribed maxima of 15,000 acres and 15,000 population are, in 1910, both disregarded.[1] Many of the districts are 10 or 12 miles from side to side. Several of those in Middlesex exceed 20,000 acres, whilst others in more sparsely populated counties apparently run up to two or three times this area. Some districts, both in the Metropolis and in the populous urban districts of the Midlands and the great towns exceed 100,000 in population; whilst there are many between 30,000 and 100,000.[2] If, in the judgment of the Local Government Board, a population of 15,000 is as many as a District Medical Officer can properly attend to, there is the gravest reason for inquiry into the efficiency of the medical

[1] (*a*) *Population as Basis of Calculation.*—Out of eighty-nine districts in London Unions that we have inquired into, five have a population under 15,000; eighty-four have a population far exceeding 15,000. Out of fifty-eight districts in provincial and rural Unions, that we have inquired into, thirty-two have a population under 15,000; twenty-six have a population exceeding 15,000.

(*b*) *Acreage as Basis of Calculation.*—Out of seventy-one districts in London Unions, seventy districts are under 15,000 acres; one district is over 15,000 acres. Out of sixty districts in provincial and rural Unions, fifty-four districts are under 15,000 acres; six districts are over 15,000 acres.

[2] Thus, two of the District Medical Officers of St. Pancras have respectively 59,839 and 57,937 persons in their districts, and one at Clapham has 51,361; whilst some of the District Medical Officers of Aston have no fewer than 60,117, 77,983, and even 110,962 to care for. Three of the districts of Birmingham exceed 120,000 in population. In the opinion of the British Medical Association, "Several of the districts are far too large . . . it is regrettable that the Local Government Board should allow the limits to be exceeded." (Report of the Poor Law Commission, 1909, *Q.* 39469.)

service in districts containing six or eight times that population.

The selection of the District Medical Officer, the amount of his remuneration, and the detailed conditions of his appointment are left entirely to the discretion of the Guardians, who have usually, for this purpose, no expert advice at their command. In the first years of the Poor Law Commissioners the new Boards of Guardians were strongly urged by them to put these appointments up to competition among the medical practitioners of the Union, and to appoint the man who, being duly qualified, offered to take the post (including the supply of the necessary medicines) at the lowest price.[1] This gave rise to much objection, and the Poor Law Commissioners and their successors in office gradually became converted to the advantage of transferring the competitive pressure from price to quality—offering an adequate salary for the duties required, paying separately for drugs and other accessories of the treatment, and even providing an official dispensary and a salaried dispenser. Unfortunately, but few of the 646 Boards of Guardians have yet adopted the new policy, in spite of all the pressure that the Local Government Board has exercised. In the great majority of Unions the District Medical Officers still have to find their own drugs and medicines, and any dressings and bandages that are required, and they are paid fixed stipends which vary from as little as £10 or £15 a year up to as much as £300 or £400, a

[1] First Annual Report of Poor Law Commissioners, 1835, p. 53; Report of the Poor Law Commissioners on the Further Amendment of the Poor Law, 1839, pp. 73-8, 156-287; Reports of House of Commons Committees of 1838, 1844, 1854, and 1864; *Life and Times of Thomas Wakley*, by S. Squire Sprigge, 1897.

very usual figure being £100; together with additional fees for midwifery cases and operations.[1] Many of them

[1] The amount of work imposed upon the District Medical Officer does not depend so much upon the area or population of his district as upon the policy of the Board of Guardians and the character of the Relieving Officer. This has made it difficult to arrive at a satisfactory method of remuneration. The indeterminateness as to what part of the community is entitled to his services makes it impossible to adopt the system of the friendly societies and clubs of payment by head of population or membership. This is perhaps as well, as such a method of payment has been found to have great disadvantages of its own. It is a natural suggestion that the District Medical Officer should be paid per case attended, the plan actually adopted with regard to vaccination. But payment per case would, it is contended, have the result of encouraging the increase of the medical service. From the Poor Law standpoint, although it is thought desirable to get all children vaccinated, the Boards of Guardians feel no desire to get all the sick treated, but seek, on the contrary, to treat as few as possible. They have accordingly been led, on the advice of the Local Government Board, to adopt a system of fixed salaries to cover all ordinary medical treatment. The system of a fixed stipend does not, however, lend itself to the practice of granting medical relief "on loan," because each particular case has cost the Guardians nothing, and they are therefore unable either to determine precisely what they have lent or legally to recover it as a debt. Various Boards of Guardians have accordingly tried to combine a fixed stipend, with additional fees for each case attended, up to a fixed maximum. For instance, "the Bedford Union is worked on the per case system, combined with a fixed payment per head for paupers on the permanent list; but then it turns out that the latter are too frequently permanent invalids. The system often leads to a great deal of bickering, sometimes the District Medical Officer does not get orders where he considers he ought to have them, and then has to attend cases gratuitously." The practical failure to recover any appreciable sums for relief on loan (as distinguished from payments made by relatives) has discouraged such a system so far as ordinary treatment is concerned. Extra fees are, however, nearly always paid for midwifery (to which we devote a separate section) and for important surgical operations, which are naturally infrequent. It may be said that, in the remuneration of the District Medical Officers, there is no intelligible relation between the amount of work and the amount of pay, and that they are, on this account, very frequently dissatisfied with their position. It is suggested that the most acceptable system would be a scale based on both area and population. "I am of opinion that," said Dr. Prior in 1883, "making due allowance for special cases, the basis of calculation should be £10 per 1000 of population and £5 per 1000 acres; the payment for an average-sized district of 12,000 acres and 4000 population at this scale would stand at £100 per annum" (Poor Law Conference, South Midland *Medical Relief*, p. 125). In very few districts does the payment at present amount to so much as this. Out of 133 cases (where population and acreage are given) 123 are below the rate of £10 per 1000 population and £5 per 1000 acres; 10 are at or above this rate.

declare that they do not receive more than 4d. or 6d. per visit.[1] Both the amount and the method of the remuneration of the District Medical Officers have repeatedly been made the subject of official criticism, which was brought forcibly to the notice of the Poor Law Commission. "It is undeniable," testified the Poor Law Medical Inspector of the Local Government Board, "that the majority of medical officers, in or outdoor, are paid salaries miserably inadequate."[2] This is obviously due to the continuance, in a veiled form, of the practice unfortunately encouraged by the Poor Law Commissioners, of putting the office up to

[1] Report to the Poor Law Commission on Poor Law Medical Relief, Appendix, vol. xiv., by Dr. J. M'Vail, pp. 119-21.

[2] Report of the Poor Law Commission, 1909, Appendix No. xxi. (A), par. 25, to vol. i. (Evidence of Dr. Fuller, Inspector for Poor Law Medical Purposes in the Provinces of England and Wales.) The British Medical Association, who obtained evidence from 1900 Poor Law Medical Officers, also drew attention to the inadequacy of their salaries, and to "the absence of any uniform principle in fixing such salaries" (*ibid. Q.*39013, par. 3). In twenty-four Unions in England, the salaries of the Medical Officers are stated to work out at a fee per visit varying from 9d. to 8s. 10d. (*ibid.* Appendix No. xviii. (B) to vol. iii.). Certain Boards of Guardians state a fixed salary as working out at so much an order, but it must be remembered that in such Unions cases on the permanent medical list are not included at all, so that these calculations do not represent the whole work contracted for. Thus in one Union the salaries of the Medical Officers in the various districts worked out, in 1905, at 2s. 7¼d. per order, 4s. 6½d. per order, 2s. 5¾d. per order, 2s. 8½d. per order, 2s. 10d. per order. In another Union in the same year, at 6s. 10d. per order, 4s. 9d. per order, 3s. 9d. per order. In a third Union in 1904, at 25s. 10½d. per order, 9s. 9¾d. per order, 6s. 4½d. per order, 4s. 11¾d. per order, 3s. 3¼d. per order. In a fourth Union the remuneration of a whole-time officer worked out at 1s. 11d. per order. In another case the amount was 1s. 5¼d. per order. Remuneration per order varies, therefore, between 1s. 5¼d. and 25s. 10½d. ; the latter high figure was quoted by a Local Government Board Inspector to justify his recommendation that the numbers of District Medical Officers be reduced in that district. He further gives 3s. 9d. per order as the average for the whole of the London Unions. It may be added that the Local Government Board's own statistical returns as to outdoor medical relief calculate the "average remuneration per order" (which, in 1906, in the Metropolis varied from 1s. 2d. to 34s. 9d. and averaged 3s. 4d.), *without taking into account "the permanent list."* This seems to be very misleading.

competitive tender. The Medical Inspector himself stated that when, on one occasion, he "was a candidate for an outdoor medical officership, . . . a colleague of mine offered to do the work for nothing for a year if he was appointed, and afterwards at a much less salary than I asked for."[1] "When I have objected to the salaries paid to the medical officers," remarked one of the General Inspectors of the Local Government Board, "the Guardians answer: 'Well, at all events, we have only to advertise it, and we shall get any amount of candidates who are perfectly ready to come forward and do the work on the terms we offer. In the face of that, can we, in the proper performance of our duty to the ratepayers, offer more than we can get what we want for?'"[2] What was not fully considered by the Poor Law Commissioners, and is still not adequately realised by the Boards of Guardians, is that, so long as these appointments are thrown open to private practitioners, they will be taken for other reasons than the salaries offered. "One knows," testified a competent witness, "that the medical men in a great many instances do not take office for the emolument which they will get from the office, but for various other considerations. Probably one of the chief considerations is to keep somebody else out.[3] There are a certain number of men who have the medical work in a certain area between themselves and they naturally want to keep another practitioner from coming in. That is one motive. Another is that holding Poor Law offices does indirectly bring

[1] Report of the Poor Law Commission, 1909, *Q.* 10460.

[2] *Ibid. Qs.* 8920, 9320.

[3] 'The local village doctor generally is obliged to take the Poor Law appointment to keep out other competitors.' (Report of the Poor Law Commission, 1909, *Q.* 47921, par. 15.)

them practice. . . . Even taking all that into consideration, I do not think that there is any justification for not paying a man a fair value for his work. I think it is very undesirable that Medical Officers should be able to say: 'Well, if they find fault with me, at all events I feel this, that I am giving them more than their money's worth.'"[1] "The evils arising, or likely to arise, from this underpayment," said another witness, "are various. The Medical Officer is compelled to economise his time too strictly; he cannot afford to supply expensive medicines or to carry out modern improvements in medical treatment."[2] Nevertheless, only in two or three instances

[1] Report of the Poor Law Commission, 1909, *Q.* 9320. This evidence was confirmed by that given by the Secretary of the Poor Law Medical Officers' Association (*ibid. Q.* 33419).

[2] Report of the Poor Law Commission, 1909, *Q.* 33391, par. 4. It seems gradually to have become customary for the Guardians in their contract with the District Medical Officer, to undertake to supply certain "expensive" drugs, usually cod-liver oil and quinine. The selection of these drugs in this way seems, in view of altered prices and the changes in medical practice, somewhat out of date. Potassium iodide, for instance, is sometimes included, sometimes not. Diphtheria anti-toxin is hardly ever supplied; though the Local Government Board has informed one Union that this may be done (Local Government Board to Winchcombe Board of Guardians, July 1906). One District Medical Officer found that he spent 8s. upon it for two cases only, so that the anti-toxin is, in fact, hardly ever used for paupers. The Local Government Board has lately declared, in answer to an inquiry, that not only the above but also antiseptic surgical dressings, cocaine, phenacetin, trional, antipyrine, salicylate of sodium, tincture of digitalis, and serum preparations ought all to be included in "expensive medicines." In one rural Union, the Vice-Chairman of the Board of Guardians stated that the District Medical Officer got no allowance for even the most expensive medicines, and that he had been heard to complain that his salary hardly covered the cost of the medicines he supplied (*ibid. Qs.* 71432, 71433). "By the present method," declared a private practitioner, "the medical treatment has to be carried out very economically, for the doctor might very well spend all his salary in providing efficient medical treatment" (*ibid. Q.* 36967). "The health of the poor does suffer to some extent," stated a District Medical Officer; "we could do more justice if we were paid better; if there is a choice between an expensive and an inexpensive method of treatment not quite so good, I am afraid they get the inexpensive method" (*ibid. Qs.* 79425-8). "Drugs should be provided by the Guardians," said a

have the whole services of a Medical Officer been secured, at a "full-time" salary.[1]

In Scotland the conditions of service[2] of the Outdoor Medical Officers are very similar to those obtaining in England, except in regard to the fixity of tenure of the office. In England the Medical Officers can be dismissed from their appointments only by the Local Government Board, on proof of incompetency or neglect of duty, and this is the case also with the Medical Officers of poorhouses in Scotland. But Outdoor Medical Officers, as the representative of the Scottish Poor Law Medical Officers' Association complained, "have always been considered to have a different Tenure of Office, and may be dismissed by their Parish Councils with or without cause being given; and even if appealed to, the Local Government Board declare that they have no power to prevent dismissal."[3] It was pointed out in evidence before the

Medical Officer of Health, "the doctor giving a prescription to be taken to the chemist. The poor would then get the drugs they need, and not what the Medical Officer thinks he can afford to give them on his diminutive salary" (*ibid.* Appendix No. clix. (par. 8) to vol. vii.).

[1] Such "full-time" salaried District Medical Officers exist at Aston, Birmingham, Stepney, Swansea, etc. Such a District Medical Officer, devoting his whole life to his Poor Law patients, is under no temptation either to let their numbers increase or to subordinate their interests to other claims. But the Local Government Board, though not refusing to sanction full-time appointments, apparently does not favour or encourage them. This appears to be owing to the feeling that such a system would tend to conflict with the Local Government Board ideal of having a Poor Law Medical Officer every three or four miles in the country, or every 2000 or 3000 houses in the town, so that every destitute sick person should have medical attendance within reach.

[2] As in England, the salaries of the Medical Officers are, in many instances, entirely inadequate. Out of 410 cases (being about one half the total number of Medical Officers in Scotland), 306 had salaries below £50 per annum, while only 21 had over £100 per annum (Report of the Poor Law Commission, 1909, *Qs.* 58011-7). No extra fees are paid for fractures, midwifery, etc. "We think," said the representative of the Scottish Poor Law Medical Officers' Association, "we ought to be paid extra fees for such cases, the same as medical officers in England" (*ibid. Q.* 57922, par. 30).

[3] *Ibid. Q.* 57922, par. 26.

Poor Law Commission that this insecurity of tenure involved much hardship. "This arbitrary power on the part of Parish Councils," stated the same witness, "has been used, in many instances, in a very unjust manner, and Medical Officers have been dismissed from causes other than 'incompetence or neglect of duty.'"[1] "They can be, and have been, dismissed," stated another witness, "without reasons being given, thus being deprived of home and employment. In many cases dismissals are caused by disagreements with the Parish Council, or something in connection with the doctor's private practice."[2] "It is notorious," said a Medical Officer of Health, "that the medical service in the Highlands is impaired in efficiency through the withholding of the right of appeal to Poor Law Medical Officers under threat of dismissal. Until their tenure of office is put upon the same footing as that of Poor Law Officers in England and Ireland, and of Public Health Officers in Scotland, the medical service will not habitually command the respect nor attract the candidature of the best men. Sometimes the wrong inflicted upon dismissed officers is incalculable."[3]

[1] Report of the Poor Law Commission, 1909, *Q.* 57922, par. 26.

[2] *Ibid.* *Q.* 66273, par. 11.

[3] *Ibid.* *Q.* 66117, par. 36. See also Appendix No. cxix. (pars. 1, 5, 6) to vol. vi., evidence of J. M. Ross. "I am strongly of opinion," stated a Medical Officer, "that Poor Law Medical Relief and medical assistance to the poor would be enormously benefited by the Medical Officers to Parish Councils having the power to appeal to the Local Government Board before dismissal. Being thus more independent, they would be in a position to put forward suggestions for the improvement of local administration. The Medical Officer often being the only doctor in a large district, his duties in an isolated parish are much more comprehensive and responsible than in a town—granting certificates as to the mental condition of patients; reports as to the conditions under which lunatics and children, boarded out in private dwellings, are residing; reports to School Boards as to non-attendance of scholars; reports to the Procurator Fiscal regarding sudden deaths and

B.—The Organisation of the Work of the District Medical Officer

(i.) *The Relieving Officer*

To the medical critic, it must appear extraordinary that the pivot on which the whole organisation of the Poor Law medical relief turns is the Relieving Officer,[1] who has no medical qualifications. He is, in practice, the executive authority. He issues the Medical Orders, which alone set the District Medical Officer in motion, at his unaided discretion.[2] By giving urgent orders[3] on the slightest excuse he is able, if he chooses, to give the District Medical Officer much unnecessary

criminal offences; the ordering of extra nourishment and advising as to improved surroundings of the legal poor; the certifying of applicants for parish relief; certifying of paupers as to whether fit to be removed to poorhouse; the advising of the public generally as to isolation of infectious cases and sanitation (though supervised by the County Medical Officer of Health, the local doctor has to initiate proceedings). All of which show that Medical Officers' duties are often of a most delicate nature, requiring great tact and firmness, as between the interests of the Parish Council, the public, and the pauper. This indicates the necessity of his official position being an independent one." (*Ibid.* Appendix No. xiv. (par. 6) to vol. vi., evidence of Dr. Bell.) See also Report of the Departmental Committee on Poor Law Medical Relief (Scotland), 1904, pp. 86-8.

[1] "I question," said the Hon. Sydney Holland, "whether the Relieving Officer is the person to deal with it at all" (Report of the Poor Law Commission, 1909, *Q.* 32866).

[2] In a large number of Unions the grant or refusal of a Medical Order is practically left to the discretion of the Relieving Officer. In one populous Union, "the medical relief" is "in all cases ordered by the Relieving Officer, the Committee (of the Board of Guardians) merely confirming his action. The order in each case lasted for a month." (Reports of visits by Commissioners to Unions in England and Wales, No. 2 E, p. 11.) In another large urban Union the "orders for medical relief are sanctioned *en bloc*" (*ibid.* No. 24 C, p. 63). In another Union, "Medical orders are given with practically no inquiry, and the recipients do not appear before the Committee" (*ibid.* No. 112, p. 178). These facts are confirmed by the Medical Inspector of the Local Government Board, who stated that, in some Unions, "an order for Outdoor Medical Relief is given without any inquiry, simply on the application of the person" (Report of the Poor Law Commission, 1909, *Q.* 10302. See also, *Q.* 16780).

[3] It is said to be a practice in some Unions to mark all Medical Orders "urgent" that are given out of regular hours.

trouble. Under such a system a District Medical Officer is quite in the dark as to the weight to be attached to the order that he receives from the Relieving Officer; he can feel no assurance that his services are really needed, or that the case is one of urgency. We have even heard of instances in which he has suspected, apparently with some justification, that the order has been applied for by a malingerer, given by a Relieving Officer, or marked by him urgent, in order to vex or harass the doctor in revenge for some former lack of compliance on his part with an unwarranted request. If the District Medical Officer, obeying the dictates of humanity, attends any urgent case without the Relieving Officer's order, he not infrequently finds himself refused, "on some frivolous pretext or another," the midwifery fee or other emolument to which he would normally have been entitled.[1] As the Relieving Officer alone is in constant attendance at the meetings of the Board of Guardians he is often able, if he chooses, virtually to overrule the District Medical Officer's recommendations. Nor is the Relieving Officer always accessible. In a rural Union it may be a six or eight miles' journey to his house, with no cheap or easy means of conveyance. In an urban district his office is not always known,[2] and he is usually in attendance only at fixed hours. Unlike the District Medical Officer, he is not always required to reside in his district. We have been told that in the whole parish of Birmingham there is no resident Relieving Officer, all of them living outside the Union and some of them nearly two miles beyond its boundaries.

[1] Report of the Poor Law Commission, 1909, *Q.* 33391, par. 11.

[2] See, for instance, *ibid. Qs.* 38688-9.

It is to the credit of the District Medical Officers that their representations to the Poor Law Commission took the form, in the main, of complaints that many poor persons who in fact need their attendance are, under the present system, deterred from getting it; and that, when such persons do succeed in obtaining a Medical Order, the delay has often injurious results.[1] It has been pointed out that this would not be the case if, instead of the Relieving Officer, it was the District Nurse, the Certified Midwife, the Health Visitor, the Sanitary Inspector, or any qualified person under obligation to search out and report cases of illness, who notified to the District Medical Officer that a sick person was in need of medical attendance.

(ii.) *Poor Law Dispensaries*

It is sometimes said that the two different systems of outdoor medical relief are those with a Poor Law dispensary[2] or without it. The essential distinction between them is, however, as we shall show, not the attendance of the patients at a dispensary, but in the arrangements for the supply of drugs, etc. In the Metropolis and some other large towns[3] there is, in every Union, one or more Poor Law dispensaries or

[1] See *post*, p. 69.

[2] We use the term "dispensary" exclusively for a consulting room and place for delivering medicines, *provided otherwise than at the expense of the medical practitioner himself.* For an account of such dispensaries in the Metropolis and in certain provincial Unions, see the Report on Poor Law Medical Relief, Appendix, vol. xiv., by Dr. J. C. M'Vail, pp. 126-39.

[3] We have not found any complete list of such dispensaries, but they exist at the following towns (among others), viz. Birmingham, Cardiff, Cheltenham, Derby, Gloucester, Kettering, Leeds, Newport (Mon.), Plymouth, Reading, Sheffield and Wolverhampton.

public consulting rooms maintained by the Board of Guardians, at which the District Medical Officer attends at fixed hours, and at which prescriptions are made up by a salaried dispenser.[1] In the Metropolis these Poor Law dispensaries were established at the instance of the Poor Law Board, under the Metropolitan Poor Act of 1867. They are, as a rule, disconnected from the Workhouse, but may be conjoined with Workhouse receiving wards, relief stations, or the Relieving Officer's residence, each dispensary generally containing: (1) a waiting-room for the patients; (2) a dispensing room; and (3) consulting rooms for District Medical Officers. The Local Government Board has always urged: (1) that each dispensary should not be more than a mile from the dwelling of any patients; (2) that there should be in each sufficient work to occupy the time of the dispenser. But the 158 districts of the Metropolis have still only 138 dispensaries.[2] There must be many patients two or three miles from one of them. Thus, it was stated that "the Relieving Officer for No. 2 district (of Woolwich Union) lives at Lee Green,

[1] The dispensers, who are not under the orders of the District Medical Officer but hold entirely independent appointments, receive fixed salaries of £100 to £150 a year, with residence, coals and gas. They come under the Poor Law Officers' Superannuation Act, and get pensions. Their duties include in some cases a certain amount of nurse's work, *i.e.* removing and replacing surgical dressings, bandages, sterilising instruments, etc. Further, it is their duty to keep the "prescription letters" when the patients are discharged "relieved," though only about 50 per cent of the patients return their prescription letters. At Stepney the prescription forms are left at the dispensary every visit (like case-papers at a hospital) and not taken home and frequently lost, as in the case of other Unions. Occasionally the duties of dispenser to the Workhouse, and dispenser for the District Medical Officer are combined (as in Greenwich, E District, and in St. George's, Hanover Square, Districts B, C, D, E); or (as in District A, St. George's, Hanover Square) the Guardians contract with a chemist to supply the necessary medicines.

[2] There are none in Lewisham and Hampstead, and there are also eleven districts in the other Unions without them.

and many of the applications for relief are made to him from the poor residing at New Eltham, four miles off. A person residing at New Eltham requiring urgent medical relief would have to go four miles to obtain an order, and would then have to walk another two miles to deliver the order to the District Medical Officer."

As regards premises, in most cases the relief office and dispensary are contained in the same building. In London the dispensary is usually situated in a poor quarter on the ground floor, occasionally on the first floor, of an old dwelling-house, and is seldom built for, but only adapted to, its purpose. One, contained in an old dwelling-house, was reported on by the Local Government Board Inspector in 1899 as "far from satisfactory," and, as regards accommodation, the waiting-room was very cold and cheerless, no painting or whitewashing had been done for several years. It was found in the same condition in 1907. In another, the board-room and dispensary, contained in two old dwelling-houses, not very suitable for the purpose and meant to be only temporary, have been in use for twelve years. In Sheffield, Birmingham, and Derby the dispensary is part of the Union offices, and was built for the purpose. There is a large central waiting-hall, on one side of which the Relieving Officer's rooms open, and on the other the doctor's rooms and dispensary. The people can therefore come up and get Medical Orders from the Relieving Officers and then cross to the doctor's consulting room and then get their medicine from the dispensary.

At each of the Metropolitan Poor Law dispensaries three, four, or five District Medical Officers attend,

usually each for one hour a day. Each attends only to the patients of his particular district. The hours fixed vary in different Unions, but are usually between 9 A.M. and 1 P.M. on every day except Sundays. The dispenser is in attendance for six or seven hours on every week-day, between 9 A.M. and 6 P.M. On Saturday afternoons (when the dispensary nearly always shuts at two o'clock), and on Sundays, the District Medical Officer usually supplies medicines at his own house and at his own expense. In spite of having fixed hours (viz. 11.30 A.M. to 3 P.M., 5 P.M. to 7 P.M. daily), the patients come at odd hours, and are often attended to if the dispenser happens to be there.

It is to be noted that the fixing of the hours during the working time of the day, and even an occasional want of coincidence between the hours of the District Medical Officer and those of the dispenser, would seem to cause unnecessary loss of earnings to the sick poor. This, we are told, is frequently complained of; and it must be an element in preventing advantage being taken of the Poor Law medical service, especially where it is a case of taking a child to the dispensary. It is, for instance, said that "a poor person residing in Wapping requiring medical attendance would probably apply for a medical order at, say, 10 o'clock. She would then be referred to the Raine Street dispensary and probably see the District Medical Officer shortly after 11 o'clock. But she would not be able to obtain the medicine order until 1 o'clock." It is somewhat remarkable in a service intended to provide for the wants of the very poorest that the hours are not so fixed as to enable the District Medical Officer to be consulted either late in the evening or on

Saturday afternoon; though the "sixpenny doctor" does his greatest business at such hours, and some of the provident dispensaries have followed his example.

It must, however, not be supposed that the District Medical Officer, who has to attend daily at the Poor Law dispensary, does not also pay domiciliary visits. He is required to visit whenever directed to do so by the Relieving Officer, who gives such orders freely whenever he thinks the case a serious one. In the Metropolis nearly as many of the patients are seen at home as at the dispensary.

In rural Unions, and in those of most urban districts, there is no Poor Law dispensary. The District Medical Officer visits the patients who have been granted Medical Orders indiscriminately with his other patients. Or he may fix particular days and hours at which he attends at his own surgery or at his two or three branch surgeries in the principal hamlets of his district. We do not gather that the proportion of domiciliary visits differs appreciably in the country or in towns without Poor Law dispensaries from that in the Metropolis.

From the medical standpoint the essential difference between the system of Poor Law dispensaries and no such system is that, in the former, the drugs ordered are made up and supplied on the spot by a salaried dispenser at the expense of the Board of Guardians. In the other case, they are supplied at the cost of the District Medical Officer himself, and made up usually by himself or by his own dispenser. Hence it may be assumed that, except in London and a score of large towns, drugs are found by the District Medical Officers.[1]

[1] Except the special drugs mentioned in their contract with the Guardians; see *ante*, p. 22.

(iii.) *The Supply of Medical Extras and Nursing*

As we shall describe later, the extent to which Medical Orders are issued varies in different Unions, according to the policy of the Board of Guardians. But even in those Unions in which Medical Orders are freely issued, so that the services of the District Medical Officer are practically accessible to all the lowly paid sections of the population, a difficulty occurs about what are called "medical extras." In the medical attendance of the sick poor, recovery often depends on more than drugs and hygienic advice. The term "medical extras" is not recognised in all Unions, and the term "nourishment" is used instead. It connotes "those necessary articles of food or medical or surgical appliances which will conduce to the recovery or improvement of health of the patient." These are sometimes supplied, sometimes not. In the Unions of Derby and Steyning (Sussex) "medical extras" are held to be covered by the money relief; the clerk to the board in the latter Union writes, "Medical extras are not favoured—we give liberal relief in cases of sickness (sometimes 15s. a week) and insist that extras shall be purchased by the pauper; 'extras' become in many cases only additional relief, and you have two relieving officers—the doctor and the relieving officer—and the extras do not always reach the sick." In other Unions "medical extras" consist of: (*a*) Nourishment, such as meat, milk, even oranges (probably as treatment for scurvy-rickets), and occasionally brandy or wine; or of (*b*) Medical and Surgical Appliances, such as trusses, spectacles, or leg-irons.[1]

[1] At Northampton trusses in most cases are furnished by a local tradesman

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In many Unions it is ordered that, as the recommendations of Medical Officers for meat and stimulants are regarded as equivalents to orders for additional relief, they should in all cases be accompanied by a report from the District Medical Officer (in one Union[1] the Relieving Officer) in a prescribed form, setting forth the particulars of each case ascertained by personal inquiry.[2] In others, the rule is that "medical extras and other relief are only to be supplied in case of emergency, and not continued if the case might with profit be admitted to the infirmary";[3] or that they are not to be given unless the "District Medical Officer certifies that the patient can be efficiently treated at home." In a few Unions the rule is that where there has been no order of the Board of Guardians, medical extras are to be given only "on loan" by the Relieving Officer, "except to

at the Guardians' expense. At St. Pancras there is the same arrangement, but the fitter comes to the dispensary. Spectacles, where mentioned, are said to be supplied by a local optician; at St. Pancras, cases recommended by the District Medical Officers are sent to the workhouse infirmary; in a difficult case the Medical Officer there tests the eyesight, but in the majority of cases this is done by an optician, who will attend, if necessary, at the patients' homes. At Birmingham, an oculist attends at the parish offices the first Monday in each month at 11 A.M. to examine the eyes of out-relief patients and children from the Roman Catholic certified schools; also once every fortnight (Wednesday) at the Workhouse, and once every fortnight (Tuesday) at Marston Green Homes. As regards teeth, these are seldom supplied by the Guardians. We understand that in some cases in the Metropolis they have been supplied. It is, however, reported that the great majority of the Poor Law aged patients suffer from dyspepsia, due to the absence of teeth or the use of food unsuitable for that absence. In a rural Union, where the Guardians are chiefly farmers, it is idle to expect them to provide for paupers what they do not think necessary to provide for themselves; but suitable food might be provided for the toothless. In London simple dentistry is sometimes performed. The removal of septic teeth ought, indeed, to be regarded as a necessity.

[1] Holborn.

[2] Rules of Bridge, Cardiff, Crediton, Evesham, Hastings, Haverfordwest, Oxford, Taunton, and other Boards of Guardians.

[3] Rules of Holborn and Lewisham Boards of Guardians.

such applicants as are ascertained by previous inquiry to be destitute."[1]

In several London Unions special orders are given to mothers suckling children on dairymen of repute in the district to supply milk according to the doctor's orders—occasionally, we are told, milk is given by Relieving Officers without being prescribed by the District Medical Officers. In the case of ailing infants, orders are sometimes given on the borough council's milk depôt for humanised milk.[2] In rural districts, in certain Unions where distances are great, there is delay in obtaining the necessaries—and this delay in some cases may have serious results. The District Medical Officer for North Witchford (Cambridgeshire) points out that a sick pauper, in his Union, might have to send eight miles to the Relieving Officer to get the doctor's recommendation endorsed, and that frequently he has no one to send—the consequence is that the doctor feels more inclined to give the necessaries himself. Another District Medical Officer, for a rural district in Staffordshire, told us that he also frequently gave necessaries out of his own pocket on this account. On the other hand,

[1] Rules of Eastbourne, Hartley Wintney, Merthyr Tydvil, Trowbridge and Melksham, Whitchurch (Hants) and Wycombe Boards of Guardians.

[2] We have it in evidence that, in one case in 1905, where application for relief was made by a man who was out of work, for his starving wife and infant twins of seven weeks old, the Relieving Officer gave, as a case of "sudden and urgent necessity," some rice and flour, bread and treacle (!); but no food for the babies beyond two tins of condensed milk in the course of six weeks, and no money to buy it with. One of the babies died; and the Coroner elicited the fact that the mother had tried to keep it alive on biscuits dipped in condensed milk. On the facts being subsequently represented to the Board of Guardians, the action taken by the Relieving Officer was not disapproved of (*Qs.* 25531-42); nor did the case lead to any Circular by the Local Government Board directing proper food to be supplied to infants, when they were relieved in kind, on the plea of "sudden and urgent necessity."

in the Union of Pewsey, Wiltshire, we were told by the District Medical Officer that he relied in these cases on private charity, and that it never failed him. Pointing to a village up on the Downs, he said that if a cottager were seriously ill there, he could rely on a pint of beef-tea and a milk pudding being sent up by the farmer's (employer's) wife daily, and that he always got brandy from the clergy of the district.[1]

The administration as regards "medical extras" illustrates the clashing of two principles, viz. the Poor Law deterrent principle, and the medical principle, that the best possible must be done for the patient. Whereas it seems clear that the decision as to what is necessary to restore a patient to health should rest with the doctor alone—the onus of such a decision now legally appears to rest ultimately with the Relieving Officer (in Scotland with the Inspector of Poor[2]) or the Guardians. In the majority of Unions investigated, medical recommendations are never disregarded.[3] When a Medical Order is given, the District Medical Officer has to assume that he is dealing with a case of destitution, and is legally bound to attend it without asking questions. Yet as soon as the case requires "extra nourishment" he

[1] "The doctor in some villages is sufficiently acquainted with the charitable in his locality to be able, by means of a note to them, to obtain anything that is required." (Report on Poor Law Medical Relief, Appendix, vol. xiv., by Dr. J. C. M'Vail, p. 124.)

[2] "The medical officer at present has the power of recommending medical extras, but this is subject to the veto of the inspector of poor—a veto which has been exercised frequently." (Report of the Poor Law Commission, 1909, *Q.* 57922, par. 29. See also *Qs.* 65554 (par. 12), 65679-83, 65781.) The Medical Member of the Local Government Board for Scotland is, however, of the opinion that "in practice this veto seems to be more or less a dead letter." (*Ibid.*, *Q.* 56605, par. 39.)

[3] In two Unions medical recommendations are not acted upon unless endorsed as urgent or countersigned by the overseer or a Guardian.

has to furnish particulars ascertained by personal inquiry. He knows that, in case after case, recovery is impossible unless more nourishment—to say nothing of better housing, clothing, etc.—is supplied. At present he has no power to do more than recommend to the Board of Guardians that specific "medical extras" should be provided — a recommendation which is never encouraged, often greatly discouraged, and not infrequently ignored. It is difficult to suggest a remedy. Some District Medical Officers have urged that they ought to be given the power peremptorily to order for their patients whatever is necessary to promote their recovery—exactly as the Medical Officer in the workhouse infirmary (like a hospital doctor) habitually does. But this would be to enable the District Medical Officer to order unlimited outdoor relief for the sick poor, which would certainly result in abuse, partly because it is stated that some doctors give medical recommendations for the sake of becoming popular, and partly because, since so many have to find their own medicines on an inadequate salary, it is only natural that if they thought a little extra food would do as well as medicine they would order it. What appears to be necessary, from the Public Health standpoint, is that the District Medical Officer should be required to take the responsibility of deciding whether the patient's home circumstances are such as to give a reasonable chance of recovery. If they are not, he must be in a position to point out authoritatively, in such a way that it cannot be disregarded, what is lacking. If this is not forthcoming—perhaps because the Board of Guardians considers it undesirable to afford the necessary amount of outdoor relief to the

patient in question—the District Medical Officer ought to have the power of ordering the removal of the patient to the appropriate institution, where all the requisites of recovery would be supplied as a matter of course. Such a power, it may be observed, is possessed in infectious cases by the Medical Officer of Health; and—in the absence of any stigma of pauperism—is exercised without popular objection.

From the medical standpoint, one of the greatest obstacles to recovery among the sick poor who are treated in their own homes is the lack of proper nursing. The District Medical Officer has no power to order a nurse to be provided. The Boards of Guardians have power to appoint salaried nurses for the outdoor sick, but they have almost uniformly refused to do so. In a small minority of Unions they pay a subscription to the local nursing association, so that the paupers may obtain a share of the services of the district nurse. It is one more anomaly that the sick poor thus enjoying the best nursing do not thereby become paupers. But over the greater part of the country there is no district nurse; and it is rare for the Guardians to make any sort of provision for nursing the outdoor sick poor.[1] The Medical Investigator

[1] There used to be an idea that one outdoor pauper could nurse another; and some Boards of Guardians still embody in their bylaws that: "Out-paupers will be required to attend other out-paupers in sickness, when ordered by the Relieving Officer to do so." (Rules of Kingsclere Board of Guardians.) Some Boards occasionally allow a shilling or two to a neighbouring woman to look in upon a sick patient. This is, however, discouraged and restricted. "No allowance," run the rules of several Unions, "shall be made for nursing except in special cases." (Rules of Warwick Board of Guardians; similarly, in various terms, at Brixworth, Cheltenham, Banbury, etc.) At Chichester, where it so happens that the Workhouse Medical Officer is also the Outdoor Medical Officer for the whole Union, the workhouse nurses are sent out as required, to attend to the patients on outdoor relief. "The result is,"

appointed by the Poor Law Commission reports that "in many villages and their surrounding neighbourhood, I found that no district nurse whatever was available. District Medical Officers complained very much of this want of assistance, and the complaint was well founded. . . . Quite unquestionably, in some rural districts the want of sick-nursing of paupers is a serious defect in the present system of Poor Law medical relief."[1] This was, indeed, frankly stated by the General Inspectors of the Local Government Board. "The lack of nursing upon the outdoor sick poor," testified one of them, "is another source of hardship, and one which urgently needs to be dealt with."[2] The fact that wool, lint, and bandages are hardly ever supplied by the Guardians aggravates the evil. The District Medical Officer can order nothing better than clean rags for dressings, "lest" (as one of them said) "the bad legs should ruin him."[3] As things are, it is unfortunately painfully true, as an experienced District Medical Officer stated, that "many cases die

says the Medical Inspector, "that at Chichester we get a vastly better nursing staff than we have in other Workhouses of the same size," and the outdoor poor are better nursed. (Report of the Poor Law Commission, 1909, *Qs.* 10376-9.) A similar arrangement is in force at Merthyr Tydvil (*ibid.*, *Q.* 48888 (par. 6), and Appendix No. lv. (par. 6) to vol. v.), and at Rochdale and Sculcoates.

[1] Report on Poor Law Medical Relief, Appendix, vol. xiv., by Dr. J. C. M'Vail, p. 112.

[2] Report of the Poor Law Commission, 1909, Appendix No. xix. (A), par. 22, to vol. i. (evidence of Mr. Baldwyn Fleming).

[3] "Many of the old people whom I saw were afflicted with ulcers of the legs; the use of proper and sufficient dressings for such ulcers was the exception. Lint and gutta-percha tissue and other non-porous coverings are seldom provided. Linen rags are the rule. These are usually obtained from neighbours or from the charity of the better-off community. Linen rags saturated with a medicated lotion will be comfortable enough, so long as the rags are kept wet, but at night, when the patient goes to sleep, the lotion will quickly evaporate, and in the morning the rag and ulcer will be closely adherent, and not separable without a good deal of pain." (Report on Poor Law Medical Relief, Appendix, vol. xiv., by Dr. J. C. M'Vail, p. 102.)

simply from want of proper nursing. I cannot," he said, "speak strongly enough on this point. It is one of the Medical Officer's greatest drawbacks that he cannot get efficient nursing for his outdoor cases."[1] "It is dreadful," reports a Local Government Board Inspector, "to think of the amount of unnecessary inconvenience, to say the least, suffered by out-patients now, looked upon as a matter of course, and allowed to continue with no practical effort to prevent it. If expense were incurred it would be doubly justifiable. Firstly, because of the suffering it would alleviate. Secondly, for the more cynical reason that it would restore the patient to health, and get him off the rates much more quickly. Medical Officers are handicapped in their work when they have no intelligent nursing power behind them, and know that it is useless to try many things that might be done if there were the requisite attendance at hand."[2] There is even no nurse in attendance at the Poor Law dispensaries, though such an attendant—usual in the ordinary out-patient department of a hospital—would

[1] Report of the Poor Law Commission, 1909, *Q.* 34566, par. 6 (c). "There is no doubt in my mind," testifies another witness, "but that the medical assistance to the poor (paupers) is seriously affected by the complete absence of any organised scheme for the proper nursing of the patients in their own homes." (*Ibid.*, *Q.* 75774, par. 6.) Nor need this attendance be wholly that of a trained nurse. "Much help could be given, and better results obtained," says a District Medical Officer, "by the employment of respectable women to thoroughly cleanse and keep clean the homes of the poor where there is sickness in the house, and a qualified nurse is not necessary for this purpose." (*Ibid.* Appendix No. cxlviii. (par. 6) to vol. vii.) "The very poor people, I am sure," says another witness, "are very much neglected indeed; there are a great many deaths due to it (inadequate nursing) that would otherwise get better." (*Ibid.*, *Q.* 34672.) "It is probably true that neither in urban nor in rural districts are the outdoor sick as well nursed as they might be, and that some regular system of nursing would be an advantage." (Report of the Departmental Committee on Poor Law Medical Relief (Scotland), 1904, p. 77.)

[2] Thirty-fifth Annual Report of the Local Government Board, 1905-6, p. 466 (Mr. Fleming's Report).

be a great assistance to the District Medical Officer and the dispenser, and add greatly to the comfort of the patients. At Stepney the Poor Law dispensary is in the same building as the receiving house for children; so that the District Medical Officer can ring for a nurse to come if he thinks it desirable. It has been suggested that a probationer from the workhouse infirmary might well be required to be in attendance at the doctor's hours, where she would gain experience in bandaging and treating slight cases of injury, sores, etc.

C.—The Patients of the District Medical Officer

(i.) *The Number of Patients*

The District Medical Officer is not responsible for medical attendance on the entire population of his district. He is required to attend only on those who are entitled to his services and who claim them. These vary enormously from district to district. The persons entitled to his services are only those who, as being deemed "destitute," have been furnished with a "Medical Order" from the Relieving Officer. Thus, whether a sick person is or is not entitled to medical attendance does not depend upon the character or severity of the illness, or upon its probable effect on the neighbours or on the family, but upon the decision of a non-Medical Officer, as to a non-medical circumstance; that is, the fact of "destitution." It is an added cause of variation that there appears to be no statutory or generally known definition of destitution

for the purpose of medical relief. It is admittedly not an absolute lack of possessions, though it has apparently sometimes been interpreted so rigidly as practically to exclude everybody who was not sufficiently destitute to accept the shelter of the Workhouse. Mr. Albert Pell in 1888 said he was a member of a Board of Guardians in London where outdoor medical relief had been almost abolished, and that he was a member of a Board in the country where it had been entirely abolished.[1] The Poor Law Commission did not, in 1907, find any Union with so limited a definition as this. But in the Ellesmere Union (Shropshire) it was given in evidence that no outdoor medical relief whatever was granted to any one who was not also in receipt of ordinary outdoor relief. The Guardians admittedly believed that unless they gave outdoor relief the applicant would not legally be eligible for medical assistance. Destitution is, for this purpose, elsewhere often taken to be the inability to afford, without encroaching on necessary food and shelter, the lowest possible fee of a medical practitioner —that of the "sixpenny doctor," or the "copper dispensary" in the poor quarters of the large towns. In other cases, the practical definition of destitution for medical relief includes the normal condition of practically all the agricultural or unskilled labourers of the district.[2] The Local Government Board has

[1] Report of House of Lords Select Committee on Poor Relief, 1888, *Qs*. 1449-50, 1532.

[2] In the Union of East and West Flegg (Norfolk), for instance: "Able-bodied people, if earning less than 2s. 6d. per head, per week, in family, may have medical orders for man, wife, and children; grown-up sons earning and living at home to be reckoned in this average, where father and mother require relief, not otherwise." (Resolution of East and West Flegg Board of Guardians, 1904.) In the Unions of Evesham (Worcestershire) and Petersfield (Hampshire) the weekly wage limit is 3s. per head of family; whilst in the Cleobury

laid it down (though the decision has so far not been widely promulgated) that "the test of the guardians' duty in the matter is the destitution of the patient; and this will not necessarily depend upon his being in actual receipt of poor relief, but may consist in his being unable to obtain at his own cost *the requisite medical attendance, nursing and accommodation.*"[1] Thus, it appears that, in a case requiring anything more than simple attendance and medicine, destitution may, in law, have no other meaning than inability to pay the fee required for the necessary treatment or operation. We understand that, according to this definition, in strict law, a patient requiring for the preservation of his life an expensive surgical operation, and unable to pay the surgeon's fee would, if no free hospital were accessible, be entitled, although not otherwise destitute, to claim that it should be performed at the expense of the poor rate.

But it is apparently no part of the duty of any Poor Law Officer to search out disease, however dangerous or injurious it may be to the patient, the family, or the neighbours. The proportion of the sick for whom a Medical Order is granted depends, therefore, not merely on the view taken of the meaning of "destitution," but also on the extent to which the sick apply for Medical Orders. This appears to vary greatly, according to the knowledge and disposition of the poor. In the slums of the great towns there appear to be many of the poorest families who are completely unaware of their right

Mortimer Union (Shropshire) Medical Orders are apparently freely granted to all applicants who are not in occupation of more than three acres of land—meaning, we assume, to the whole wage-earning population.

[1] Local Government Board to Holbeach Union. (*Poor Law Officers' Journal*, vol. xiv. p. 297; *Poor Law Annual*, 1907-8, p. 808.)

to obtain free medical attendance, or unacquainted with the formalities necessary to procure it. In the working-class districts of the north of England, whilst there may be more general knowledge, there is a great repugnance to apply for the "parish doctor," even when the right to his services is known. On the other hand, there are rural districts in which practically every wage-earning family obtains his services as a matter of course.

The number of the District Medical Officer's patients depends very largely upon the policy and arrangements insisted on by the Board of Guardians. In all Unions the sick have to overcome the reluctance of the Relieving Officer whose business it is to ward off applicants for assistance from the rates. But the tendency naturally is for the Relieving Officers to grant Medical Orders freely and indiscriminately; sometimes in order to protect themselves against the risk of having an applicant die for lack of help;[1] sometimes "with a view," as the President of the Association of Poor Law Unions stated, of "getting rid of" applicants for relief on the easiest possible terms. A Relieving Officer will say, for instance, "we will give you a medical order if you like, but we will give nothing else."[2] Frequently every person, well or ill, who receives outdoor relief, is put on "the permanent list," and becomes entitled himself to send for the District Medical Officer whenever he chooses.[3] In the laxest Unions, as we have gathered, Medical Orders are given to all who apply for them, without even being entered

[1] Report of the Poor Law Commission, 1909, *Qs.* 22767-71.

[2] *Ibid.*, *Q.* 25024.

[3] In the Metropolis alone there are 20,000 persons on the permanent list.

in the Application Book.[1] It was even given in evidence before the Poor Law Commission that, in one Union, the practice is for the Relieving Officers to sign a batch of such orders at a time, with the names and dates blank, and to leave them with the shopkeepers of the villages, from whom any person gets one who chooses to ask for it.[2]

This lavish and indiscriminate grant of Medical Orders, by medically unqualified persons, without any verification of the fact of illness, or of its urgency or gravity, has, we think, a disastrous effect, both on the quality of the service rendered and on the spirit in which it is accepted. We have already[3] alluded to the friction that arises between the District Medical Officer and the Relieving Officer. Moreover, a lavish distribution of Medical Orders to all applying for them is a contravention of the present contract with the District Medical Officer, who is paid a meagre salary for attendance only on parishioners who are both sick and actually destitute. All this tends to make the District Medical Officers reluctant and suspicious—in fact, to quote the words of one of them, to make them regard the holders of Medical Orders "as paupers rather than as patients."[4] Nor is the effect of this indiscriminate grant of peremptory orders to the District Medical Officer, to visit persons who may or may not be ill, any less harmful to the recipients. Whatever may be the advantage of a public organisation of medical assistance, as

[1] See Report of the Poor Law Commission, 1909, *Q.* 10302.

[2] *Ibid.*, *Qs.* 70671-82. In one Union the workhouse porter is instructed to give Medical Orders to all who apply for them (and to mark them all "urgent") after the Relieving Officer's hours of attendance.

[3] See *ante*, p. 26.

[4] Report of the Poor Law Commission, 1909, *Q.* 51859, par. 7.

universal and as free—if not also as compulsory—as that of education, a careless and ignorant issue, by a Destitution Authority, of Poor Law Medical Orders to persons not really entitled to them encourages fraud and malingering. The holder of a Medical Order may have merely pretended to be ill or pretended to be destitute; he is under no responsibility with regard to his own illness, or to the order which he has obtained; he presents it or not, as he chooses; he takes the medicine or throws it away at his option; he follows the doctor's advice, or remains dirty and dissolute, exactly as he pleases—without feeling under any obligation to the community to co-operate in his own cure, or under any kind of compulsion to abandon the evil courses which may have led to his ill-health.

On the other hand, in other Unions the instructions of the Board of Guardians to the Relieving Officer are such as to discourage him from granting any such orders.[1] Much, with this view, is made of "the

[1] It is assumed that outdoor medical relief is an open door to other forms of pauperism, to which it is apt to lead. Many of the witnesses before the Poor Law Commission were of this opinion (see, for instance, *ibid.*, *Qs.* 4138-9, 5624-7, 6127-31, 8399, 11160, 13433, 20115a, 24741 (par. 46), 28919-21, 31693 (par. 11b), 33487 (par. 47), 34072 (par. 9), 35048, and Appendices Nos. xii. (par. 23) to vol. i., and viii. (C) to vol. ii., etc.), but investigation did not give much support to the assumption. The Medical Investigator appointed by the Poor Law Commission reported that to him at the outset it seemed "a perfectly natural one, and I had no doubt of finding abundant evidence of its soundness in the first Union to be inspected. I decided to ask every inmate of its workhouse who could give any information on the subject whether he or she had received medical Out-relief before getting any other kind of relief from the Guardians, and accordingly spent an afternoon interviewing the paupers. In reply to inquiry, it appeared that in no single case had their pauperism begun by Out-medical Relief, independent of other Out-relief. The replies were so unexpected that I asked the master to continue catechising on the same lines and to give me a note of the particulars of all the answers obtained. He did so, and the result was similar." Dr. M'Vail then extended his inquiry, so as to include persons on outdoor relief. The outcome was that, "In only five out of 490 indoor paupers, and in only

stigma of pauperism," which still attaches to the grant of a Medical Order, though to a less degree than to admission to the Workhouse or the grant of outdoor relief in money. The recipient of medical relief only is technically as much a pauper as the inmate of the Workhouse. The cost of his relief may be charged to and recovered from his relations (son, daughter, husband, parent, grandparent). It is true that the Medical Relief Disqualification Act has removed the disqualification for voting for Parliament, or for the county, parish, or town council, from all receiving medical relief only. "But," as is rightly said, "when a grant of brandy, meat, or groceries is made to those in receipt of medical relief only, it appears to be a very narrow line that

twelve of 1198 outdoor paupers, or in practically 1 per cent of each of the two classes, had pauperism begun with medical Out-relief, so that in only this 1 per cent is it possible that, in the rural Unions, medical Out-relief had led the way to Indoor Relief, or Outdoor Relief, in money or in kind. The figures given for 1st January 1905 correspond very closely to these. In a total of 6018 paupers in the eleven rural Unions only sixty-six, or very little over 1 per cent, were in receipt of medical relief only. And it cannot be assumed that even this 1 per cent was led into pauperism by receiving medical Out-relief. In short, I found it impossible to get on a statistical basis any evidence of this alleged evil influence of medical Out-relief. There is . . . a somewhat greater statistical possibility that in cities medical out-relief may be an inducement to general pauperism." (Report on Poor Law Medical Relief, Appendix, vol. xiv., by Dr. J. C. M'Vail, 1907, pp. 141-2.) In the Metropolis, where it is "the nearly unanimous opinion of Relieving Officers" that "the obtaining of Medical Orders, especially in the cases where nourishment is prescribed," is "a most prolific cause" of chronic or long-continuing pauperism, it was "found that of a total of 237 male operatives in the boot and shoe trades, a Medical Order formed the kind of relief first given in thirty-four cases, or about one-seventh of the total." (Report on the Relation of Industrial and Sanitary Conditions to Pauperism in London, by A. D. Steel-Maitland and Miss R. E. Squire, p. 15.) This, however, leaves it uncertain whether, even in those cases, the cause of pauperism was not the disease, rather than the issue of the Medical Order. The Royal Commission seems to have made no attempt to get any evidence as to the relative effect on subsequent pauperism of cases of disease left unattended to, and cases of disease for which a Medical Order was granted.

separates the disenfranchised pauper from the medical case."[1] The word "pauper" is, in some Unions, deliberately made use of as a deterrent. In the forms of Medical Order employed in some of the Metropolitan Unions the word is put in prominent type once (and sometimes twice). In many of the rural Unions, on the other hand, the word does not appear on the Medical Order. Mr. H. C. Burdett, in giving evidence before the House of Lords Committee on Metropolitan Hospitals in 1877, attributed to "this very simple matter, which seems to have escaped public attention," the comparatively small numbers of applicants for Poor Law medical relief.[2]

This restrictive policy is even expressed in standing orders or bylaws. Thus, Relieving Officers are often forbidden to grant Medical Orders without first paying a personal visit to the home of the applicant and investigating his circumstances,[3] in order not to find out how best to cure the sufferer, but, if possible, to discover some ground which makes him ineligible for aid. Other Boards expressly say "that orders by the Relieving Officer for Medical attendance must be more charily given, due inquiries being made when possible at the house before being granted, or at any rate at the earliest moment possible after being

[1] On investigating this point the clerks to the Guardians in thirty-seven Unions reply that persons receiving medical relief and medical extras are *not* classified as receiving medical relief only, and are, therefore, excluded from the Parliamentary Register. In twenty Unions persons receiving medical relief and medical extras are classified as receiving medical relief only, and are thus not excluded. The disqualification is particularly remarkable when the patient is suffering from an infectious disease, which, if he had been dealt with by the Medical Officer of Health and maintained out of the rates in a Public Health hospital, would not have made him a pauper.

[2] Committee of House of Lords on Metropolitan Hospitals, 1877, p. 727.

[3] Regulations of Bromsgrove Board of Guardians ; also at Calne and many other places.

granted."[1] In some Unions the applicant for a Medical Order is required to attend personally before the Guardians at their meeting, and explain, at the cost of half a day's earnings, how he comes to need medical aid. "Midwifery Orders," says one Board, "shall not be given by the Relieving Officer, except in urgent cases, without the consent of the Board of Guardians, given on personal application to them."[2] Occasionally the grant of Medical Orders in midwifery cases is restricted to families having less than a prescribed income, it may be 15s., or 18s., or 21s. a week, whatever the number of children,[3] or it may be at the rate of 2s., 2s. 6d., or 3s. a week for each member of the family.[4] An even more usual way of staving off applicants is, whatever their circumstances, to insist on granting the Medical Order only as "relief on loan,"[5] this being

[1] Instructions of Wincanton Board of Guardians.

[2] Rules of Keynsham Board of Guardians.

[3] Rules of the Chertsey, Lymington, Godstone, and Lewisham Boards of Guardians.

[4] "That where the earnings of a family amount to 3s., per week for each member thereof, orders for medical aid be not given, except in fever or other extreme cases." (Regulations of Evesham Board of Guardians.) "Able-bodied people, if earning less than 2s. 6d. per head in family, may have Medical Orders for man, wife, and children. . . . Midwife; basis not to exceed 2s. per head in family." (Resolution of East and West Flegg Board of Guardians, 1904.)

[5] So far as we have ascertained, it was in Mr. Corbett's Report of 1871 that was revived the suggestion thrown out in 1840 that medical relief in particular might be given on loan; and even that it should be "generally granted by way of loan" (Third Annual Report of Local Government Board, 1873-4), without regard, it would seem, to the probability of its being recovered. This opinion of the inspectorate, though constantly pressed on Boards of Guardians, did not, in 1877, receive the explicit endorsement of the Central Authority. An influential proposal to make all relief (and especially all medical relief) recoverable as if given on loan was definitely negatived. "The policy of the existing law," it was declared, "is that the question whether or not relief shall be granted on loan, or in other words, whether it shall be recoverable at a future time, is to be determined by a consideration of the actual circumstances existing at the time the relief is granted. (Local Government Board to Chairman of Central Poor Law Conference, 12th May 1877; Seventh Annual Report of Local Government

sometimes printed, as a matter of course, on the form. "All orders for medical attendance," says a Suffolk Board of Guardians, "shall be granted in the first instance by way of loan, the applicant to repay 10s. for each midwifery case, and 5s. for each other case."[1] The applicants then remain liable to repay the cost; and the Relieving Officer is sometimes allowed a commission of 20 per cent on what he can recover.[2]

Board, 1877-8, p. 54.) The Local Government Board had pointed out in an instructional letter in 1852 that what cannot be legally given must not be lent, and that the power of lending is only to be exercised where the Guardians think fit to do something less than absolutely give the relief applied for in cases where the application is lawful. In such cases, and in such only, they may lend it; and such loans should never be made without the necessary steps for recovery being in due time taken. Hence, in the very strictly administered Unions of Whitechapel and St. George's-in-the-East, medical relief is practically never given on loan. It is hardly ever found that the applicant's position is good enough to warrant granting the relief by way of loan. At Richmond (Surrey) medical relief is given on loan only "if the board be of opinion that the applicant will be able to repay the expenses incurred on his or her recovering." (Rules of Richmond Board of Guardians.)

[1] Rules of Mitford and Launditch Board of Guardians; similarly in various terms, at Hinckley, Ruthin, St. Asaph, Llanfyllin, Warwick, Yeovil, Monmouth, Cosford, Nantwich, and many other places. "Fulham charges in advance the definite sum of 1s. for medical relief to all applicants, who must personally appear before the board to prove their destitution and inability to pay. Only those who cannot repay, therefore, go to the trouble of applying—to the great reduction of medical relief." (Report on the Overlapping of the Work of the Voluntary General Hospitals with that of Poor Law Medical Relief, by Norah B. Roberts, p. 11.)

[2] It is said, however, that very little is actually recovered. For instance, in one Metropolitan union repayment is nominally required at the rate of 2s. 6d. for seven days' medicine and attendance (or for a less period). But the total amount so repaid during the last quarter of the year was only 6s. "Very little is recoverable," said a District Medical Officer of Birmingham, "and I believe very little has been recovered; certainly if recovery has ever taken place at all it has not been adequately done. The thing is a farce." (Report of the Poor Law Commission, 1909, *Q.* 44438.) "Giving . . . medical relief on loan is generally held *where practised indiscriminately* to be of small effect, as repayment is very rare. It is said at Lewisham to be 'absolutely useless, as the people know well that repayment is never insisted upon.' The precaution is found in Lambeth to be 'quite a farce and the people know it.' In Camberwell, in force for three years, it has had no influence whatever; even in midwifery cases repayment is exceedingly rare. Nor have

There is evidence that the practice of giving Medical Relief only on loan has, especially when first established and with regard to any but the most serious ailments, a very deterrent effect on applicants. "It has," even in the Metropolis, "a certain effect in preventing persons applying who would otherwise have applied."[1]

But the deterrent effect is found "to gradually pass away."[2] Moreover, it has been suggested, on high authority, that if a charge is made for the services of the District Medical Officer, and this relief is granted "on loan," and actually repaid, the Board of Guardians runs a risk of competing with Medical Clubs and other forms of medical insurance.[3] A more ingenious way of deterring applicants is to resolve "that when relief is administered to a labouring man who is himself ill (if the disease is not contagious) the Board requires that some of the children shall come to the Workhouse during the sickness."[4] When the Medical

Holborn, Hackney, and Hammersmith met with any real success. Willesden adopted the precaution in November last, but so far not a halfpenny has been repaid." (Report on the Overlapping of the Work of the Voluntary General Hospitals with that of Poor Law Medical Relief, by Norah B. Roberts, p. 11.)

[1] Report of the Poor Law Commission, 1909, *Q.* 23077.

[2] *Ibid.*, *Q.* 23079.

[3] *Ibid.*, *Q.* 2738. To make any substantial charge for Medical Relief is, in the case of destitute persons, an absurdity; whilst the making of a nominal charge was objected to by an experienced Poor Law Official as being actually "an inducement for persons to apply for Medical Relief, if they found they could get it so cheaply." (*Ibid.*, *Qs.* 20271-5.) "The loan system," declared a medical witness, "should be abolished, as it is calculated to increase pauperism . . . and discourage thrift." (*Ibid.*, *Q.* 44421, par. 4.)

[4] Report of Atcham Board of Guardians, 1871; also adopted by the Pewsey Board of Guardians. "The method," states the Report of the Atcham Board of Guardians, "also acts as a test of destitution, for in almost every case where the parties have refused to send the children"—refused, that is, to plunge their children into the General Mixed Workhouse, for the Atcham Union had no separate institution for its children—"they have gone without relief altogether," and, as the Report optimistically assumes, "have had other means of support, and should not have applied to the Relieving Officer."

Order has been given, it is made the duty of the Relieving Officer to visit the case frequently and regularly;[1] not to see whether the patient is obeying the doctor's orders, or whether anything else is needed to restore him to health, but in order to discover whether he has not some undisclosed resources which would permit of the relief being withdrawn. The Guardians are, in fact, as one Committee reports, "strongly of opinion that a large number of the cases relieved would manage without assistance from the Guardians if they were properly and systematically visited and dealt with by the Relieving Officer."[2]

We have found the practice of some Boards of Guardians even more severely restrictive of the use of the District Medical Officers than is implied by the foregoing bylaws. Thus, the Bradfield Union in this way claims to have reduced the number of Medical Orders granted from 700 to 47 per annum.[3] In the Bermondsey Union, where the poor are said to "have more difficulty in getting relief now than they used," the permanent list of those on whom the District Medical Officers have to attend has fallen from over 1000 in 1901 to 322 in 1906, not because there is less sickness in Bermondsey, or less destitution, but merely because more difficulty has been put in the way of the sick poor getting Medical Orders.[4]

[1] "That the Relieving Officers be required to make at least fortnightly visits to the homes of all persons receiving relief on account of temporary sickness, and to visit the old and infirm cases at least once a quarter." (Regulations of Evesham Board of Guardians.) Similarly at Cheltenham, Warwick, Haverfordwest, Oxford, Luton, Holywell, and many other places.

[2] Report of Special Committee of Willesden Board of Guardians; MS. Minutes, Willesden Board of Guardians, 13th December 1905.

[3] Report of the Poor Law Commission, 1909, *Qs.* 9499, 19781, and Appendix No. ccxi. (A) to vol. vii.

[4] *Ibid.*, *Qs.* 20360-63.

Nor is there any doubt as to the cause of the reduction. One District Medical Officer informed us that he was convinced that the reduction in the number of Medical Orders granted in a particular Union (from 572 in 1870 to 40 in 1899) was due entirely to the deterrent effect of insisting on prior investigation and personal application to the Board of Guardians.[1] The St. Pancras Board of Guardians reduced the number of its Medical Orders from 5324 in 1899 to 2546 in 1903,[2] by making stringent inquiries on every application, requiring the applicant to appear personally before the Board, tendering the Medical Relief on loan in many cases, and offering the alternative of admission to the Workhouse whenever deemed advisable.

From a public health standpoint it must appear a grave defect that any who are sick and who are unable otherwise to obtain medical assistance fail to receive it from the District Medical Officer. As we shall show later,[3] there is evidence that, in some parts of the country, a very large proportion of the cases of sickness go without any medical treatment whatsoever. Others, especially in the poorer quarters of the large towns, seek medical assistance at a fee which makes any accurate diagnosis, careful advice, or competent treatment economically impossible. It is not too much to say that the proportion of the sick for whom medical attendance is provided by the District Medical Officer varies, from Union to Union, without reference to the prevalence of ill-health or to the gravity of the cases, but according to the orders

[1] Report of the Poor Law Commission, 1909, *Qs.* 34076-8, 34164.
[2] *Ibid.*, *Q.* 23074 ; see also *Qs.* 18812-16.
[3] See post, pp. 168, 212.

and practice of the Board of Guardians, the knowledge and discretion of the Relieving Officer, and the personal popularity of the District Medical Officer, from not more than 5 to 10 per cent up to 60 or 70 per cent.

As to the class of persons who actually do secure the attendance of the District Medical Officer there is some doubt and some conflict of testimony. His patients include, to begin with, all the ordinary outdoor paupers who happen to be sick. In some Unions all outdoor paupers on the permanent list are regarded as entitled to medical relief without a special medical order.[1] In others, all such receive permanent medical orders irrespective of whether they are ill or not. The consequence is that, in the Metropolis, the heaviest day's work at the Poor Law Dispensary is that on which the paupers attend to receive their weekly dole. In many Unions all the aged poor on outdoor relief are given permanent medical orders as a matter of course. These often think that unless the District Medical Officer sees them now and then and hears their complaints, they run a risk of having their outdoor relief stopped. It is reported that at the end of 1898 there were over 2000 persons in St. Olave's Union in possession of permanent medical orders, being about 1½ per cent of the population. On the other hand, on 31st December 1906 there were reported to be only 107 paupers "on the permanent list" in what is now called the Southwark Union.

[1] The District Medical Officer ought to inform the Relieving Officer of all such cases attended without a medical order (General Consolidated Order, 1847); and is sometimes specifically required to do so (Rules of Calne Board of Guardians); but it is not always done. Thus the statements furnished to the Local Government Board as to the number of cases treated are said to be very misleading. Far more work is done by the District Medical Officers than would appear from the Local Government Board returns.

There were on the same date no fewer than 3252 on the permanent list in Camberwell and 2644 in the Poplar Union. This does not necessarily mean lax administration. In St. George's-in-the-East, where the policy of the Board of Guardians is most strict, outdoor medical relief is freely granted, without, so far as can be seen from the statistics, causing any increase in ordinary pauperism. There is no permanent list of persons entitled to medical relief, but the Relieving Officers are allowed to issue medical orders in all cases in which they think medical attendance is required, including those of able-bodied men in employment at the current rate of wages.[1] Altogether, there were in the Metropolis on 31st December 1906, 20,000 persons on the permanent list for medical relief, as compared with a total of 117,126 medical orders issued in the year.[2]

[1] In the year 1906 no fewer than 4463 medical orders were given in this small union; or twice as many as in that of St. Marylebone. It is also to be noticed that the large proportion of Jews in St. George's-in-the-East who do not usually apply for ordinary relief, apply freely for medical relief. (Report of the Poor Law Commission, 1909, *Qs.* 17533, 29317.)

[2] To go into greater detail, in the thirty-one Metropolitan Unions, with their 158 District Medical Officers, there were on "the permanent list" of 131 out of the 158 districts on 31st December 1906, 18,874 patients; so that the total must exceed 20,000. The total number of orders issued during 1906 was, for 138 districts where there were dispensaries, 63,597 for the dispensary and 44,192 for the patients' homes; whilst for the twenty districts without dispensaries, 9337 were issued; making a total of 117,126 in all, of which 1146 were for midwifery. But the existence of the permanent list and the variations in the duration of the orders makes it impossible to draw any inferences from these figures, either as to the number under medical attendance or as to the amount of the work of the District Medical Officers. Each order may be good for one, two, three, four or six weeks, for three months or six months, or until the next Board meeting, or it may have no limit. The replies of District Medical Officers as to the duration of Medical Orders give the following remarkable divergence of practice:—

One week	Burton-on-Trent.
Two weeks	Burton-on-Trent.
,, ,, ...	Wolverhampton (two doctors).
Three weeks	Burton-on-Trent.

But the patients attended by the District Medical Officer are not only those who are in receipt of ordinary relief. There are, in nearly all Unions, persons in receipt of medical relief only.[1] These often

One month	Aston.
,, ,, ...	Coventry.
,, ,, ...	Derby.
,, ,, ...	Dalby.
,, ,, ...	Dudley.
,, ,, ...	Leicester.
,, ,, ...	Stoke-on-Trent.
,, ,, ...	Walsall.
,, ,, ...	Wolverhampton.
,, ,, ...	Worcester.
Six weeks	West Bromwich (two doctors).
,, ,, ...	Northampton.
Three months . . .	Birmingham.
,, ,, ...	Burton-on-Trent.
,, ,, ...	Menden.
,, ,, ...	Wolstanton and Burslem (two doctors).
Six months	Wolstanton and Burslem (two doctors).
End of illness . . .	Aston (two doctors).
,, ,, ...	Dudley (four doctors).
,, ,, ...	Coseley.
,, ,, ...	Kidderminster.
,, ,, ...	King's Norton.
,, ,, ...	Oldburg.
,, ,, ...	Menden (two doctors).
,, ,, ...	Northampton.
,, ,, ...	Solihull.
,, ,, ...	Stoke-on-Trent.
,, ,, ...	Wallsall (three doctors).
,, ,, ...	Wolstanton and Burslem.
,, ,, ...	West Bromwich (three doctors).
,, ,, ...	Wolverhampton.

In the Metropolis seven Unions fix no time for the duration of their medical orders, seven fix three months, sixteen one month, and one a week.

[1] Taking England and Wales as a whole, more than one-eighth of the paupers are stigmatised as such merely because they have had to avail themselves of the services of the District Medical Officer, for themselves or for some members of their families. No fewer than 216,022 persons thus became officially classed as paupers during 1906-7, as being in receipt of Outdoor Medical Relief only. In the great city of Norwich, in the Unions of Beaminster, Bridgwater, Chard, Dorchester, Dursley, East and West Flegg, Gloucester, Hereford, Hungerford and Ramsbury, Isle of Wight, Leominster, Loddon and Clavering, Marlborough, Mere, Pershore, Pewsey, St. Neot's,

include cases which would not be considered eligible for the ordinary outdoor relief; sometimes (as we learn from the Wrexham Union) persons of a "better class than the ordinary type of pauper." So in Leeds, we are told, "A good many people come to the guardians for medicines who are much above the ordinary pauper class; not, be it understood, people who can well afford to pay—perhaps not at all to pay the ordinary fees of medical men—but who could pay something"; a class, says another informant, "between the permanent pauper and the thrifty club member." Especially in the rural districts, and among the casual labourers of the great towns, there are cases of families where the earnings only just suffice for ordinary maintenance, and will not pay for a doctor; sometimes the doctor has refused to attend because his last bill has not been paid. In the country the agricultural labourers, or at least those having large families and who are not in clubs, get medical relief only, where they would be refused ordinary outdoor relief. There are also many persons just on the verge of pauperism, living from hand to mouth, who apply for a medical order in any temporary sickness. We hear of "the increasing numbers who apply for medical assistance who are not otherwise eligible for relief . . . who do not belong

Shepton Mallet, Sudbury, Trowbridge and Melksham, and Upton-on-Severn, about one-third of all the persons thus legally branded as paupers are so in respect merely of this attendance of the parish doctor; in Alresford, Clun, Fordingbridge, Swaffham, Wells (Somerset), Whitchurch, Winchester, about one-half; in Abingdon, Headington, Ledbury, Martley, Tetbury, the proportion exceeds one-half; and in the city of Exeter actually 2270 persons out of 3386 were paupers only because of their receipt of Outdoor Medical Relief. (House of Commons Return, Poor Law Relief (Paupers relieved in a year), No. 250 of 1908.) Is there any advantage in bringing into the admittedly demoralising contact with the Poor Law so large a number of persons as 216,022 in a single year, merely because they need medical attendance?

to the destitute poor."[1] From the Isle of Thanet it is reported that there is no special *class* which receives medical relief only; and this is, perhaps, often the case. Elsewhere, on the other hand, medical relief is reported by others to be made use of by persons who study "how to get on the outdoor relief list—it is the first step." "The Relieving Officer," it is reported to me from Wells Union, "is practically the sole judge in the matter, and he gives an order in cases (especially confinement) where, after due inquiry into the facts, he is of opinion that the applicant is not in a position to pay for a private doctor."

(ii.) *The Character of the Cases treated by the District Medical Officer*

The great majority of the Poor Law cases of the District Medical Officer are those of the aged. Cases of chronic infirmity for which very little can be done, make up the largest number. Children are not very frequently found in the list; the proportion to adults is roughly stated officially to be not as high as one in three. Midwifery cases may be frequent or rare, according to the custom of the country and the policy of the Board of Guardians. The other patients of the able-bodied period of life, whether male or female, are almost exclusively cases of advanced disease, in which it is usually hopeless to look for recovery.

(*a*) *Senile Infirmity*

In most Unions the majority of the Poor Law patients of the District Medical Officer are old women

[1] Report of West Midland Poor Law Conference, 1903 (paper by Mr. F. W. B. Cripps), p. 114.

or old men, living on a pittance of outdoor relief, and granted permanent Medical Orders as a matter of course. They suffer from a chronic state of infirmity, which takes the form of bronchitis, rheumatism, and so on. They are in most cases eager for the attendance of the District Medical Officer, and grateful both for his visits and for the bottle of medicine that he gives.[1] The home conditions of these patients are, in the towns, nearly always unsatisfactory. Even in the country they often suffer from lack of the necessary attendance. In too many cases they live in a state of squalor and filth. It seems to us that the services of a qualified medical practitioner are here largely wasted. What would be more appropriate would be the regular weekly (or in some cases daily) visits of a trained nurse, who would call in the District Medical Officer only when his services were really required.

(*b*) *Midwifery*

In some Unions, one of the most usual occasions for the services of the District Medical Officer to be called for is that of confinement. For attendance in these cases the Medical Officer usually receives a special fee of 10s., 15s., or 20s. for each simple case, and of £2 if instruments are used. Such a method of payment may be open to the criticism—which we have heard made—that it affords a temptation to use instruments more often than is necessary.[2]

[1] "The old and decrepit poor in particular," writes the clerk of one Union, "derive much comfort from the care and attention of the District Medical Officer."

[2] A conference of women Guardians in 1902 brought this matter to the notice of the Local Government Board in the following terms:—

"As regards fees, a very careful inquiry was made in 1902, throughout the

Moreover, the very payment of a special fee is said to increase the number of midwifery orders. A Local Government Board inspector did not scruple to say in 1900 that "if the district medical officer's salary included midwifery fees, there would be fewer such cases applying to the guardians." On the other hand, the payment of a special fee facilitates the grant of midwifery orders "on loan." There is thus a conflict of policy, between that which would discourage the doctors from letting midwifery orders be applied for, and from using instruments too freely, on the one hand; and, on the other, the desire to use the device of giving the orders on loan. As long ago as 1852 the Poor Law Board usually

Metropolitan, and in some country unions, as to the different systems by which district medical officers are remunerated for attendance on confinement cases. As a result of this inquiry, it appears first that great diversity of opinion exists as to the construction to be put upon Arts. 182, 183, of the General Order of 24th July 1847 and Art. 10 of the Metropolitan Dispensaries Order of 22nd April 1871. Although in some unions inclusive salaries are paid, a very general impression prevails that boards of guardians are bound to pay, at all events for outdoor cases:—10s. for attendance at a normal confinement; 40s. when instruments are used.

"As a further result of the inquiry it becomes clear that the percentage of instrumental deliveries is invariably low when the medical man is paid by inclusive salary, and the figures in such cases compare favourably with those obtained from voluntary lying-in charities. On the other hand, a very striking contrast is apparent in the case of some of those unions which adopt the plan of paying extra fees for forceps cases. The following are given as instances:—

(*a*) 18 cases; 13 of these instrumental.
(*b*) 8 ,, 6 ,, ,,
(*c*) 40 ,, 19 ,, ,,
(*d*) 14 ,, 5 ,, ,,

(The doctor was absent at time of delivery in the nine other cases)."

The conference suggested that medical men holding appointments under the Poor Law should be paid such inclusive salaries, without extra fees, as should justly remunerate them for their services. The Local Government Board replied that it was "always ready to consider proposals made to them by individual boards of guardians for the suspension of the Articles of the General Consolidated Order of 24th July 1847, providing for the payment of fees to Poor Law medical officers."

recommended the Guardians, as the midwifery fee allowed to Medical Officers is an extra one, to cause it to be understood that relief of the nature in question would be granted by way of loan, and that the repayment of the whole, or such part of the fee as the Guardians might determine, would be rigidly enforced by them. In the majority of Unions the loan practice is adopted; every applicant in some places (as at Nantwich and Northwich) being given a printed notice to this effect along with the order. On the other hand, if a loan is to be made only when the circumstances of the applicant are such as to warrant an expectation that it can be repaid, there is no more reason for making a midwifery order "on loan" than any other medical order. Hence in the very strictly administered Unions of St. George's-in-the-East and Whitechapel, midwifery orders are hardly ever given on loan. In these Unions, and some others, the applicant for a midwifery order has to appear before the relief committee and explain why no other provision has been made for the expected confinement. In many other Unions the midwifery order is given, as a matter of course, to labourers not earning more than 18s. or 20s. a week; or where there are not less than three [1] or four [2] young children at home.

[1] Rules of Beaminster, Chertsey, Lymington, Romsey, Williton, and St. Thomas, Exeter, Boards of Guardians.

[2] Rules of Bridport, Eastbourne, Godstone, Lewes, Lewisham, Merthyr Tydvil, Trowbridge, Warwick, Whitchurch, and many other Boards of Guardians. "Necessarily under the Poor Law the point of view in these cases is solely the financial circumstances of the applicant, not the future health of the prospective mother. Manifestly for her health the most important confinement is not the fifth, but the first. If not properly guided in it, illness may result which will lead to permanent ill-health. But a labourer, it is held, should be able to pay for the doctor for the first confinement, and so it is only when the family has increased to four that

For these reasons the number of midwifery cases attended by each District Medical Officer varies enormously, quite irrespective of the number of births, or the poverty of the district. In the Metropolis, in 1905, the total was 1247; but it must be remembered that in London each of the twelve medical schools necessarily sends out its students to attend, free of charge, at least the minimum number of confinements required before obtaining a qualification to practise. In some Unions (among them Marylebone, St. Pancras, Stepney, and Whitechapel) the Board of Guardians engages midwives to attend to confinements, paying so much a case. In half-a-dozen Unions in the Metropolis (Bethnal Green, Greenwich, Mile End, Southwark, Shoreditch, Stepney) the District Medical Officer's salary includes midwifery cases, which he attends if required, receiving a fee only if an anæsthetic is necessary. In the rural districts application is rarely made for the services of the District Medical Officer in midwifery. The great majority of cases are dealt with (as is also the case in London) by women, whether or not technically qualified as midwives, as private practitioners.

Under the Midwives' Act of 1902, and the rules framed by the Central Midwives' Board, the 12,000

relief is given." (Report to the Poor Law Commission on Poor Law Medical Relief, by Dr. J. C. M'Vail, Appendix, vol. xiv. p. 110.) As long ago as 1844 Lord Shaftesbury (then Lord Ashley, M.P.) moved in the House of Commons :—"That every woman claiming medical assistance from the parish in consequence of being pregnant shall be entitled, in all cases, to the aid of the medical officer with her first child, and also with the second or others which may follow, provided she present a certificate from the medical officer who attended her in her previous confinement, stating that circumstances had occurred in it out of the ordinary and natural course of events, which rendered it desirable that she should have medical attendance on the next occasion of delivery." (*Hansard*, vol. xcvii. p. 633, 16th March 1844.)

practising midwives in England and Wales are legally required to have a qualified medical practitioner sent for in cases of difficulty or danger.[1] No provision was made for the remuneration of the doctor thus imperatively summoned; and, in a large proportion of the cases, the patient is quite unable to pay him. The Local Government Board has suggested that the Guardians should pay under section 2 of the Poor Law Amendment Act, 1848. In some Unions the Boards of Guardians have demurred to making any payment in such cases to a private practitioner, considering that the duty should fall exclusively on the District Medical Officers.[2] In other Unions the Boards of Guardians make the payment provided that the doctor—summoned perhaps in the night—has first obtained a note from the Relieving Officer authorising his attendance,[3] or provided that it is proved that application was first made, and made in vain, to the District Medical Officer; or provided that the case is, after inquiry, considered by the Guardians to be destitute. In many cases difficulty is experienced in speedily obtaining medical assistance.[4]

With regard to the very common restriction of Midwifery Orders, many of the medical witnesses

[1] Report of the Poor Law Commission, 1909, *Qs.* 21665-73, 22981-5, 38380 (pars. 41, 42), 73-38582.

[2] As at Southwark, Camberwell, Wolverhampton, Totnes, Derby, etc.

[3] Report of the Poor Law Commission, 1909, *Q.* 38324, par 12.

[4] "It is becoming a matter of great difficulty," said a District Medical Officer, "for a midwife to get a doctor, as the latter naturally is not anxious to undertake work of an anxious and laborious kind, often through the night, without any prospect of getting a fee." (*Ibid.*, *Q.* 51859, par. 6; see also *Qs.* 41489 (pars. 25, 37, 38), 51871-2.) About 3 per cent of the cases visited by midwives require medical assistance, and midwives at present occasionally pay the doctor's fee out of their own pocket. See Report of Departmental Committee on the Midwives Act, Cd. 4822 and 4823, 1909.

before the Poor Law Commission attributed serious consequences, in the low standard of health of working women, in the excessive infant mortality, and in various defects in the children who survive, to the frequent lack, in poor families, of qualified attendance at childbirth. "In many emergencies," stated a great medical authority, "there is no time to obtain a Medical Order from the Relieving Officer; and by the time medical help is secured the opportunity for successful treatment may have passed."[1] It was, for instance, confidently asserted that a fourth or one-third of those blind from childhood—a large proportion of whom become permanent paupers—are blinded shortly after birth by *ophthalmia neonatorum*, which can usually be prevented by simple medical care.[2] There is evidence that in the rural districts of Scotland women suffer in childbirth through neglect. From 1878-82 inclusive the percentage of deaths of women at childbirth was 0·17 of the population in the islands, while it was only 0·12 in the most

[1] Evidence of Dr. E. J. Maclean, Senior Gynæcologist at the Cardiff Infirmary, before the Poor Law Commission, 1909, *Q.* 49493, par. 7. This was confirmed by the Poor Law Medical Officers themselves. Their Council "think that much suffering is likely to accrue to poor lying in women, owing to friction arising between District Medical Officers and Poor Law officials, owing to the refusal of midwifery orders by the latter, where cases of urgency have been attended by the former without first getting these orders. It is believed that the tendency will be more and more for the District Medical Officer to decline altogether—as he is legally entitled to—all pauper cases where a midwifery order is not forthcoming." (*Ibid.*, *Q.* 33391.)

[2] *Ibid.*, *Qs.* 28169, 49516. Dr. N. B. Harman, the Ophthalmic Inspector to the Education Committee of the London County Council, informs us "that we may safely consider one-third of those blind from childhood"—a positively increasing percentage of the population—"to have been blinded shortly after birth from *ophthalmia neonatorum*. One child in every 100 births suffers from the disease, and one child in every 2000 births was blinded or partly blinded thereby, very largely owing to the lack of immediate treatment of a simple kind. . . . Most cases are developed by the third day, and the safety of the sight depends on early treatment."

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unhealthy group of the towns.[1] This is probably owing to the paucity of medical practitioners or even skilled midwives.[2]

(c) *Children*

The extent to which the Poor Law doctor[3] is made use of for children appears to vary in different districts;[4] probably not only according to the proportion

[1] Roger M'Neill, County Medical Officer, Argyleshire, *Edinburgh Medical Journal*, July 1887.

[2] We must draw attention to a diversity of treatment of these cases in Scotland, which results in no little preventible suffering and mortality, if it does not also have consequences gravely affecting domestic morality. Under the Scotch Poor Law, as it has been interpreted by the Law Courts, an expectant mother who is the wife of an able-bodied man may not, however dire her necessity, lawfully be granted by the Destitution Authority, whether in the Poorhouse or in her own home, either medical or midwifery attendance, or food or other necessaries, *so long as she is living with her husband.* In fact, the grant of any relief whatever to such a woman, even to save her or her infant from immediate death, and even with the sanction or consent of the Parish Council or the Local Government Board, would be an illegal payment, liable to be surcharged at audit. On the other hand, the expectant mother, who is unmarried, or whose husband has deserted her, may, if destitute, not only be granted adequate medical attendance and maintenance, whatever her past or present conduct or character, but can actually claim it as of legal right, whatever the Parish Council may decide in the matter, and can enforce this claim by summary appeal to the Sheriff or to the Local Government Board for Scotland.

[3] All children boarded out within the Union, where there is no Boarding-out Committee, are supposed to be regularly inspected once a quarter by the District Medical Officer, who is paid a fee of half-a-crown for this medical overhauling. There is evidence that this inspection is seldom adequately carried out. (Report on the Condition of the Children, by Miss E. Williams, p. 95; Report on Poor Law Medical Relief, Appendix, vol. xiv., by Dr. J. C. M'Vail, p. 76.) Where there is a Boarding-out Committee this medical inspection can be dispensed with. With regard to the children boarded out beyond the Union, there is no regular medical inspection at all.

[4] In one great Midland Union the District Medical Officer informed us that of 189 cases analysed, only thirty-four were under fourteen, whilst forty-four were between fourteen and sixty, and 111, or nearly two-thirds of the total, besides others for whom the ages were not given, were over sixty. In a populous East End Union, excluding "the permanent list" (who are

of children in the population of the locality and the existence of voluntary hospitals treating children as out-patients,[1] but also according to the policy of the Board of Guardians and the popularity of the District Medical Officer. In some districts, as we are informed, relatively few children are brought to the Poor Law dispensary; and the District Medical Officer is not often called upon to visit them, except in grave cases. The result of the deterrent influence of the "stigma of pauperism" and of the discouragement by the Board of Guardians and the Relieving Officer of applications for medical orders, is that few parents of the poorest class think it necessary to have the parish doctor for children's ailments. When a child is brought to the District Medical Officer, it is commonly for diarrhœa or some definite zymotic disease. The ill-educated mother apparently seldom recognises that a child is ill without some easily noticeable symptoms of this kind. Measles and whooping-cough remain untreated, with grave results,

mostly aged), 38 per cent of the remainder were children. We have made a statistical analysis of 963 medical orders of an East End Union, covering about two months *and again excluding the "permanent list."* Of these 11 per cent were two or under, 6 per cent were between two and six, and 14 per cent were between six and sixteen, making altogether 31 per cent under sixteen. There were 32 per cent between sixteen and forty-five (20 per cent women); and 28 per cent between forty-five and sixty-five (14 per cent women), making altogether 60 per cent between sixteen and sixty-five. There were only 8 per cent of sixty-five and upwards; but it must be remembered that the "permanent list" is not included. The existence of this "permanent list," in unknown and varying numbers, and of varying constituents, vitiates all Poor Law medical statistics.

[1] "There is one feature about the Medical Relief in this Union which differentiates it from any other Union I have visited; that is the large proportion of children on whose behalf application is made for Medical Relief. In some of the districts quite half of the patients treated are children, while in other Unions the proportion is very seldom so much as one in three. . . . I understand that the out-patients' department at St. Bartholomew's and the Children's Hospital are unpopular with mothers because they have to wait so long." (Reports on Outdoor Medical Relief in the Metropolis, 1904.)

alike in the spread of these diseases and in the occurrence of sequelæ of the most serious kind.[1] In the same way, defects of the eyes, the ears, the throat, and the nose, imperfections of the teeth, incipient spinal curvature and malformations of all kinds, which could be successfully dealt with in infancy or childhood, remain entirely untreated, and often unnoticed, until a cure has become impossible. It is plain that it is to this lack of medical care in childhood that much of the ill-health and defectiveness of adults is to be directly attributed.

(*d*) *Wage-earning Adults*

The wage-earning adult usually does not apply for a medical order for his own illness until some disease actually incapacitates him from pursuing his accustomed avocation. Thus, he or she may suffer for years from cough without medical treatment; and may come to the District Medical Officer only at such an advanced stage of consumption that hygienic advice has become of little use; and no treatment is of any avail. The Poor Law does not encourage the wage-earner smitten with incipient tuberculosis either to recognise the danger to which he is subject, or to face the Relieving Officer with a request for a medical order, until he or she is very ill. In most Unions, indeed, the Relieving Officer and the Board of Guardians would refuse to give the order to an applicant who was not actually so ill as to be unable to continue at work. The result is that whilst the District Medical Officer is besieged by consumptive patients in an advanced stage, for whom he can

[1] See *post*, p. 168.

practically do nothing, those patients in the incipient stage whom he could save by hygienic advice as to their methods of life, and open-air treatment, are (except in the unique case of Bradford)[1] neither instructed nor encouraged to come to him in time.

D.—General Results

It is part of the curious lack of medical statistics or medical reports relating to the work of the District Medical Officers that practically no statistical information is available as to the kinds of diseases, the methods of treatment, the number and frequency of attendances, the drugs or appliances supplied, or the results effected by the Poor Law outdoor medical service. Nor do the District Medical Officers receive any official encouragement or even recognition of good and efficient service. They have no medical superior to whom they can report; they are not even in official communication with the Medical Officers of Health of their districts, or with the County Medical Officer.[2] As some of them complained, they

[1] See *post*, p. 113.

[2] An old Order of the Local Government Board required District Medical Officers to send weekly returns of new cases of sickness among paupers to the Medical Officer of Health. This, we are told, has fallen into complete desuetude. In London and the large towns, there seems to be no official contact and no regular communication between the District Medical Officer and the Medical Officer of Health. The District Medical Officer, who necessarily acquires an early and intimate knowledge of the diseases prevalent in his district, does not, with rare exceptions, place his knowledge at the disposal of the Medical Officer of Health. It seems a further anomaly that the local registrar of births and deaths is in official contact neither with the Medical Officer of Health nor the District Medical Officer. The first information that the Medical Officer of Health receives of the outbreak of a particular disease in his district may (if the disease is not one of those compulsorily notified) come to him only after the sufferers are dead, and then only by way of the weekly returns which the local registrar may be required

are never asked, either by the Boards of Guardians or by the Local Government Board, for particulars of their success or failure in treating cases, or for details of any improvement in treatment that they may have introduced.[1] Moreover, by what seems to have been an official oversight that we do not understand, these 3713 District Medical Officers are left to do their work without either supervision or inspection by the Local Government Board.[2] From 1834 down to the present day there has been no official inspection of this Poor Law Medical Service, which costs in salaries, dispensaries, and drugs alone, nearly £500,000 sterling annually.

"Good administration" of medical relief is apparently always taken to mean, not curing the sick or preventing ill-health, but cutting down the number

to make, for a payment of 2d. each. This is not any reflection on the local officials, whether registrar or District Medical Officer. Neither of them forms any part of, or has any place in, the public health organisation. In the rural districts there is no more formal connection between the work of the District Medical Officer and that of the Medical Officer of Health than in the towns, but it often happens that one of the District Medical Officers is also Medical Officer of Health for the whole rural sanitary district, and thus combines, but only over a part of his area, both sources of information, and both public health and Poor Law powers.

[1] "The local board of guardians do not ask the advice of the district medical officers. . . . The medical officer of the workhouse is constantly asked to state what he would consider beneficial for the inmates, but during the fifteen years I have been a district medical officer I have never been asked once for my opinion." (Report of the Poor Law Commission, 1909, *Q.* 50281, par. 10.) "Want of sympathy with and appreciation of the work of a medical officer is to the best sort of men more disheartening than want of proper payment. . . . Several officers told me, some of their own accord, how glad they would be to have supervision of the right sort, and to know that any suggestion they might wish to make would receive consideration by a body which itself had skilled advice for its guidance." (Report on Poor Law Medical Relief, by Dr. J. C. M'Vail, p. 122.)

[2] Report of the Poor Law Commission, 1909, *Qs.* 34566 (par. 6 (b)), 34648, and Appendix No. xci. (par. 6) to vol. vii. It was stated that, with the exception of two unprinted reports on the London dispensaries, there were no systematic reports in existence on the working of Outdoor Medical Relief. (*Ibid.*, *Q.* 22923.)

of medical orders. With this object, as we have seen, many Boards of Guardians try to deter the poor from applying for relief. The effects of this policy are most serious. Thus the Medical Superintendent of the Mill Road Infirmary of the West Derby Union (Dr. Nathan Raw) stated, "people will struggle on with a disease and spend all their money, and then apply to the Poor Law, in some cases almost when the people are dying . . . in many cases they are deterred from seeking it until it is too late."[1] "The neglect of the poor to apply for Medical Relief," said another witness, "is partly due to the idea that Poor Law relief is a degradation. It has been so officially styled by the Poor Law Board, and I believe it is so considered by many of those engaged in the administration of the Poor Law."[2] "You will find," it was said, "that in most cases where" the delay in getting prompt medical assistance "is the fault of the people, it is because sending for the doctor means making themselves paupers."[3] The representatives of the British Medical Association were emphatic in their testimony that the association of the public medical aid with the Poor Law was in itself deterrent; it was, they said, "the experience of every practitioner . . .

[1] Report of the Poor Law Commission, 1909, *Q.* 37946; see confirmatory evidence by Dr. Niven, Medical Officer of Health, Manchester, *Qs.* 38380-626. "The people have to be driven to us, as a rule," deposed a District Medical Officer. (*Ibid.*, *Q.* 44200.)

[2] *Ibid.*, *Q.* 25373, par. 157.

[3] *Ibid.*, *Q.* 41629 (Evidence of Dr. J. S. Cameron, Medical Officer of Health, Leeds). "There is very considerable unwillingness on the part of the working classes to apply for an order for medical treatment," testified another Medical Officer of Health, "on the ground that they lose caste, lose their vote, and become paupers. It is not generally known that by having medical relief the franchise is not lost. It is probable that the Relieving Officers, in their endeavour to diminish Outdoor Relief, do not concern themselves to make known the fact that the Legislature has drawn this distinction between medical and other forms of relief." (*Ibid.* Appendix xliv. (Part I. (b)) to vol. ix.)

that people avoid calling in the parish doctor because he *is* the parish doctor."[1] The reluctance to come forward and state their need is increased by the fact that it is not to a medical man or a nurse that the sick persons have to make their applications for public medical assistance, but to the Relieving Officer,[2] who, as we have seen, almost inevitably comes to think of himself as bound to do all that he can to keep people "off the rates."[3] To the Relieving Officer, under the instructions of the Local Government Board and the bylaws of the Boards of Guardians, this medical treatment of the sick by the District Medical Officer, even without other aid, is not to be denied to those who are both in need of it and actually destitute, but is nevertheless to be restricted to as few cases as possible. The Hon. Sydney Holland, who has been a Poor Law Guardian in two different Unions, and whose experience of hospital administration is very great, informed the Poor Law Commission that when he was a Guardian he himself entirely acquiesced in this policy, and "thought it was a very good thing. I thought that everybody who came before us was a swindler and must be most carefully inquired into, and asked whether he had not drunk too much, and all the rest of it. That is the ideal Guardian, a man who prevents imposition. . . . All Poor Relief," he con-

[1] Report of the Poor Law Commission, 1909, *Qs.* 39389-91.

[2] "It stops the more decent ones, the really more deserving cases," deposed one District Medical officer. (*Ibid.*, *Q.* 51863.) "I think," said a Medical Officer of Health, the reason why they do not call in the Poor Law doctor . . . is because they have to go to the relieving officer to get an order first." (*Ibid.*, *Q.* 41982.)

[3] "Probably as long as medical relief is only granted on an order obtained from the same officer who with grudging hand gives an order for ordinary relief, the respectable poor will be as unwilling to apply for the former as for the latter." (*Ibid.* Appendix No. xliv. (Part III.) to vol. ix.)

tinues, "is given reluctantly. Every Guardian is told to give it reluctantly; every Poor Law Officer gives it reluctantly, and, in fact . . . the only person you relieve in the Poor Law is the person who is starving. . . . It is exactly the same with regard to medical relief. You are not to treat medically unless they are paupers." The result is, as he remarked, "that the poor people were dissatisfied with the medical relief they got from the Poor Law; that it is given grudgingly . . . the man going to the Relieving Officer being put in the dock, questioned up hill and down dale, and treated as a thief."[1]

The advocates of this policy of restricting the use of the District Medical Officers assert that it results in no hardship to the poor, or injury to the community. On this point much evidence was taken by the Poor Law Commission. Unfortunately, the authoritative testimony thus obtained does not support the optimistic assumptions of the advocates of restriction of public medical aid. Whilst some of the witnesses seemed to take for granted the present system as inevitable, and not to have noticed any of its drawbacks, the great majority of the medical practitioners who gave evidence were definitely of opinion that a "deterrent" administration of Poor Law Medical Relief was "a real danger to the public,"[2] and that it was responsible for much of the excessive mortality among infants and unnecessary ill-health and premature invalidity among the wage-earners. Many of them went further, and deposed that, in their opinion, the stigma of pauperism that was attached to the mere use of the services of the

[1] Report of the Poor Law Commission, 1909, *Qs.* 32776-86.

[2] *Ibid.*, *Q.* 25373, par. 157.

District Medical Officer, by the very fact of his connection with the Poor Law, and the inconvenience and delay caused by having first to make application to the Relieving Officer,[1] were, in themselves, even without stringent administration, inimical to the health of the district. This has been demonstrated by many instances. It was asserted that the present high mortality from the diseases of young children, and also many serious complications among those who survive, are undoubtedly due to the common lack of medical attendance in the families of the poor, for what are regarded as the simple affections of measles and whooping-cough, and mild and often unrecognised cases of chicken-pox and scarlet fever.[2] "There is a widespread disinclination," testified a Medical Officer of Health for a Metropolitan Borough, "to utilise the services of the Poor Law doctors. In consequence of this failure to seek skilled advice, many cases of infectious disease go unrecognised, and to this we must attribute the comparative ineffective-

[1] Thus, as one medical witness put it, "a pauper, therefore, being taken suddenly ill at twelve o'clock, cannot see the Relieving Officer before next morning, the necessary inquiries into his case will not be made until, perhaps, the afternoon of that day, and the doctor may not see the patient until the day after that." (Report of the Poor Law Commission, 1909, *Q.* 38631, par. 12.) "The present system of medical assistance to the poor," it was said, "is unsatisfactory, as cases of serious delay from time to time occur in obtaining orders for medical attendance in urgent cases. . . . The method by which medical assistance can be obtained in the absence of the Relieving Officer, who may be gone, for instance, in charge of a pauper lunatic to the asylum, causes dangerous delay." (*Ibid.* Appendix No. iv. (par. 1 (b)) to vol. vii.) The difficulties and delay caused by this procedure in rural districts were forcibly put by many District Medical Officers. (See *ibid.*, *Qs.* 34566 (par. 6), 34631-4, 70631 (par. 3), 70648-51, and Appendix No. lxxv. (par. 8) to vol. vii.; and emphasised by the British Medical Association (*ibid.*, *Q.* 39013, par. 31.) See also *ibid.*, *Qs.* 38795, 41556, 50775-8, 51466 (par. 32), and Appendices Nos. lxviii. (par. 4) to vol. v. and xlvi. (par. 33) to vol. ix.

[2] Even in the country "the health of the children suffers somewhat," admitted a rural District Medical Officer, owing to the restriction of relief. (*Ibid.* Appendix No. lxxxvi. (par. 7) to vol. vii.)

ness of our modern methods of dealing with scarlet fever and diphtheria." [1] Nor does the Board of Guardians, aiming at restricting medical relief, make things easier for those responsible for the health of the district. "Both friendly suggestions," publicly states a Medical Officer of Health, "and simple reports appear to cause irritation and resentment on the part of Relieving Officers and all officials connected with the Poor Law administration." [2] A case

[1] Report of the Poor Law Commission, 1909, Appendix No. xlv. (par. 2) to vol. ix. "I have found children suffering from severe chest complications following measles," said another Medical Officer of Health, "for whom no help had been sought, owing to poverty and unwillingness to send for the Poor Law Medical Officers." (*Ibid.* Appendix No. xcviii. (par. 1) to vol. v.; see also *ibid.* Appendix No. xlvii. (par. 20) to vol. ix.) Even in a populous urban district adjoining the Metropolis, out of 8494 cases discovered, only 43 per cent had any medical attendance at all.

TABLE SHOWING THE NUMBER OF CASES INVESTIGATED OF THE RESPECTIVE DISEASES NAMED, THE NUMBER OF THESE CASES ATTENDED BY A MEDICAL PRACTITIONER, AND THE TOTAL NUMBER OF DEATHS OF CHILDREN UNDER FIFTEEN YEARS OF AGE DYING FROM THESE DISEASES DURING THE THREE YEARS ENDING 1906.

Diseases.	No. of Cases.	Cases attended by Medical Practitioner.	Deaths under 15 Years of Age.	Percentage of Cases attended by Medical Practitioner.
Measles	2734	1417	118	51·7 per cent
Whooping-cough	1629	851	102	51·5 ,,
Chicken-pox	732	359	...	49·0 ,,
Mumps	848	242	...	28·5 ,,
Tuberculosis	32	28	155	87·5 ,,
Influenza	51	23	6	45·0 ,,
Ringworm	959	364	...	37·9 ,,
Ophthalmia	140	38	...	27·1 ,,
Other diseases	1369	377	...	27·5 ,,
	8494	3689	381	43·4 ,,

(*Ibid.* Appendix No. xliii. (par. 9) to vol. ix.)

[2] Report on the Sanitary Condition of the Handsworth District, 1908, by R. A. Lyster, Medical Officer of Health, p. 9.

was brought to the notice of the Poor Law Commission in which, when an officer of the Public Health Department was seeking to get sick children treated by the District Medical Officer, this action was made the subject of serious reproof by the Destitution Authority.[1]

"As a typical illustration of the great waste of money entailed by the present methods of Poor Law administration," officially reports a Medical Officer of Health, "I may mention a case that occurred in this district. Two cases of scarlet fever occurred in a family of six children. The mother was a widow with no income. There was sufficient room in the house for the proper isolation of the cases, and they could have been nursed at home, if a little help could have been obtained. Every possible effort was made to get assistance from the Poor Law authorities, but without success, and the cases were removed to the Isolation Hospital. Nine days later, two more children had to be removed, and ten days later still another two. The total cost to the district for the treatment of these cases was £55, whereas a total allowance of £5, or even of food only, would certainly

[1] At Hampstead, in 1904, when measles were very prevalent, the officers of the Public Health Authority, finding many cases in poor families without medical attendance, urged the calling in of the District Medical Officer. The Hampstead Board of Guardians thereupon addressed the following rebuke direct to a subordinate officer of the Hampstead Borough Council (a health visitor acting under the instructions of the Medical Officer of Health) :—

"DEAR MADAM—The Guardians desire me to inform you that the assistant relieving officer at Kilburn has reported that you have recommended people to apply for the aid of the Poor Law in Kilburn, where it subsequently appeared that the family were not by any means destitute. The Guardians desire me to point out to you the importance of using discretion before calling upon the Poor Law for assistance in respect of medical relief, as it often happens that this method of receiving Poor Law relief by poor people leads in the end to the loss of their independence.—Yours faithfully, H. WESTBURY PRESTON, *Clerk*." (Report of the Poor Law Commission, 1909, Appendix No. xlv. (par. 20) to vol. ix.)

have prevented this unnecessary expense. This is a single instance. The sacrifice of life, health, and money resulting from the untreated cases of disease is beyond estimation." [1] "Among the poor," says the same authority, "there is a vast amount of infectious illness continually present. Many of such cases remain unreported, untreated, practically unknown. They serve, however, as a continual and ever-present focus for the spread of such diseases among the general public. There is thus constituted a most grave public danger. The only possible way to remove such danger is to devise improved and more easily available means for treating these cases. Treatment and prevention are inseparably associated in practically all disease. The one is essentially the complement of the other. By adequately providing for the early recognition and the proper treatment of all disease, an almost incredible improvement in the public health would rapidly result. The mere existence of disease, altogether apart from any consideration as to whether it is accompanied by destitution or not, should be sufficient to ensure proper medical treatment, if the public are to be relieved of the ever-present dread of the sudden and rapid spread of infection." [2]

Nor is the danger confined to the notifiable zymotic diseases. It was given in evidence on high authority that the very great mortality from phthisis—a disease to which no less than one-seventh of the total cost of the Poor Law is said to be directly or indirectly due [3] —is to be attributed in no small degree to the fact

[1] Report on the Sanitary Condition of the (Handsworth) District, 1903, by Robert A. Lyster, Medical Officer of Health, p. 11.

[2] *Ibid.*

[3] Report of the Poor Law Commission, 1909, *Q.* 38213.

that sufferers are not encouraged to present themselves for treatment in the early stages of the disease,[1] when it is often curable, but when they are still capable of going to work, and are not regarded as destitute and thus not technically eligible for a Medical Order. Under the present arrangements of the Poor Law medical service, such cases are left outside its ken, until in due course the ravages of the diseases have reached a stage at which the sufferer, having in the meantime perhaps infected other members of the family, becomes simultaneously eligible for Poor Law medical relief and incapable of deriving from it any real advantage. In fact, the Poor Law doctor seldom knows phthisis in any but its incurable stage, shortly before the sufferer enters the workhouse to die. In some places, it is said, one-third, and even one-half, of the deaths from phthisis take place in the Poor Law institutions.[2] Much the same may be said of

[1] "At the Out-relief Committees," reports a Local Government Board Inspector, "one hears of men and women who have struggled with this disease (phthisis) as long as possible before applying for relief, often sleeping in small rooms with children. . . . Out-relief is generally given till finally the sufferer enters the workhouse infirmary to die, in the meantime, possibly, having infected other members of his family." (Report of the Poor Law Commission, 1909, Appendix No. xi. (A), par. 133, to vol. i.) "Those people," said one District Medical Officer, "are very often too far gone for one to do any good to them." (*Ibid.*, *Q.* 51899.) "They do not come under the Poor Law Medical Officers," deposed the Medical Inspector of the Local Government Board, "until . . . the patient is probably . . . incurable as far as being returned to work fit as an able-bodied man." (*Ibid.*, *Qs.* 10216-18.) "We have had very rarely what are called curable cases, or cases in the first stages of phthisis pulmonalis, under treatment by Poor Law medical officers or in Poor Law medical institutions." (*Ibid.*, *Q.* 10482.) "The whole of my experience up to now is that it is very unusual indeed for what is called a curable case to come to the Poor Law." (*Ibid.*, *Q.* 10687.) In this connection it is interesting to note that at the International Congress on Tuberculosis, held in Paris in October 1905, it was resolved "that poor relief should assume a more preventive character, and take a more active part in promoting good sanitation."

[2] "More than half the deaths from this disease in Finsbury occur in institutions, and with few exceptions in Poor Law institutions." (Report of the Poor Law Commission, 1909, *Q.* 94287, par. 7.)

cancer, which fills so many workhouse beds, but which the Poor Law doctor hardly ever sees at a stage at which he can operate with any advantage. "Every year," it was authoritatively stated, "many persons die of cancer whose lives could have been saved had they sought medical advice in time. Especially is this true of the poor."[1] "The Poor Law medical officers," says the Medical Investigator appointed by the Poor Law Commission, "see any amount of inoperable cancers, and incurable Bright's disease, and overlooked rheumatic fever in children, causing heart disease later on."[2] Less dramatic, but even more frequent, are the cases of chronic disability brought about by rheumatism and gout, heart disease in its various forms, varicose veins and ulcerated legs, and other affections which account for so many of the premature invalids among the workhouse inmates, and which could have been cured if they had received proper medical treatment at any early stage, before neglect of the incipient disease had led to actual cessation of wage-earning and consequent destitution.[3]

[1] Report of the Poor Law Commission, 1909, Appendix No. xlv. (par. 9) to vol. ix.

[2] Report on Poor Law Medical Relief, Appendix, vol. xiv., by Dr. J. C. M'Vail, p. 108.

[3] A grave problem which, in our judgment, cannot be any longer ignored is that presented by the widespread suffering of the poor from venereal diseases. "These," testified a medical expert, "constitute one of the greatest evils of the age. I am not sure that they do not give rise directly and indirectly to more suffering and more injury to us as a nation than even tuberculosis." (Report of the Poor Law Commission, 1909, *Q.* 52840, par. 15; see also the evidence of Dr. Allan, the Medical Superintendent of the Leeds Poor Law Infirmary, *ibid.*, *Qs.* 41231-346.) Here the lack of medical attendance has very grave results. The Boards of Guardians habitually refuse a Medical Order in such a case, if they become aware of it. Thus one Union puts in its bylaws: "Persons affected with venereal disease to be granted indoor relief only." (Rules of Docking Board of Guardians.) "Provident associations, friendly and trade societies rigorously exclude persons suffering from these (venereal) diseases from their medical benefits.

"I have carefully examined over 4000 cases of consumption," deposed the Medical Superintendent of a Poor Law infirmary, "and of these people approximately 60 per cent would never have come within the range of the Poor Law had they not had that disease."[1] In short, as one witness significantly put it, "Guardians who deter the poor from coming for medical relief are themselves causing pauperism, for, as Mr. Joseph Chamberlain has said, 'preventable disease is the great agent for filling our workhouses.'"[2]

But even where the Guardians do not pursue this restrictive policy, there are serious defects in the Poor Law medical service. We have already mentioned the inadequate salaries paid to the Medical Officers. These "small salaries," we were told, "lead to a perfunctory mode of dealing with cases." "Poor Law medical officers," said an experienced doctor not in the Poor Law service, "do far more than they are paid to do, but it is absurd to expect a medical man to give proper medical attendance to the poor of a population of perhaps over 20,000 persons for £100 a year or less." "The Poor Law Medical Officer," we are told, "is so inadequately

Most general hospitals refuse to admit them." (Report of the Poor Law Commission, 1909, *Q.* 52840, par. 16; see also *ibid.*, *Qs.* 37927 (par. 10), 37928-30.) A very large number of cases thus remain untreated in the early stages of the disease, with terrible effects in the contamination of innocent persons, and of a new generation. Presently, when the ravages of disease have gone so far as to make life outside an institution quite impossible, the sufferers enter the workhouse—too late to be really cured—to be, at great cost, relieved, patched up, and discharged; returning often again and again until eventually they die in the workhouse. In some Unions, however, the Guardians are often "very severe" on applicants suffering from venereal disease, and do all they can to make them go elsewhere. (*Ibid.*, *Q.* 21504.) Such patients are sometimes forcibly ejected from workhouses. (*Ibid.*, *Q.* 19462a.)

[1] *Ibid.*, *Q.* 38219.

[2] *Ibid.*, *Q.* 25373, par. 63.

paid that he cannot afford time to go into the cause of all the diseases he meets with. He treats them with the 'bottle of physic,' whilst the thing that has caused it remains undiscovered and unremedied."

Under these circumstances, we are not surprised to find existing a certain dissatisfaction with the outdoor medical service of the Poor Law. The Medical Inspector of the Local Government Board, who "has no duties in connection with the supervision or administration of Outdoor Medical Relief," [1] informed the Poor Law Commission that, "unofficially," he was "constantly hearing complaints" that patients on outdoor medical relief were not well and sufficiently attended.[2] The District Medical Officers, said one witness, "do the work according to the pay." He did not think the paupers were treated as well as the paying patients. "The doctor," he said, "takes these positions in order to further his private practice, and I am afraid the poor very often have to suffer for that reason; he takes it too cheap." [3] "The present plan of medically assisting the poor under the Poor Law," said a medical practitioner, himself a Guardian, "is not an efficient system. The average Poor Law Medical Officer (outdoor) does not give the satisfaction he ought to his patients." [4] "The working classes," stated another medical practitioner, "have the idea that the attention they get from the Poor Law doctor is not satisfactory." [5] "They feel," said another witness, that "the District Medical Officers have not the time to attend to them." [6] "I am inclined to

[1] Report of the Poor Law Commission, 1909, Appendix No. xxi. (A), par. 29, to vol i.

[2] *Ibid.*, *Q.* 10572.

[3] *Ibid.*, *Qs.* 71430-4.

[4] *Ibid.*, *Q.* 42509, par. 2.

[5] *Ibid.*, *Q.* 43150.

[6] *Ibid.*, *Q.* 44672.

think," deposed a Shropshire Guardian, "that they do not get much of his services. He goes round to them in a casual way, but there are very great complaints that the patients of the Poor Law . . . do not get very much attention from the doctors. . . . I merely speak from my knowledge of the cottagers themselves, and where there is illness, I find if there are more important cases in the neighbourhood the poor are neglected."[1] "The poor people are very dissatisfied, I find," said the Hon. Sydney Holland, "with the medical relief that they get from the Poor Law authorities; it is given in a grudging spirit, and they do not believe in it."[2] One of the District Medical Officers himself admitted "that the tradition of the service is that every pauper is to be looked on as being such through his or her own fault, and the tendency is to treat the case accordingly. . . . In the town . . . I believe that the tradition, as to a pauper, is that he is a shade only above a criminal. . . . Now to this tradition the medical officer tends, like all other officers, to become a victim, and the tendency is that the case of sickness is treated as a 'pauper' and not as a 'patient.'"[3]

These complaints appear to us to do less than justice to the District Medical Officers themselves. So far as we have been able to see anything of their

[1] Report of the Poor Law Commission, 1909, *Qs.* 71725, 71774.

[2] *Ibid.*, *Q.* 32536.

[3] *Ibid.*, *Q.* 51859, par. 7. "I certainly think," says a country medical practitioner, "the health of the community suffers owing to the insufficiency of the medical attendance." (*Ibid.* Appendix No. xxviii. (par. 7) to vol. vii.) "The poor," said another medical practitioner, who is himself a Poor Law Guardian, "are choked off by the Relieving Officer, and by the Guardians in many cases; and I am afraid the manner of some of the medical officers chokes them off as well." (*Ibid.*, *Q.* 42519.) On the other hand, taking the practice as a whole, there is a good deal of testimony that the Poor Law patient is as well treated as the ordinary club member.

work, we have been struck by their personal kindness to the poor, and by their desire to relieve suffering. It must be remembered that the majority of the cases that they have to attend are of the most disheartening kind—largely old people, with chronic complaints, or persons of far more than the average degree of ignorance, carelessness, poverty, and intemperance; with the drawbacks of bad housing, insufficient and unsuitable food, the poorest kind of clothing, inadequate attendance,[1] and an almost total lack of skilled nursing. They have no power to secure a better environment for the patient whom they are supposed to cure. In the majority of cases they have to accept the situation as they find it, and to obey the Medical Order which the Relieving Officer has granted. The Medical Officer visits the home and does the best he can in the way of diagnosis—with the patient perhaps covered with filth, lying on a bundle of rags in a dark and dirty room. "You cannot," we were told, "under these conditions, so thoroughly give your mind to the case, nor be so careful in overhauling the patient."[2] In too many

[1] Here is a case which one of the Committees of the Poor Law Commission happened to visit. Their report says: "This is the case of a man dying of cancer in the throat. We found the door locked, and but for a kindly neighbour who opened a window and found the key, we could not have got in, the man being quite alone, hardly able to speak, and horribly ill. The house very poor. A daughter earns 9s., the only regular income, and the rent is 4s. 2d. The old wife had gone to a neighbour where she would earn 4d. by minding the house. The Relieving Officer did seem to see the horror of this man lying there locked in, and suggested sending the ambulance. Relief, 5s. and a loaf." (Reports of Visits by Poor Law Commissioners to Unions in England and Wales, No. 22 G, p. 56.)

[2] The diagnosis filled in by the District Medical Officer on the admission forms of patients sent in to the infirmary by him does not, we are informed, reveal any very thorough examination. Such descriptions as debility, senility, and catarrh are found to cover many specific diseases. "It is notorious that the diagnosis of disease is much less accurate in 'outdoor' than in 'indoor' medical work owing to the unfavourable conditions

cases all his efforts are rendered nugatory by the horrible condition of filth and vermin in which he finds the patients.[1] In face of all the difficulties of their task, it is, we think, wonderful that the Medical Officers achieve any results at all. When we consider the method and amount of their remuneration, and the conditions of their duties, we are impressed with the zeal and devotion displayed, with the humanity shown to the poor, and with the large amount of unpaid, unrecognised, and unrecorded work performed by them as a class.

But taking into account all the evidence, there emerge two main criticisms on the outdoor medical service as a system involving a large expenditure of public money. In too many Unions, it is clear, outdoor medical relief begins and ends with a bottle of medicine. But in the twentieth century, we have ceased to believe in the bottle of medicine. What the patient himself desires and begs for is a bottle of physic.[2] The District Medical Officer has, amongst others, to deal with "a class of persons practically well who are never satisfied unless they are supplied

associated with medical work in the homes of the extremely poor." (*An Examination of the Amount of Indoor Pauperism in Three Metropolitan Boroughs*, by J. Basil Cook, 1908, p. 2.)

[1] Here, again, we must record our conviction that the services of a skilled medical practitioner are too often quite wasted. What is wanted primarily is a nurse, who should at any rate go before the District Medical Officer into the miserable homes, wash the patient, where practicable change the linen, and by organising the removal of some of the dirt, opening the windows, and generally cleaning up the place, render it possible for him to make a useful diagnosis.

[2] "They want something to show for the doctor's visit, and that something is probably a large bottle of medicine, of which they are to take two tablespoonfuls every four hours. Unless they got this, many of them would not believe that they were really receiving medical treatment." (Report on Poor Law Medical Relief, Appendix, vol. xiv., by Dr. J. C. M'Vail, p. 123.)

with medicine of some sort," or, as another official describes them, "permanent medicine swallowers of rather a hypochondriacal nature, whose ills might equally well be cured by bread pills or coloured water with a nasty taste."[1] "It is those cases," says another, "which provide the tales of burnt sugar and peppermint water, and which lead to careless treatment generally. Could one eliminate them, I am certain the standard of cure of the entire Poor Law cases would be raised, though I firmly believe that it is usually good." In too many Unions, it is clear, as one officer reported to us, "outdoor medical relief with us, to a very great extent, begins and ends with an easy supply of medicines." It is a general characteristic of the Poor Law patient that he consumes his medicines with great rapidity. But this habit of disposing of the case by satisfying the craving for medicine has a darker side. "My experience as temporary medical officer in four London Poor Law infirmaries," writes one able doctor, "has convinced me that the bottle of physic . . . is a very curse. It is responsible for what is known as the mortality of delay." It is not regarded as any part of the duty of the Poor Law Medical Officer to insist on, or even to inculcate, the personal habits necessary for recovery. "Under the Poor Law there is practically no sanitary supervision of phthisis in the home of the patient. . . . Phthisis cases are maintained in crowded unventilated houses. . . . Diabetes cases live on the rates and eat what they please. Infirm men and women supported by the Poor Law are allowed to dwell in conditions of the utmost personal and domestic uncleanliness. . . . It

[1] Reports on Outdoor Medical Relief in the Metropolis, 1904.

is not worth while entering on any reform of the Poor Law unless this policy is changed. Beneficiaries must be compelled to obedience, alike in their own and in the public interest. And the officers who are placed in direct charge of the beneficiaries must themselves be subject to supervision and discipline."[1] The second criticism is that, from first to last, there is, in the Poor Law medical service, no thought of anything but "relief." It is not regarded as any part of the duty of the District Medical Officer to take any steps to prevent disease, either in the way of recurrence in the same patient, or in its spread to other persons.[2] His work is entirely unconnected, on the one hand, with the institutional treatment of the sick in the workhouse or Poor Law infirmary,[3] and on the other with the operations of the Medical Officer of Health. It is not regarded as any matter of reproach to a Board of Guardians or to its staff that numerous mild cases of scarlet fever or chicken-pox and even 30 or 40 per cent of the cases of measles or whooping-cough, ringworm or mumps should be wholly destitute of medical attendance, to the serious danger of the public health.[4] It is not even the business of the District Medical Officer to reduce the amount of sickness in his district. All that he is charged to do, as it is all that he is paid to do, is to "relieve destitution" in a certain specialised way, namely, to supply "medical relief"

[1] Report on Poor Law Medical Relief, Appendix, vol. xiv., by Dr. J. C. M'Vail, pp. 91 and 149.

[2] "The Guardians are not appointed for disease prevention or health preservation. They are there to protect paupers from dying of starvation." (*Ibid.* p. 93.)

[3] For an exception at Lambeth, see *post*, p. 124.

[4] See *ante*, p. 74.

to those applicants who have braved the deterrent attitude of the Relieving Officer and satisfied him that they would otherwise be without it. From first to last, in short, the outdoor medical service of the Poor Law has no conception of the Public Health point of view.

CHAPTER III

THE INSTITUTIONAL TREATMENT OF THE SICK UNDER THE POOR LAW

(A) *The Workhouse*

The institutional treatment of the sick poor under the Poor Law[1] is, primarily and normally, provided for by the workhouse, with which each of the 646 Unions is provided. In nearly all the rural Unions, which form a majority of the whole, and in all but the largest towns, the workhouse remains the only Poor Law hospital. These institutions were not intended for the reception of the sick, and their buildings (except those erected within the last thirty or forty years) were not planned with this object. In 1834 the destitute sick were, as a rule, left in their own homes, on a pittance of outdoor relief, with the attendance of the parish doctor. The 1834 Report recommended no change in the system of outdoor relief of the sick; and no such change was ever advocated or contemplated by the Poor Law Commissioners of 1835-47, or by the Poor Law

[1] For this very imperfect account of the "indoor medical service" of the English Poor Law we have had to rely principally on the annual reports of the Local Government Board and the evidence given to the Poor Law Commission, especially that of Dr. Downes and Dr. Fuller, and that of Dr. Bygott, Dr. Nathan Raw, Dr. Edwards, Dr. Stonham, Dr. Allen, Mr. Spurrell, etc. See also our *English Poor Law Policy*, 1910.

Board of 1847-71.[1] Each workhouse gradually set aside a sick ward, but this was intended for such of the inmates as became sick. There was no thought of admitting sick persons to the institution. The admission of persons suffering from contagious disease was occasionally even forbidden. Gradually, however, it came to be the practice for the destitute sick who had no one to attend to them, and who had no other institution open to them, to be admitted to the workhouse; and in the course of a generation the workhouses were found to be very largely peopled by the infirm, the disabled, the chronically sick, and even the sufferers from acute diseases. By 1869 it was recognised that what was then officially termed "the hospital branch of Poor Law administration"[2] had reached large dimensions. The policy of the Central Authority thenceforth definitely took the form, so far as the sick were concerned, of pressing for the provision of the most efficient institutional treatment that could be obtained. "There is one thing," said the President of the Poor Law Board in 1865, "that we must peremptorily insist on, namely, the treatment of the sick in the workhouses being conducted on an entirely different system, because the evils complained of have mainly arisen from the workhouse management—which must, to a great extent, be of a deterrent character—having been applied to the sick, *who are not proper objects for such a system.*"[3] "If you have a sick man upon

[1] See our *English Poor Law Policy*, 1910, p. 120. Until 1865 there was no medical inspector or adviser regularly attached to the Poor Law Commission or the Poor Law Board. (Report of the Poor Law Commission, 1909, *Q.* 22913.)

[2] Twenty-second Annual Report of the Poor Law Board, 1869-70, p. x.

[3] Mr. Gathorne Hardy (*Hansard*, vol. clxxxv. p. 163).

your hands," said one of the Local Government Board Inspectors in 1888, "the best thing you can do with him is to give him the best possible attention, to cure him and restore him to his work again."[1] Such an improvement in the institutional treatment of the sick seemed, to the zealous Inspectorate of 1869-86, a useful auxiliary, if not the logical complement, of their crusade against all outdoor relief.[2] Especially since the establishment of the Local Government Board has the pressure of the Central Authority on the Boards of Guardians, to get them to provide better structural accommodation, new infirmaries, elaborate hospital equipment, trained nurses,[3] and additional medical staff, been persistent and unrelenting.

Unfortunately, the great majority of the Boards of Guardians have failed to carry out this policy. It was brought to the notice of the Poor Law Commission by the medical inspectors of the Local Government Board, by accredited representatives of the medical profession, by philanthropists acquainted with the workhouses in the rural Unions and the smaller towns, as well as by Poor Law Guardians and their officers, that two-thirds of the sick now receiving institutional treatment at the hands of the Destitution Authority—amounting, as we have reason

[1] Report of House of Lords Committee on Poor Law Relief, 1888, *Q.* 381.

[2] "It was admitted by the sterner opponents of Out-relief," said a witness before the Poor Law Commission, "that the success of their restrictive regulations rendered necessary proper provision for the remedial treatment of the sick poor elsewhere than in their own homes, where the conditions were 'destitution' of the means necessary for recovery." (Report of the Poor Law Commission, 1909, *Q.* 43626, par. 9.)

[3] Report of the Departmental Committee on the Nursing of the Sick Poor in Workhouses, 1902; "Nursing in Workhouses and the Report of the Departmental Committee," by Dr. Arthur Downes, in Report of Poor Law Conferences, 1903-4, pp. 91-106.

to believe, in England and Wales alone, to something like 60,000 persons—are still in the general mixed workhouses. It was stated that they were, in many cases, receiving treatment inadequate to their needs and inappropriate to their diseases; and that this was resulting, not only in unnecessary personal suffering, but also in a prolongation of the period during which they were maintained at the public expense, and, in too many cases, in their premature permanent disability. On the other hand, so deterrent are the conditions in these general mixed workhouses that many poor persons suffering from incipient disease—sometimes of a contagious character—and requiring institutional treatment, refuse to enter their doors, until they are driven in by actual destitution in a moribund state. It is impossible to avoid the conclusion, in face of this evidence, that the continued retention, in the general mixed workhouses—which were so emphatically condemned by the Report of 1834—of a large number of sick persons requiring curative treatment amounts at the present time to a grave public scandal.

(i.) *The Rural Workhouse*

We may conveniently consider first the small rural workhouse, of which there are about 300 with fewer than fifty sick beds in each. Such a workhouse—containing habitually a score of men and women with chronic rheumatism and asthma, and suffering more or less from senile imbecility and paralysis; half-a-dozen children from one to thirteen subject, from time to time, to the usual diseases of childhood; the "village idiot," and various harmless lunatics and

feeble-minded of both sexes and all ages; every few months a lying-in case; a few phthisical patients; occasionally individuals with all sorts of ailments; and now and then a tramp with smallpox upon him—is, over nearly half the superficial area of England and Wales, the only institution in the nature of a hospital available for the country-side.[1] These 300 small rural workhouses accordingly annually deal, in the aggregate—apart altogether from the "chronics" and the persons suffering merely from senility—with thousands of sick persons who require curative treatment.

In most of these rural workhouses the buildings—which, as we have seen, were never intended for the reception of sick patients—are, to quote the words of a Local Government Board Inspector, "old and ill-adapted to meet modern requirements . . . for the treatment of the sick."[2] Some of them, reports the Medical Investigator appointed by the Poor Law Commission, were not even erected "for workhouses, but for factories or other purposes; and in one or two cases the institution consists of a curious conglomeration of old houses of various sorts, set up anywhere within the boundary walls, and apparently altered or

[1] Over half the superficial area of England and Wales—largely the same half—there is, it seems, also no isolation hospital accommodation provided by the Public Health Authority. Medical practitioners and benevolent neighbours often attempt to send acute (non-infectious) cases, and those requiring more than the simplest surgery, to the voluntary hospital in the county town, but there is, even for these cases, frequently no such hospital available within fifty miles. In the Atcham Union, for instance, celebrated for the relentless persistence with which outdoor relief has been refused, "pauper infectious cases of all sorts have to be treated on the Workhouse premises, in the midst of a community of 400 or 500, many of whom are children." (Report of the Poor Law Commission, 1909, *Q.* 70186, par. 3.) Scarlet fever epidemics and isolated smallpox cases have been so dealt with. (*Ibid.*, *Qs.* 70197-8.)

[2] *Ibid.* Appendix xi. (A), par. 144, to vol. i.; also *Q.* 5360.

added to in irregular fashion as occasion arose. . . . In at least one case the buildings are much too crowded on the site. . . . The floors . . . were of wood, often old wood, with wide seams for dirt to lodge in. More than one-fourth of the wards, whose measurements he obtained, "failed to comply with requirements," as to the minimum cubic space per inmate. In more than one-third of those visited, the hot-water supply—"an absolute essential for the proper management of a workhouse or workhouse infirmary"—was "more or less defective."[1] The bathing and sanitary accommodation for the sick is, as we have ourselves noted, often sadly old-fashioned. Perhaps the most important consequence of the structural defects of the old workhouse building—with its small and often ill-ventilated rooms, its old wooden floors and absorbent walls, and its primitive sanitation—is that they often involve a disposition of the patients that is, to say the least of it, neither comfortable nor curative. "At present," reports an Inspector, "in the sick wards of a small country workhouse, it sometimes happens that children and adults, persons suffering from phthisis, offensive cases, and imbeciles are not separated from each other, and it seems to me that classification in this respect is what is most needed."[2] The Poor Law Commissioners, on visiting the sick wards of a provincial workhouse, found that "one mentally deficient

[1] Report on Poor Law Medical Relief, by Dr. J. C. M'Vail, Appendix, vol. xiv., pp. 19, 22, 23. In the Scotch poorhouses "the cubic space provided" was reported in 1904 to be "often wholly inadequate." (Report of Departmental Committee on Medical Relief (Scotland), 1904, pp. 25, 30-31.)

[2] Thirtieth Annual Report of the Local Government Board, 1900-1901, Appendix B, p. 120, Mr. Preston Thomas's Report; and again, Thirty-Fifth Annual Report of the Local Government Board, 1905-6, p. 473.

patient keeps crying out, day and night, at frequent intervals, disturbing the other patients. He seemed to be in great discomfort, if not pain; but is not removed on the ground of economy."[1]

However desirable may be the structural advantages of a modern hospital building, with its elaborate classification by wards, we are bound to say that we regard the somewhat primitive buildings of the old rural workhouses as the least of their drawbacks. The Commission found, in workhouse sick wards, no such scandalous instances of overcrowding, dirt, and insanitation as were formerly revealed in workhouse inquiries; and, as we are glad to add, no such neglect and inhumanity. The worst defects of the rural workhouse sick wards of the present day, apart from the general conditions of admission, centre round the medical attendance and nursing. None of these 300 rural workhouses has, or indeed needs, a resident Medical Officer; but the conditions under which the medical attendance is afforded are, in too many cases, such as to make curative treatment almost impossible. The Guardians appoint one of the local practitioners to be the Medical Officer of the workhouse, and

[1] Reports of Visits by Commissioners, No. 65 C, p. 134. This adverse judgment on the general mixed workhouse in the rural Unions, as, for half England, the "hospital branch of the Poor Law," does but follow the verdict of the medical profession. The *British Medical Journal* in 1895, after an elaborate investigation of the sick wards of the rural workhouses, summed up as follows in terms which, we fear, are still in the main true: "The buildings match the service; we read of no bathrooms; no supply of hot and cold water, but such as is carried from a distance; sanitary arrangements defective or absent; no proper provision for the comfort or privacy of lying-in women; no surgical supplies; no screens for decency; overcrowding in wards where the helpless sick live, sleep, and eat all the year round; miserable dark rooms for the use of the coarsely termed 'dirty cases'; no classification; no means of isolation; dreary airing courts; indeed, an absence of all intelligent appreciation of the needs of the sick." (*British Medical Journal*, 1st June 1895, p. 1231.)

expect him, at the most meagre stipend, to do all that is required for all the patients. These stipends —we have it on the authority of the Medical Inspector of the Local Government Board—are, in the majority of cases, "miserably inadequate."[1] In one workhouse that the Poor Law Commissioners happened to visit, containing as many as sixty-seven sick patients, they found that the Medical Officer, who had held the post for thirty years, received only £70 a year, out of which he stated that he sometimes spent as much as £25 in medicines.[2] We desire to bring no accusation against a hard-worked and ill-remunerated class of doctors. "It would be easy," we are told, "to name Medical Officers whose work is beyond praise. . . . Unfortunately, there is another side to the picture."[3] But it is impossible to escape the conclusion that, in not a few Unions, the workhouse Medical Officer finds himself able to attend only irregularly and infrequently, and to give only a perfunctory service. We learn that "instances may be quoted where (making all allowances for the possible inaccuracies in the porter's book) a few minutes in the house two or three times a week constitutes the ordinary attendance of the workhouse Medical Officer."[4] Nor can they afford to spend much time when they do attend. "Entries recently taken from porters' books in several Unions," declares the Inspector, "show that some Medical Officers frequently only stay for a few minutes in the house,

[1] Report of the Poor Law Commission, 1909, Appendix No. xxi. (*a*), par. 25, to vol. i.

[2] Reports of Visits by Commissioners, No. 93, p. 163.

[3] Thirtieth Annual Report of the Local Government Board, 1900-1901, Appendix B, p. 106 (Mr. Fleming's Report).

[4] *Ibid.*

and very rarely long enough to make an examination of the bodily condition of the patients and of their surroundings. The Medical Officer should certainly, and with sufficient frequency to ensure the object, thoroughly examine each of the patients, and particularly the bedridden ones, as to bodily condition and cleanliness, also the beds, bedding, appliances, and all other details connected with the proper treatment and nursing of the cases."[1] The impression of the inadequacy of the medical treatment afforded to the sick poor in some of the small rural workhouses does not rest on such general evidence only. "It is most desirable," said one of the General Inspectors of the Local Government Board, "that the Medical Officers should be much better remunerated than they are. They should be so remunerated that they could fairly be called upon to do the work as it ought to be done. There is a difficulty now if you say to a Medical Officer, 'I find that you have been very little in the workhouse,' and he says, 'I do all that I consider necessary; that is my business, not yours.' . . . I have come across striking instances in which I have been able to show a complaint. I remember going into a workhouse when the Medical Officer was not there. I said to the nurse, 'Have you any bed-sores?' She said, 'There is not a bed-sore in the place.' I went into one of the wards, and I saw one man looking very miserable. I said to the nurse, 'Is that man all right?' She said, 'Yes.' I said, 'Let me see his back.' She turned him over. He had a bad bed-sore. I looked at several other cases, and I found many bed-sores. I sent for the

[1] Thirtieth Annual Report of the Local Government Board, 1900-1901. Appendix B, p. 106 (Mr. Fleming's Report).

doctor. . . . 'I am horrified,' he said. . . . If (he) had been properly paid to do his work thoroughly, he would probably have examined those patients. But he took the nurse's word for it because he was receiving an inadequate salary, and did as much work as he thought the money was worth."[1] The Poor Law Commissioners found on their visits some confirmation of this testimony. In one workhouse where the sick ward seemed unsatisfactory, they saw the workhouse Medical Officer, and on questioning him, he "quite frankly admitted that he was not able to give to the patients as much attention as they ought to have. This he laid at the door of the Guardians, who, he said, would neither remunerate him sufficiently, nor provide him with an assistant."[2] With the meagre remuneration of the workhouse Medical Officer goes the system—in the rural workhouses still, we are informed, almost universal[3]—of requiring him to provide, at his own expense, all the medicines that he prescribes. This system leads to serious results. It encourages, we are told, the workhouse Medical Officer to prescribe alcohol (which the Guardians pay for) instead of the other remedies of the pharmacopœia.[4] The workhouse Medical Officer practically finds himself limited to the simplest

[1] Report of the Poor Law Commission, 1909, *Q.* 9480.

[2] Reports of Visits by Commissioners, No. 20, p. 45.

[3] Report of the Poor Law Commission, 1909, *Qs.* 4943, 10779, 10781; Report on Poor Law Medical Relief, Appendix, vol. xiv., by Dr. J. C. M'Vail, p. 28. This system is now deplored by the Local Government Board, and the Boards of Guardians are advised—often in vain—on the making of a new appointment to agree to provide the drugs. But the more common practice has not yet been forbidden by the detailed regulations in which the Local Government Board minutely prescribes the conditions of the appointment. (Report of the Poor Law Commission, 1909, *Qs.* 4943, 10194-203, 10453-8 11782-3, etc.)

[4] *Ibid.*, *Q.* 10199-201.

remedies. "Human nature," says one of the Inspectors, "will not allow him to use anything which is very expensive. He cannot try the up-to-date drugs which may save a person's life. . . . It is a very important point, and I believe the present system may cost the life of an inmate of a workhouse."[1] What is far worse is the fact that "there is nothing to prevent an unscrupulous Medical Officer," as a workhouse doctor expressly pointed out, "from using inferior drugs and stinting his patients with medicine."[2] That such things do happen is unfortunately borne out by authoritative evidence. "About three weeks ago," testified the Medical Inspector of the Local Government Board, "I was inspecting a workhouse, and I noticed a case in bed; I asked the Medical Officer what the case was, and he told me that it was a case suffering from syphilitic disease, and apparently, from what he said, it was curable. I asked him if the case was having drug treatment. He said, 'No, I cannot afford it; my salary is not sufficiently adequate for me to find the expensive drugs necessary.' I asked him then whether he had reported this matter to his Guardians, and he said, 'No,' and I advised him to do so. . . . I think," added Dr. Fuller, "*that is a very good example of cases that frequently come under my notice.*"[3]

The inadequacy of the medical attendance in the small rural workhouses is rendered more disastrous by defective nursing. In spite of all efforts of the Local Government Board, which have, in the past two decades, effected great improvements, there are still many rural workhouses without even one trained

[1] Report of the Poor Law Commission, 1909, *Q.* 4943.
[2] *Ibid.*, *Q.* 34566, par. 3. [3] *Ibid.*, *Q.* 10610.

nurse;[1] there are still scores in which there is absolutely no nurse, trained or untrained, available for night duty;[2] there are even some, so far as we can ascertain, in which there is no sort of salaried nurse at all. Everywhere the master and matron have still to employ pauper assistants to help in attending to the sick. In spite of all that has been done, "the reports of the Local Government Board inspectors . . . show very clearly that this deplorable system of pauper assistants is far from decreasing in as rapid a manner as may have been hoped after the issue of the Nursing Order of 1897."[3] "Looking at the facts with regard to the individual rural Unions which I visited," reports the medical investigator appointed by the Poor Law Commission, "I have concluded that the nursing staff is insufficient in the majority of them. . . . In one workhouse the sick wards contain twenty-four beds, of which sixteen were occupied, nine of them by bedridden cases, and one of these with a bed-sore. For all this work there

[1] The nursing Order of 1897 requires that, where there are three salaried nurses, one of them must possess training, and hold the position of Superintendent Nurse. But there is nothing in the Order or elsewhere making it obligatory on the Board of Guardians to employ three salaried nurses, or, indeed, any salaried nurses at all. The result is, that there is, as the Senior Medical Inspector of the Local Government Board testified, "some little tendency . . . to evade the Order by calling the nurses anything but nurses, or in some cases, perhaps, not appointing an extra nurse which would just bring them within the Order." (Report of the Poor Law Commission, 1909, *Q.* 23144. See also *Qs.* 6527, 6533.) In some workhouses the Order is evaded by appointing what are called "ward maids" to do the work of nurses. (*Ibid.* Appendix No. lvii. (par. 2) to vol. ix., Memorandum from the Workhouse Nursing Association.)

[2] In one Inspector's district, he reports: "In fourteen workhouses it has not been found possible to provide a night nurse." (*Ibid.* Appendix No. lvii. (A) to vol. ix.)

[3] *Ibid.* Appendix No. lvii. (par. 2) to vol. ix. One Inspector actually reports in his district an increase in the number of pauper attendants in the sick wards. On 1st January 1905 there were 159, on 1st January 1908 there were 175,

was only a single nurse, both for night and day service, and her duty included attendance on confinements in the lying-in ward, though these, fortunately, were infrequent. . . . In only two or three of the rural workhouses have I been able to form the opinion that the staff is sufficient." [1]

It does not need statistics of the mortality and of the recoveries in workhouses, which unfortunately are lacking, to persuade us that, under such conditions as we have described, curative treatment of the thousands of sick patients in the 300 small rural workhouses is, to say the least, difficult. The phthisis cases, of which there are many hundreds, seem to be given up as hopeless, there being usually no sort of special provision for them.[2] The acute cases needing prompt treatment, constant nursing or expensive remedies, appear sometimes to fare almost as badly. "When I came to this workhouse," said a nurse, "I was told 'the pneumonia cases generally die with us.'" [3] A dim appreciation of the medical conditions in these small rural workhouses, combined with the stigma of pauperism, explains why the sick poor insist on remaining in their own homes, however insanitary and overcrowded these may be. The general mixed workhouse is, in fact, as long as possible

[1] Report on Poor Law Medical Relief, by Dr. J. C. M'Vail, Appendix, vol. xiv. pp. 28, 29.

[2] See the Return by the Medical Inspector of the Local Government Board, Report of the Poor Law Commission, 1909, Appendix No. xxi. (D) to vol. i. "Generally speaking," says an Inspector, "there is no provision for the treatment of these (phthisis) cases in the workhouse." (*Ibid.* Appendix No. xi. (A), par. 133, to vol. i.) See also Report on Poor Law Medical Relief, by Dr. J. C. M'Vail, Appendix, vol. xiv. p. 91. In Scotland, "nearly every poorhouse" now "makes some accommodation for the segregation of phthisis cases." (Report of the Poor Law Commission, 1909, *Q.* 56725.)

[3] Memorandum from the Workhouse Nursing Association, *ibid.* Appendix No. lvii. (par. 2) to vol. ix.

shunned even by those who would benefit by it, to the grave detriment of the public health. Where such conditions exist—and we fear that they are characteristic of the majority of the rural Unions —the Guardians would, to put it mildly, not be warranted in adopting a policy, so far as the sick are concerned, of "offering the house," and refusing outdoor relief. Any suggestion for entrusting to the Destitution Authority powers of compulsory removal to such a general mixed workhouse—even of the worst cases of neglected sickness and dangerous insanitation—is plainly quite out of the question.

(ii.) *The Urban General Mixed Workhouse*

We do not wish to suggest that the structural conditions and medical and nursing attendance characteristic of the 300 small rural workhouses, with their few thousands of sick, are equally characteristic of the 300 general mixed workhouses of the urban or more populous Unions, in which, as we regret to infer, there are ten times as many sick cases.[1] In London, and a score of other large towns, there have been developed separate Poor Law infirmaries, which we shall presently describe. But short of this development there is, among the general mixed workhouses of the 300 urban Unions, every possible variety in the character and efficiency of their provision for the sick. Some of these general mixed workhouses are as old, as ill-adapted for use in the "hospital branch of the Poor Law," as badly equipped, and furnished

[1] About 150 of them have between 50 and 100 sick beds, and the other 150 have between 100 and 400.

with as inadequate a medical and nursing staff[1] as the worst of the small rural workhouses that we have seen. But under the constant pressure of the Local Government Board there has gone on, for forty years, a steady process of improvement. Here and there we find new sick wards added to the old workhouse building; the Guardians have begun to provide the drugs and medicines; the pauper attendants have been gradually replaced by salaried "ward-maids," and these by nurses; the nurses have got trained and a superintendent nurse has been installed; occasionally

[1] In 1900 it was incidentally stated that out of 629 Unions making returns, 585 had no resident Medical Officer in the Workhouse. (Minutes of Evidence of Departmental Committee on Nursing of the Sick Poor in Workhouses, 1902, Part ii. p. 187.) In one Inspector's district alone there was, in 1906, out of forty Unions, one workhouse having 352 sick patients, and there were four having between 200 and 300 sick patients, without a resident Medical Officer; there were two workhouses having over fifty sick patients without a superintendent nurse; there were a dozen in which there was no paid trained nurse on duty by night, even in two cases for as many as thirty-five and fifty-one patients; there were a dozen in which there were more than fifty patients to each nurse on night duty, and a dozen also in which each nurse on day duty had more than half that number to attend to. (Report of the Poor Law Commission, 1909, Appendix No. xxii. (C) to vol. i.) This district (Lancashire, Westmorland and part of Cumberland) is believed to be above the average in respect of workhouse nursing. "The majority of Guardians," observed the Medical Inspector of the Local Government Board, "naturally do not understand or appreciate the necessary standards of medical and nursing administration which should obtain." (*Ibid.* Appendix No. xxi. (A) (par. 14 (i.)) to vol. i.) Even in some of the large urban workhouses, the medical investigator appointed by the Poor Law Commission, after taking all the circumstances into account, came to the conclusion "that the medical staff is hardly ever sufficient. The amount of medical work is too great to permit of its thorough performance." He reports, in particular instances, "the nursing staff . . . insufficient"; in one case "seriously inadequate." (Report on Poor Law Medical Relief, by Dr. J. C. M'Vail, Appendix, vol. xiv. pp. 45, 49.) In 1905 the 300 "country workhouses" had only 68 superintendent nurses, 586 nurses, and 105 probationers (total, 759) among them for their 10,000 sick and infirm. The 300 "town workhouses," had 163 superintendent nurses, 1390 nurses, and 1093 probationers (total, 2646) for their 70,000 or 80,000 patients. These figures may be contrasted with those of the 50 or so separate Poor Law infirmaries, which had, for their 40,000 patients, 879 nurses and 1611 probationers (total, 2490).

on the occurrence of a vacancy we find that a young resident doctor has been appointed; the superintendent nurse and the resident Medical Officer gradually win greater independence from the master and matron;[1] until, finally, when the workhouse has long been overfull, the Guardians have perhaps yielded to the repeated suggestions of the Inspector, the criticisms of the Medical Inspector and the injunctions of the Local Government Board itself, and agreed to erect an entirely new and independent Poor Law infirmary.[2] We have not found it possible to estimate how many Unions, and what proportion of their aggregate sick population of thirty or forty thousand, are, at this moment, at each of these various stages of development. But all these sick wards of general mixed workhouses, however far they may have developed along the lines of improvement, seem

[1] See, for instance, the Special Order to the Basingstoke Union.

[2] Unfortunately some large towns have not yet taken this step. "The most conspicuous exception," observes one Inspector, "is at Plymouth, where the Guardians, some years ago, decided to build a new infirmary, but subsequently rescinded their resolution, and have since expended a good deal on old buildings without a satisfactory result. The wards are old-fashioned, ill-constructed and ill-ventilated; they are so scattered as to make proper administration and supervision very difficult; they have been repeatedly reported as quite inadequate for the cases requiring admission; a good many of the nurses have to live in the town for want of room, and the whole workhouse has been overcrowded. The Medical Officer has frequently represented to the Guardians the serious evils of the present arrangements, but so far nothing effectual has been done." (Thirty-Fourth Annual Report of the Local Government Board, 1904-5, Appendix B, p. 219, Mr. Preston Thomas's Report.) "Lately, however, the existing wards have become so obviously inadequate that the Guardians have been driven to action, and they have submitted to the Local Government Board plans for an infirmary to hold 300 patients." (Report of the Poor Law Commission, 1909, Appendix No. viii. (A) (par. 35) to vol. i., evidence of Mr. Preston Thomas.) At Bristol, where hundreds of sick of all kinds are crowded together in most unsuitable buildings, old and even insanitary, there is a deadlock between the Guardians, who want a cheap scheme, and the Local Government Board, which refuses to sanction such a scheme but cannot, apparently, compel the adoption of any. (*Ibid.*, *Qs.* 5362-4.)

to us—from the standpoint of curative treatment of the sick—to suffer from the blight of being, and being felt to be, pauper establishments.[1] This blight shows itself in the inability of the Boards of Guardians wholly to exclude—even from workhouse infirmaries having a dozen paid nurses—the pauper "wardsman" and the pauper attendant;[2] it is seen in the incapacity of the Guardians to realise the necessity, in what is becoming virtually a hospital ward, of a medical and nursing staff out of all proportion to what had

[1] The lack of anything in the nature of a sanatorium or convalescent home must, we assume, be a serious drawback. "We are absolutely full up in the infirmary," stated an Aston Guardian, "and when a man . . . becomes convalescent, whether he has been in the workhouse before or not, we have to transfer him to the workhouse." (Report of the Poor Law Commission, 1909, *Q.* 45836.) "Very handy is the body of the house to put people in from the infirmary," said a Chorlton Guardian; "if it was under a different authority . . . they would provide some place for convalescents." (*Ibid.*, *Qs.* 36450-51.)

[2] To take only one Inspector's district out of twelve, such pauper attendants are still to be found in the sick wards of no fewer than sixteen workhouse infirmaries having over fifty sick patients, including some with several hundred sick patients, and definitely organised staffs of paid nurses. (*Ibid.* Appendix No. xxii. (C) to vol. i.) We regret to infer that between 2000 and 3000 paupers are still thus employed in England and Wales, to eke out the deficiencies in the nursing staff. "So long, however, as the employment of paupers in sick wards as 'attendants' is tolerated," says an experienced Inspector, "it is almost impossible to be sure that the somewhat undefined line which separates the duties of an 'attendant' from those of a nurse is never overstepped. The placing of the larger workhouse infirmaries under separate management, which is viewed with increasing favour, will, however, do more than anything else to free the sick wards from all paupers other than the patients themselves." (Twenty-Seventh Annual Report of the Local Government Board, 1897-8, Appendix B, p. 125, Mr. Jenner Fust's Report.) These so-called "wardsmen" gamble with the patients at dominoes (Report of the Poor Law Commission, 1909, *Qs.* 36465-70), and are said even to divert eggs and other things from the sick, to sell them to others. (*Ibid.*, *Q.* 36472. See also *Q.* 62038.) "There is no doubt," deposed an Inspector of the Local Government Board, "that in the old days, the days of pauper nurses, . . . there used to be a great deal of bribery. If a patient wanted to be well looked after by pauper nurses, if he or she had a friend who could go in and just slip 1s. or 6d. into the pauper nurse's hand, the case received attention. If there was nobody to do any good office of that kind for a case, the case was not looked after as it should have been looked after." (*Ibid.*, *Q.* 8915.)

formerly been customary in the workhouse day room or night dormitory; it shows itself in the friction which so frequently arises between the resident Medical Officer or the trained superintendent nurse, and the workhouse master and matron, who remain in command of the whole institution;[1] and it is manifested, above all, in the repugnance of the sick poor to enter even an institution for curative treatment when admission brings them plainly into contact with the workhouse itself.[2]

[1] See Report of the Departmental Committee on the Nursing of the Sick Poor in Workhouses, 1902. "The dual control now exercised by the workhouse master, matron, Medical Officer and Superintendent Nurse," testified the clerk of a large Lancashire Union, "gives rise to friction, and is not to the advantage of the sick poor. Difficulties arising from this dual control have been experienced frequently in this Union within the last few years." (Report of the Poor Law Commission, 1909, *Q.* 36693, par. 1.) "The great difficulty is to make the superintendent nurse and the master and matron work in harmony together," deposed an Inspector of the Local Government Board; "I have one or two cases at present that are giving me a great deal of anxiety and trouble, and it is very difficult to know what to do in regard to them." (*Ibid.*, *Q.* 7454.) Where the matron "is not a trained nurse, the result of placing her in charge of the sick wards has almost invariably been friction between her and the nurses." (Report of Departmental Committee on Medical Relief (Scotland), 1904, p. 51.) See also the Memorandum from the Workhouse Nursing Association, Report of the Poor Law Commission, 1909, Appendix No. lvii. to vol. ix. The fault is not always with the master or matron. "In one union . . . the workhouse medical officer thwarted our (*i.e.* Local Government Board) endeavours for two years, because he did not think it necessary that the staff of two nurses should be increased to provide for a night nurse. This was an infirmary of eighty beds, and bed-sores were not unknown." (*Ibid.* Appendix No. xxi. (A), par. 51, to vol. i.)

[2] Where the infirmary is in the workhouse building, there is, it was repeatedly stated before the Poor Law Commission, "quite a great aversion" to enter it. (*Ibid.*, *Q.* 51479. See also *Qs.* 41751, 42538-9, 43247 (par. 6, etc.).) "I have often admitted cases to the isolation hospital," writes the Medical Officer of Health for a northern town, "who have absolutely refused to go to the workhouse infirmary." The spirit in which it is regarded by the Destitution Authority may be inferred from the fact that at Birmingham in 1885, the Board of Guardians actually made a rule to which the Local Government Board extended its express approval (Local Government Board to Birmingham Board of Guardians, 9th December 1882), that patients desiring admission to the infirmary should be made to enter it through the

(B) *The Poor Law Infirmary*

We have now to pass to the separate Poor Law infirmaries[1] which form, in the Metropolis[2] and some other large towns,[3] the most extreme development of,

main workhouse gate, upon orders of admission to the workhouse itself, in order to impress upon them that they were making themselves paupers. (Report of House of Lords Committee on Poor Law Relief, 1888, *Q.* 381.) So "at Portsmouth, where the infirmary adjoins the workhouse, everybody has to go in through the workhouse gate. The Guardians have found it necessary to insist upon the infirmary order being regarded as a workhouse order." (Report of the Poor Law Commission, 1909, *Q.* 9556.)

[1] Called also "sick asylums" or (as at Cardiff and Halifax) "hospitals."

[2] In the Metropolis (including Croydon and West Ham), where so extensive a provision exists of voluntary hospitals of all kinds, the Boards of Guardians have, nevertheless, been driven, under the constant pressure of the Local Government Board, to erect thirty-two Poor Law infirmaries (including one children's infirmary) which, varying from 242 to 793, have altogether nearly 17,000 beds (being nearly three times as many as all the voluntary hospitals put together).

[3] In the provincial Unions the development of the workhouse into a hospital has, in some cases, gone almost as far as in the Metropolitan Unions, but it has remained much less general.

In Liverpool, where the development has, perhaps, proceeded further than anywhere else out of London, the Poor Law infirmaries have three times as many beds as all the general hospitals put together. Among the nine Poor Law institutions, the most remarkable is the Mill Road infirmary, which has 900 beds. This admirable institution has one visiting and three resident doctors, fifty-six paid nurses on day duty (one to eleven patients) and twenty-two on night duty (one to twenty-seven patients); with 604 sick inmates and 100 imbeciles and epileptics. Specially designed and built as a first-class general hospital, it has been admirably equipped and staffed; and is now largely used by people who are far from destitute. The three Liverpool Boards of Guardians are reported, indeed, to receive over £4000 a year from the patients who use the various Poor Law hospitals. Special attention has been paid to tuberculosis, which is seriously prevalent. The various Poor Law infirmaries in the city (with its three Unions), which have, in the aggregate, 3000 beds, have usually 700 of them occupied by cases of tuberculosis. The three Unions have, therefore, combined to establish a special sanatorium at Heswall for the treatment of such early cases as they can get hold of. (See Report of the Poor Law Commission, 1909, *Q.* 37927, pars. 24-5, 35-6.)

The Manchester Poor Law infirmary at Crumpsall (one of four for the Manchester agglomeration), which, we gather, is virtually though not formally separately administered, has no fewer than 1400 beds for the sick and 400

to use the official phrase, "the hospital branch of the Poor Law." These institutions,[1] erected on separate

for lunatics and epileptics—being, in fact, perhaps the largest hospital in Great Britain—with three resident and two visiting doctors; seventy-eight paid nurses on day duty (one to twelve patients) and twenty-four on night duty (one to forty patients); and 957 sick inmates, and 291 lunatics and epileptics.

The Birmingham Poor Law infirmary, besides resident doctors, has three visiting physicians and one visiting surgeon. It has accommodation for nearly 1400 patients, and has usually from 1000 to 1200 inmates, treating 4500 cases a year. To cite an example from a smaller town, the Poor Law infirmary at Merthyr Tydvil is a modern building of two blocks of ten wards each, with an administrative block, containing also lying-in wards. One ward in each block has been converted into an "open-air" sanatorium for phthisical cases, for which, in addition, a separate sanatorium on the hills outside the town is about to be opened. This institution, which has 130 beds, is equipped with all up-to-date appliances, medical and surgical; and all drugs and dressings are supplied by the Board of Guardians free of charge. It has a nursing staff, including probationers, of thirty-two, some of whom are from time to time lent for outside visiting. The surgical operations performed under anæsthesia in the last five years numbered 170. (*Ibid.* Appendix No. lv. (pars. 2-6) to vol. v.) This new infirmary, however, "does not accommodate the whole of the sick. We have seventy beds on the male and fourteen beds on the female side in the main building, retained for the use of the sick. . . . In my opinion this arrangement is quite unsuitable for their proper treatment." (*Ibid.* Appendix No. xxxviii. (par. 11) to vol. v.) Other Unions which have elaborately equipped Poor Law infirmaries, with from 150 to 900 beds, are Birkenhead, Brentford, Brighton, Bristol, Burnley, Cardiff, Carlisle, Croydon, Derby, Halifax, Leeds, Portsmouth, Salford, Sheffield, Shoreham, Southampton and Sunderland.

[1] These Poor Law infirmaries are, strictly speaking, workhouses within the meaning of the term in the Poor Law statutes; but they are organised, not under the General Consolidated Order of 1847, but under special orders for the separate institutions. The Board of Guardians is required to appoint (instead of a master) a Medical Superintendent, who, giving his whole time and residing on the premises, has the entire control of the establishment. He is assisted by two or three other resident doctors, who also give their whole time. The drugs, stimulants, dressings, and surgical appliances are, like the food and other necessaries of the patients, all provided by the Board of Guardians, upon the advice and under the sole management of the Medical Superintendent. The nursing staff, too, which is extensive and includes a large nurses' training school, is entirely under the Medical Superintendent. The number of Poor Law infirmaries of sufficient standing to have such training schools for nurses, which does not include all the Poor Law infirmaries separately organised, appears to be forty-nine, having nearly 30,000 beds. It is mainly upon these Poor Law infirmaries that the workhouses throughout the country depend for their supply of trained nurses, over 400 a year being turned out by the Metropolitan Poor Law infirmaries alone, with certificates

sites apart from the workhouse, independent of the master and matron, administered by their own Medical Superintendents, having their own resident staffs of doctors and nurses, and wholly free from pauper attendants, are increasing annually in number, in size and in cost per bed, each one surpassing the last in perfection of design, construction and equipment,[1] and now probably accommodate, though in only a few score of the most populous Unions,[2] at least a third of the aggregate total of sick persons for whom the Boards of Guardians provide institutional treatment.[3] Here undoubtedly, to quote the congratulatory words of a Northern Board of Guardians, the sick poor "receive care and attention such as the average rate-

of three years' training. The connection of these infirmaries with the Poor Law involves certain consequences. All the inmates are paupers, and the cost of their "relief" may be recovered from any relatives legally liable for their maintenance. The decision as to whether or not they shall be disfranchised rests in practice, we are told, with the revising barrister (*ibid.*, *Qs.* 2341, 4140)—for instance, the inmates of Lewisham and Greenwich Poor Law infirmaries are not disqualified, whereas those in Hatfield Workhouse and in Spital Workhouse, Stoke-on-Trent, are disqualified. At Sheffield, during an outbreak of typhoid fever, an arrangement was made between the guardians and the overseers, by which the cases were not reported, and the inmates of the Poor Law infirmary were therefore not disfranchised. (*Ibid.*, *Qs.* 40239, 40240.)

[1] "Each recently finished workhouse infirmary of any size has attempted to outvie the last in the equipment, especially in regard to the operating room." (Report of the Poor Law Commission, 1909, Appendix No. xxi. (A), par. 86, to vol. i.)

[2] As already indicated, there is a tendency for the sick wards of the large progressive Union to pass, by insensible gradations, into the Poor Law infirmary. In several cases, where the last stages of the evolution are not yet quite completed in form, the institution has become substantially separately administered.

[3] We gather that the total number of patients in Poor Law infirmaries in England and Wales, administratively distinct from workhouses, is about 40,000 (without counting those in the institutions of the Metropolitan Asylums Board, who number between 3000 and 6000), which may be compared with the estimated total of about 60,000 in the sick wards of workhouses or the infirmaries forming integral parts of workhouses.

payer would find it difficult to provide for himself and his family."[1] The character of the cases treated has largely changed within the past thirty years. These Poor Law infirmaries are no longer mainly devoted to chronic and incurable cases. Their "most significant feature," we are informed, "is that they have become largely surgical,"[2] some of them having daily operations under general anæsthesia.[3] The proportion of acute cases is steadily increasing.[4] These Poor Law infirmaries are the only institutions in the Metropolis to which such infectious diseases as erysipelas, puerperal fever, measles, whooping-cough and chicken-pox can be sent for treatment, whether the sufferers are technically "destitute" or not; as well as such cases of venereal disease as cannot be received in the two small lock-hospitals.[5] They receive cases of accident and urgent sickness occurring in the streets, as well as those taking place among persons whilst in custody. They have sometimes extensive maternity

[1] Sixth Annual Report of the Workhouse Committee of the Whitehaven Board of Guardians, 1904.

[2] Report of the Poor Law Commission, 1909, *Q.* 36971. Of one infirmary it is noted that it has a specially large amount of "surgical operative work, . . . five-eighths of its cases belonging to the hospital as distinguished from the infirmary class." (Report on Poor Law Medical Relief, by Dr. J. C. M'Vail, Appendix, vol. xiv. p. 49.)

[3] In twenty-five only out of the thirty-two infirmaries in London the number of surgical operations performed under general anæsthesia was, in 1904, no fewer than 2903. (Report of the Poor Law Commission, 1909, *Q.* 23303, par. 2.)

[4] "Now they must be prepared to treat yearly an increasing number of the acutely sick." (*Ibid.*, *Q.* 23303, par. 1.) Taking, as a rough index of the proportion of acute cases, the height of the death-rate per 100 occupied beds and the shortness of the average stay, we may note that, of the total number of 88,193 patients admitted in the Metropolis during the year 1905-6, the average stay of each, once reckoned in months, was only eight or nine weeks, as compared with three or four weeks, which is the average of the general hospitals. The deaths during the year numbered 13,545, or 84 per 100 occupied beds.

[5] *Ibid.*, *Q.* 23303, par. 3.

departments. They are, moreover, increasingly used by medical practitioners among the non-destitute poor, who recommend their patients for admission, the Board of Guardians then making some moderate charge.[1] It is, in fact, confidently stated that, whilst the cost of maintenance (including interest and sinking fund) comes to about £60 a year per occupied bed,[2] there is now no difference whatever between the accommodation, treatment and nursing given in the Metropolitan Poor Law infirmaries and those given in the voluntary hospitals, except that the Poor Law infirmaries are sometimes actually better equipped than the hospitals.[3]

We do not feel competent to determine how far

[1] Report of the Poor Law Commission, 1909, par. 4.

[2] The total expenditure on maintenance, including interest and repayment of loans, in 1905-6 was £925,614, the provisions alone costing £190,613 and the drugs and appliances £32,692. The annual cost per occupied bed varied from £43 to £94. The increase in cost during the past ten years has been about £12 per occupied bed, or nearly 25 per cent. (*Ibid.* Appendix No. xiii. (B) to vol. ii.)

[3] *Ibid.*, *Qs.* 4140, 22615, 23316, 38945, 39235, etc. It is part of the general lack of medical statistics relating to Poor Law institutions that we have been unable to find any medical reports or pathological statistics with regard to what have become essentially hospitals. "So far as I am able to ascertain," says Dr. Fuller, "our workhouse infirmaries compare favourably as to percentage of successful operations with the local general hospitals." (*Ibid.* Appendix No. xxi. (A), par. 86, to vol. i.)

To the Poor Law provision for the sick poor in the Metropolis must be added the "asylums" of the Metropolitan Asylums Board, provided at the joint cost of the Metropolitan Boards of Guardians, out of the poor rate, for all persons suffering from smallpox, scarlet fever, enteric fever and diphtheria —we happily need no longer mention typhus, cholera or plague. Originally built only for paupers, these hospitals have become practically public health institutions, and as such fall to be dealt with in our chapter on the "Treatment of the sick by the Public Health Authorities" (see *post*, p. 156). Lately the work of the Metropolitan Asylums Board has been extended to children suffering from ringworm and ophthalmia; but in these institutions (like the Metropolitan Asylums Board's asylums for idiots) only children sent by Boards of Guardians are admitted; they become or remain paupers; the cost of their maintenance is recoverable from their relatives, and their parents (whether they pay or not) incur the stigma of pauperism

this claim made on behalf of the Poor Law infirmaries can be substantiated. But we notice certain general characteristics of these most modern of the institutions of the Destitution Authority. The structure tends to be elaborate, ornate and expensive. The lighting and heating, the ventilation and sanitation, the operating room and the dispensary, are all of the most costly, if not always of the most useful character. On the other hand, it is clear that, in the proportion of doctors and nurses to patients, and in the variety and specialisation of the staff, even the best Poor Law infirmary falls markedly below the standard of the London hospitals.[1] It has been suggested that this is at once caused and justified by the fact that the Poor Law infirmaries, though receiving yearly an increasing variety of diseases and accidents, still habitually contain a large proportion of chronic cases, requiring neither specialised medical skill nor continuous nursing. To some extent, no doubt, this contention is valid,[2] but we think the weight of medical evidence is in favour of the view that, so far, at any rate, as the surgical and acute cases are concerned, there is, even in the best of the Poor Law infirmaries, still inadequacy of medical

[1] Report on Poor Law Medical Relief, by Dr. J. C. M'Vail, Appendix, vol. xiv. pp. 45-6, 48-50.

[2] It is, however, a mistake to suppose that the cases so common in a workhouse infirmary do not require a staff of nurses, almost as large as do the acute or surgical cases. "A general principle in nursing in workhouses," says the Medical Inspector of the Local Government Board, is "that helpless, or wet and dirty cases, or cases bordering upon or actually suffering from senile dementia, require much more skilled care and attention from suitably trained nurses, and should take up, necessarily, much more of their time night and day than average cases of illness, such as pneumonia, rheumatic fever, etc., after the very acute stage is passed." (Report of the Poor Law Commission, 1909, Appendix No. lvii. (A) to vol. ix.)

attendance and nursing. "My general conclusion is," reports the medical investigator appointed by the Poor Law Commission, "that even where Guardians provide excellent, or perhaps extravagant, modern buildings, and equip these most elaborately with the most modern medical and surgical appliances, and furniture and furnishings, yet when they come to the appointing of a staff to do the work of these fine institutions, liberality of policy fails them, and parsimony takes its place. They may have most advanced views as to the manner in which the poor should be housed and fed, but when they come to medical work they are likely to adopt unknowingly a policy of sweating both as to the amount of work required and as to the payment made for it."[1] We are inclined to attribute the backwardness in medical attendance and nursing, not only to the inadequate salaries, but even more to the lack of other *stimuli*. The medical staff of a Poor Law infirmary has not the advantage of being under the supervision and inspection of the medical profession; the Boards of Guardians publish no medical reports of their work; they are tested by no statistics of recoveries or case mortality,[2] and encouraged by no inquiries from the Guardians or the Local Government Board as to their remedial treatment or their surgical successes. And whilst their doors are, by Local Government Board order, shut to medical

[1] Report on Poor Law Medical Relief, by Dr. J. C. M'Vail, Appendix, vol. xiv. p. 46. "These Poor Law infirmaries," said one of the witnesses before the Commission, "should have special surgeons and physicians appointed to them . . . a visiting medical staff. . . . They should not be left altogether in the hands of the resident superintendents. (Report of the Poor Law Commission, 1909, *Qs.* 36971, 36972.)

[2] "The Poor Law statistics have steered very clear of medical statistics." (*Ibid.*, *Q.* 23101, evidence of Dr. Downes.)

students,[1] and their work is divorced from the general current of clinical research, they suffer also from being equally divorced from the laboratory experiments and statistical investigations of the officers of the Public Health Authorities.

Perhaps the most striking contrast between even the best of the Poor Law infirmaries and a good London hospital is the lack of specialism in the institution of the Destitution Authority. The Medical Superintendent has to admit every case sent to him by the Relieving Officers,[2] and these non-medical functionaries naturally go more by urgency and destitution than by the kind of disease. In some Unions, indeed, the Guardians assume that all cases requiring medical attendance and nursing should be sent to the infirmary, which has, accordingly, simultaneously to treat a congeries of hundreds of patients of the most diverse kinds—the acutely sick and mere "chronics"; the expectant mother and

[1] The attendance of medical students at the "sick" asylums to be provided under the Metropolitan Poor Act, 1867, was expressly authorised by that Statute (section 29); but this provision was expressly repealed in 1869 (32 & 33 Vict. c. 63, sec. 20); and the Local Government Board declined in 1884 to sanction the admission of medical students to the Kensington Poor Law infirmary (*Selections from the Correspondence of the Local Government Board*, vol. iii. 1888, p. 224), apparently on grounds of Poor Law policy as the then Medical Officer of the Board was strongly in favour of their admission, as being advantageous to the patients, and not displeasing to them. (Report of House of Lords Committee on Poor Law Relief, 1888, *Qs*. 5474-8, 5501-8.) As to the desirability of such admission, see Report of the Poor Law Commission, 1909, *Qs*. 39237-41, 42748-52, 56605 (par. 85), 56680. It was suggested by Mr. C. S. Loch that the utilisation of the Poor Law infirmaries for medical instruction might have the effect of causing patients to be detained in the infirmary as "interesting" cases, longer than need otherwise be the case. (Report of House of Lords Committee on Poor Law Relief, 1888, *Q*. 4204.)

[2] He cannot lawfully admit any one, however seriously ill, without such an order. But there is sometimes a special order of the Central Authority empowering the Medical Superintendent to admit any urgent case at his discretion.

the senile feeble-minded; children with measles or whooping-cough, and the sufferers in advanced stages of venereal disease; the phthisical, the cancerous, and the rheumatic; the man knocked down by a motor car and the charwoman with bronchitis. "Children suffering from . . . infectious diseases have to be mixed up with adult patients."[1] There are not even any mutual arrangements among the thirty Poor Law infirmaries of the Metropolis by which each of them, in addition to its general wards, could provide specialised accommodation for one particular class of disease. In the great majority of Poor Law infirmaries—and some of them exceed in size the large voluntary hospitals—the cases have usually to lie in the common wards, and be diagnosed, physicked, and operated on by the overworked Medical Superintendent and his two or three assistant Medical Officers. The rarity, even in the Metropolis and in large towns, of visiting physicians and surgeons is here a patent drawback of these extraordinarily mixed institutions. We do not, however, gather that there has been any official encouragement to specialisation, but rather the contrary. The development of the "hospital branch of the Poor Law" has, in fact, brought us to the dilemma that it may become apparently too efficient. Boards of Guardians have been officially advised to provide for their lying-in cases in the general mixed workhouse, rather

[1] Report of House of Lords Committee on Poor Law Relief, 1888, *Qs.* 23318, 23529-35. This drawback has been repeatedly noted. "There is no ward set apart for sick children," noted the investigator into workhouses of the *British Medical Journal* in 1895, "in health, they are carefully kept from mixing with the adults, but when sick are put among the older people, and in a short time all the result of careful training may be undone." (*British Medical Journal*, 5th January 1895, p. 26.)

than develop a maternity ward at the infirmary, on the ground that the former course would deter applicants, whereas "there would be considerable danger of the Infirmary becoming a lying-in hospital, as there is great readiness and facility for obtaining admission to an Infirmary of cases that would not come into the workhouse."[1] The far-sighted provision, by the Bradford Board of Guardians, of an admirable sanitorium for cases of incipient phthisis, and the actual encouragement, by a circular to all the medical practitioners of the town,[2] of such patients to come in and be treated, before they are actually destitute, has caused some apprehension among those who cling to the idea of restricting the area even of the medical side of the Poor Law. "All specialisation in medical treatment," it is suggested, "whether phthisis sanatoria, Finsen Light or Röntgen Rays, or the new serums, should be excluded from the Poor Law institutions."[3] "Unless something is done," urged the Senior Medical Inspector of the Local Government Board, "we shall have expensive specialisation set up for persons who qualify for its receipt by becoming paupers."[4] "It would be a temptation to a man to come to the Poor Law," in order to obtain these privileges.[5]

For good or for evil the Poor Law infirmaries are growing rapidly in popularity.[6] The excellence of the

[1] Third Triennial Report of Bethnal Green Board of Guardians, 1903, p. 14.

[2] Circular letter of Bradford Board of Guardians, 12th September 1904, "All persons resident in the union, found to be in that [early] stage of the disease," stated the clerk to the Guardians, "whose income does not allow them to reside at a private sanatorium, are accepted on the recommendation of their private medical attendant." (Report of the Poor Law Commission, 1909, Appendix 63, par. 9 (F), to vol. iv.)

[3] *Ibid.*, *Qs.* 35118-21. [4] *Ibid.*, *Q.* 23193. [5] *Ibid.*, *Q.* 35117.

[6] *Ibid.*, *Qs.* 22615, 23105, 33127, 33128, 32790-2.

dietary and the accommodation—even, as has been suggested, the freedom from the perpetual observation and discipline of the students and nurses of a voluntary hospital—are attracting, to these Poor Law institutions, an ever-increasing stream of non-destitute persons.[1] It has become the custom, in certain residential quarters of the Metropolis, for the servants of wealthy households freely to use the Poor Law infirmary. In the more industrial quarters, the skilled artisans and the smaller shop-keepers are coming to regard the Poor Law infirmary—especially when, as in Camberwell, or Woolwich, or Wandsworth, it happens to be the only general hospital in the locality—much as they do the public park or library—as a municipal institution, paid for by their

[1] "The workhouse infirmary has in this and similar districts come to be looked upon as the general hospital for the district. (Report of the Poor Law Commission, 1909, *Q.* 34233 (par. 9), 34351, 34352, 34468, 34469, 36142-5.) "Practically," notes a Committee of the Poor Law Commissioners after visiting a great Poor Law infirmary in the north-west, "this infirmary is a rate-supported hospital. . . . There is no reluctance to enter it on the part of the poor, and all acute cases (except confinements) are freely admitted. . . . Last year, some £2000 was recovered from patients." (Reports of Visits by Commissioners, No. 2 C, p. 10.) To quote the words of the clerk: "The old idea of its being a degradation or a disgrace to go into a Poor Law infirmary has quite ceased." (Report of the Poor Law Commission, 1909, *Q.* 36146.) In another town "the infirmary is practically a general hospital, and caters for a class slightly better than the ordinary *habitués* of a workhouse. A considerable sum is recovered each year from relatives, as much as 10s. a week being paid in some cases. One patient, a paralytic, was mentioned as being the brother-in-law of one of the richest men (in the town), who repaid the whole cost of treatment, etc., to the Guardians." (Reports of Visits by Commissioners, No. 25 B, p. 68.) "In most infirmaries there are a certain number of paying patients," deposed a Local Government Board Inspector. (Report of the Poor Law Commission, 1909, *Q.* 13436.) In Camberwell during 1905 the Board of Guardians received £600, in Lambeth £1421, and in St. George's, Hanover Square, £474—partly in payments for treatment at rates agreed upon, partly in amounts charged to and recovered from relatives. (*Ibid.*, *Q.* 23386.) See, on the same point, Report on Poor Law Medical Relief, by Dr. J. C. M'Vail, pp. 42-43, and the Report of the House of Commons Select Committee on Metropolitan Hospitals, 1892.

rates, and maintained for their convenience and welfare. To use the phrase of more than one of the witnesses before the Poor Law Commission, the Poor Law infirmaries "are fast becoming rate-aided hospitals." "We have therefore," as the medical member of the Local Government Board for Scotland pointed out, "the administrative paradox that an institution intended by statute for the 'friendless impotent poor' has evolved into a 'pay' hospital for poor persons that may be paid for by their friends."[1] But this unperceived change results in curious anomalies. A person who is paying for his treatment in the Liverpool hospital known as the Mill Road Infirmary, however much he pays, becomes a pauper; is included in the statistics of pauperism published by the Local Government Board; cannot, in law, vote at the election of the West Derby Board of Guardians; and will be excluded or not from the register of Parliamentary electors according to the varying interpretations which the officers may put on the phrase "medical relief." The same person, treated absolutely free of charge in the Liverpool Royal Infirmary, or in the hospitals of the Liverpool Town Council, is not a pauper. This anomaly becomes the more remarkable when a Board of Guardians (as at Dewsbury), with the cordial sanction of the Local Government Board, deliberately elects to limit its own provision for sick paupers to such as suffices for the easier cases, whilst sending all that are difficult to the voluntary hospitals of neighbouring towns, to which it makes contributions from the poor rates.[2] Under these arrangements, which are becoming

[1] Report of the Poor Law Commission, 1909, *Q.* 56605, par. 88.

[2] *Ibid.*, *Qs.* 25233-8, 57483-9, 56685-7, 60159-81.

common in all but the largest towns, the sick persons become paupers or not, and their relations become liable to contribute to their maintenance or not, according to quite irrelevant accidents. Those retained in the institutions of the Destitution Authority are chargeable to their relations, and are legally paupers, however much their relations may pay. Those who are sent for the more specialised treatment of the voluntary hospitals, which are partly maintained out of the poor rate, are not paupers, and their relations cannot be required to contribute to their maintenance—unless, indeed, as is sometimes the case, the subvention of the Board of Guardians to the hospital takes the form not of an annual subscription but of the payment of so much per patient per week. In the latter case the sum so paid is, by direction of the Local Government Board, entered in the books as outdoor relief: the person in respect of whom it is paid is included in the statistics of pauperism as in receipt of outdoor relief, and his relations become liable to repay the amount.[1] The net result of these anomalies is that those patients for whose maintenance and treatment full payment is being made, by themselves or their relatives, are all certainly paupers; those who are being treated entirely gratuitously

[1] If the arrangement between the Board of Guardians and the voluntary hospital is changed in form (as from payment per patient to an annual subvention), the pauperism of the patients, and their chargeability to relations, ceases from the date of the change. This inequality of treatment of the sick is much resented. It has been urged that "as payment is not asked for in the infirmaries or in fever hospitals, why should it be required in Poor Law hospitals? Is it reasonable that, whereas the victim of typhus fever, a tumour or appendicitis is taken possession of by free-from-payment institutions, the poor wretch with phthisis, chronic rheumatism, heart disease, or ulcers is made a pauper, with the added injury that he or his relatives have to contribute to his maintenance?" (Report of the Poor Law Commission, 1909, *Q.* 60151, par. 18.)

stand a good chance of retaining the status of independent citizenship.

(C) *The Poor Law Medical Service in Scotland*

We have not had time to make any systematic investigation into the Poor Law medical service of Scotland, which was the subject of inquiry by a Departmental Committee in 1904. From the information that we have obtained we have formed the opinion that Poor Law medical relief in Scotland does not differ essentially from that in England and Wales, and that it is open to the same criticisms. The general mixed poorhouses seem to us to exhibit the same defects, as institutions for the treatment of the sick, as the general mixed workhouses of England and Wales.[1] We note the same tendency to the development of a "hospital branch" of the Poor Law, and the same tendency for these hospitals to be used increasingly by a non-destitute class of patients.[2] "Owing to the splendid equipment of our modern Poorhouse hospitals," reports the Departmental Committee on the methods of Administering Poor Relief in Eight Great Towns of Scotland (1904), "it is not thought a degradation to have relatives treated in them. They are, to a large extent, taking the place of public hospitals or infirmaries, and being separate establishments their connection with the Poorhouse is altogether lost sight of. In the case of

[1] "Except in the largest poorhouses, the sick are accommodated in the same building as the ordinary inmates. . . . In some poorhouses the sick sleep in and use the same wards as the ordinary healthy inmates." (Report of the Departmental Committee on Medical Relief (Scotland), 1904, p. 26.)

[2] *Ibid.* p. 24.

the three hospitals recently erected by the Glasgow Parish Council, the name "Poorhouse" has been dropped."[1] On the other hand, the largest poorhouses, even in the most important towns, appear to be sometimes terribly understaffed. One of the Poor Law Commissioners, after visiting two of the most important poorhouses in Scotland, reported that "in one of the Workhouses there were about 600, in the other about 800, inmates of all kinds, the numbers rising 25 to 30 per cent in the winter. *Each of these vast Workhouses had only a single resident medical officer*—in both cases a young woman. Aided only by a consultant visiting thrice a week, her duties were to examine thoroughly every inmate on entrance, in order to discover what exactly was his or her disease or infirmity; to certify which of the adults—all presumably non-able-bodied—were fit for the 'test' (work); to settle the diet and treatment of all persons actually sick; and to supervise the arrangements for the children and infants. In each of the Workhouses the 'hospital cases' alone numbered between two and three hundred. In one of them at any rate there was a phthisical ward, a surgical ward, an ophthalmic ward, a lying-in ward, and, strangely enough, a male venereal ward—all under the sole charge of the same young lady doctor who had the medical supervision of the rest of the establishment. The nursing staff was far below an English standard, extensive use being made of pauper inmates. In many of the large wards that I entered

[1] Report of the Departmental Committee on the Methods of Administering Poor Relief in Eight Great Towns of Scotland, 1905, p. xxv. See also Report of the Departmental Committee on Medical Relief (Scotland), 1904, p. 23. Glasgow is the only parish in which the hospital is entirely separate from the poorhouse. (Report of the Poor Law Commission, 1909, *Q.* 53510, par. 76.)

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there was no trained nurse in attendance, even in the daytime. In one of these institutions (I forgot to ask in the other) there were only three night nurses for all the hundreds of patients. The operations—some abdominal sections, and others of apparent difficulty—were performed by the same one young lady doctor with the help of the consultant, who was a physician! No record of the results was kept. The same one young lady doctor had to extract the teeth of patients requiring this service."[1] "For over twenty years," reported the Departmental Committee on Medical Relief in 1904, "the Central Department have urged house committees to adopt . . . a system [of trained nursing], but local prejudices die slowly, and . . . these efforts have not been generally successful; for . . . in about one-half of the sixty-seven poorhouses of Scotland untrained nursing, with the help of pauper inmates, is still the rule."[2] "Night nursing is . . . very insufficiently provided for. . . . Even in the largest and best-equipped poorhouse hospitals, the practice of employing inmates to assist the night nurses, if not actually to do the nursing itself, is almost general. In the small poorhouses, especially where only one nurse is employed . . . the night nursing, if it can be so designated, is almost entirely performed by inmates."[3]

[1] Reports of Visits by Commissioners, No. 158, p. 252; see also *ibid.*, *Q.* 56605, par. 106. "There is no rule or standard requiring that a poorhouse of and above a certain size shall have a resident medical officer. Thus . . . Paisley sanctioned for 635, and with an average daily number of 518 inmates, has a visiting medical officer only." (Report of Departmental Committee on Medical Relief (Scotland), 1904, p. 50.)

[2] *Ibid.* p. 56. The proportion of poorhouses in which trained nurses are employed has since risen to two-thirds. (Report of the Poor Law Commission, 1909, *Qs.* 55856 (par. 17), 56144.) "Pauper nursing is still legal." (*Ibid.*, *Q.* 60852.)

[3] Report of Departmental Committee on Medical Relief (Scotland), 1904, p. 62.

Under the Scotch Poor Law, as it has been interpreted by the Law Courts and by the Local Government Board for Scotland, no relief, either in the poorhouse or at home, can be granted to the dependents of an able-bodied man, however ill they may be.[1] It is stated that the more humane Parish Councils seek to evade this extraordinary provision of the Scotch Poor Law, by directing their Medical Officers, when wives or legitimate children are patently starving or seriously ill, to find some excuse for certifying the husband or father as non-able-bodied, however able-bodied he may in fact be.[2] We are not satisfied that this "subterfuge" as it was described[3] —we prefer to say this demoralising evasion of an immoral law—is sufficiently universally practised by Parish Council Officers, or is sufficiently widely known among respectable working-class families, destitute through lack of employment, to check the preventable suffering and mortality entailed by the law itself. "In point of fact," admitted the medical member of the Local Government Board for Scotland, "many cases of serious hardship do arise."[4]

[1] Report of the Poor Law Commission, 1909, *Qs.* 53068 (par. 93), 53510 (par. 43), 56605 (par. 24), 58944-6, 62615, 88821, etc.

[2] The Medical Officer, it was stated by the Medical Member of the Local Government Board for Scotland, "may, for instance, take into account not only the applicant's physiological fitness to maintain himself, but also the mental distress (!) caused by the destitution of his dependents, *e.g.* a starving wife and children. Some medical officers habitually take this into account in their estimate of an applicant's health or fitness." (*Ibid.*, *Qs.* 56605 (par. 23), 56626.) "I think," said the Legal Member of the Local Government Board for Scotland, "within the last year or two, there have been forty cases where the Glasgow Parish Council have taken the law into their own hands and have admitted" the wives of able-bodied men to the hospital. (*Ibid.*, *Q.* 53285.) See also, *ibid.*, *Qs.* 53510 (pars. 44, 45), 53285, 57054-60, 58299, 59267 (par. 61), 61072-5, 61318-21, 61371 (par. 23), 64219.

[3] *Ibid.*, *Q.* 56917.

[4] *Ibid.*, *Q.* 56605 (par. 24). That the Poor Law medical service of Scotland was, in spite of great improvements, still extraordinarily inadequate,

(D) *The Defects of the Poor Law Medical Service traced to their root*

It is, we think, impossible to avoid the conclusion that the Medical Branch of the Poor Law, now becoming an exceedingly costly service, is, at almost all points, in a far from satisfactory condition. There is, to begin with, all over the Kingdom, a remarkable lack of uniformity between district and district in the treatment accorded to the sick poor. In respect of domiciliary medical attendance we find in some places the doctor's services lavished on all who ask for them, whilst in other places they are refused to any one who is not actually destitute of the means of subsistence. "It is indefensible," rightly declares the Poor Law Medical Inspector of the Local Government Board, "that a sick and destitute person who happens to be ill in one Union should be less well nursed than his *confrère* who falls ill in the next Union, where he is well cared for and restored to the community at a much earlier period on this account alone, while his *confrère* in the neighbouring Union, owing to the inadequacy or inefficiency of the nursing staff, or both, becomes a permanent charge on the rates."[1] Yet in whole districts of England there seems to be still no other provision for the destitute

was repeatedly testified to the Poor Law Commission. "The health of the community suffers grievously owing to the insufficiency both in amount and quality of the medical assistance." (*Ibid.*, *Q.* 65889, par. 10.) "The system is not adequate," said the Medical Member of the Local Government Board. (*Ibid.*, *Q.* 56605, par. 111.) "Many die without being seen by a medical man." (*Ibid.*, *Q.* 53510, par. 117.) See also Report of Departmental Committee on Medical Relief (Scotland), 1904, pp. 70-72.

[1] Report of the Poor Law Commission, 1909, Appendix No. xxi. (A), par. 53, to vol. i.

sick, for whom the Boards of Guardians are responsible, than the inadequately staffed and badly equipped sick wards of the General Mixed Workhouse, in which —to name only one class—the phthisical patients may be stowed away, but can hardly be cured. In other districts of England, the Poor Law Authorities have, at the constant instigation of the Local Government Board, provided the best possible hospitals that modern science can suggest and that money can buy —striving, in fact, to make the lot of the sick poor more eligible than that of the patient in even a middle class household.[1] Nor does this strange unevenness of development bear any relation to the supply of other provision for the sick. On the contrary, it is in the Metropolis and the sixty or seventy largest provincial centres, where the 140 endowed and voluntarily supported hospitals of all sorts already exist, that the Poor Law infirmaries have chiefly been provided, and where they have, side by side, and even in competition with these, attained their greatest development. Just in the more remote and less populous districts, where hospital provision is most lacking, the Poor Law authorities have stood still, and scarcely advanced beyond what was done half a century ago. These extremes of deterrence and attractiveness in the institutions provided by the Destitution Authority in different districts for the sick poor, result in an even greater diversity in the classes of persons maintained

[1] "The primary object of the Guardians," it can now be said without rebuke, is "not so much to reduce the numbers in the infirmary, or even the total cost to the parish, as to render the most efficient medical attendance to the sick poor and effect their more speedy recovery to health." (Report of Dr. Quarry, Medical Superintendent of Lambeth Poor Law infirmary, April 1907.)

in them under the common designation of paupers—varying from those miserables whom nothing but the imminent approach of starvation drives into the hated general mixed workhouse, up to the domestic servants of the wealthy, the highest grades of skilled artizans and even the lower middle class, who now claim as a right the attractive ministrations of the rate-maintained Poor Law hospitals characteristic of some of the great towns.

But the absence of national uniformity, which the authors of the 1834 Report regarded with such disfavour, appears to us, in 1910, the least of the evils to which attention must be called. What seems, from the standpoint of the community, most urgently needing reform is the deterrent character which, in all but a few districts, clogs and impedes the curative treatment offered to the sick under the Poor Law. It has been demonstrated beyond all dispute that the deterrent aspect which the medical branch of the Poor Law acquires through its association with the Destitution Authority causes, merely by preventing prompt and early application by the sick poor, an untold amount of aggravation of disease, personal suffering and reduction in the wealth-producing power of the manual working-class.[1] Scarcely less harmful, it is clear, is the unconditional character of the "medical relief" given under the Poor Law. The District Medical Officer, as we have shown, finds it no part of his duty—for it, indeed, he is neither paid nor encouraged—to inculcate better methods of living among his patients, to advise as to personal and domestic hygiene, or to insist on the necessity of greater regularity of conduct. No attempt is made

[1] See *ante*, pp. 97, 98, 103.

to follow into their homes the hundreds of phthisical and other patients discharged every week from the sick wards of the workhouses and Poor Law infirmaries, in order to ensure at any rate some sort of observance of the hygienic precautions without which they, or their near neighbours, must soon be again numbered among the sick. It is a remarkable feature that the domiciliary treatment (on which nearly £500,000 a year is now spent in medical salaries and drugs alone) and the institutional treatment of the sick poor (which costs nearly £4,000,000) have, alike in the advanced and in the backward Unions, the minimum of connection with each other. Both are under the control of the same local authority, and are paid for out of the same rates. But they form everywhere[1] two essentially distinct services. The District Medical Officer never, as such, enters

[1] To this lack of continuity in the medical treatment of the Poor Law patient, as he passes from outdoor to indoor relief, or *vice versa*, there is now one interesting and experimental exception. The Lambeth Board of Guardians, struck by the large number of cases admitted to the infirmary in a moribund condition, and the occasional admission of cases that could quite well have been treated at home, got the consent of the Local Government Board, after some importunity, to place four districts under the Medical Superintendent of the infirmary, and to give him four "whole-time" assistants, who were to reside with him in the institution, but who were also, in consultation with him, to visit the sick poor outside. This arrangement (which not only contravenes the existing orders, but also reverses the invariable practice of the Local Government Board in rigidly separating "Outdoor Medical Relief" from "Indoor Medical Relief," and in insisting that each district should have its own independent District Medical Officer) was sanctioned by Local Government Board letter in June 1905. (Minutes of Lambeth Board of Guardians, 1904-5; Municipal Journal, 24th June 1904; Report of the Poor Law Commission, 1909, *Qs.* 14881, 14906-14, 21252-306.) It is interesting to find that, unknown to those concerned, there exists an early precedent for this combination. In 1839 the Poor Law Commissioners referred with commendation to the example of the Leighton Buzzard Union, where the Guardians had engaged a full-time salaried doctor, to reside within the workhouse and to attend to both indoor and outdoor poor. (Special report of the Poor Law Commissioners on Further Amendment of the Law, 1839, p. 80.)

the workhouse or infirmary. He has no power to order a patient into that institution, although he may recommend such a course. If his patient is admitted (by an order from the Relieving Officer, who has no medical qualification), he passes under an entirely distinct Medical Officer, who has charge of the institution, and the District Medical Officer is under no obligation to transmit with the patient his diagnosis or notes of treatment, and seldom does so. He is not called into consultation by the workhouse Medical Officer. He hears no more of his patient, unless it should happen that he is discharged as cured. Even then he is not reported to the District Medical Officer for observation during convalescence, or hygienic advice. He is not even reported (otherwise than by exception, in one or two districts, where private zeal has brought about voluntary arrangements) to the Medical Officer of Health, who ought to be keeping careful watch on all convalescents, notably for the sake of a vigilant scrutiny for "return cases." The patient will not be heard of again, until (as naturally soon happens) he becomes again ill. Then, even if he is in his old district, he is dealt with, without records, as a new case.[1] This complete separation between the

[1] "The patient comes into the infirmary without our knowing anything of the history or surroundings of the case, or having any knowledge of the treatment pursued up to the time of admission; and this also applies to cases which . . . revert to the District Medical Officer after discharge from the infirmary." (Report by Dr. Quarry, Medical Superintendent of the Lambeth Poor Law infirmary, April 1907.) The Infirmary Medical Superintendent's Society, as its representative deposed before the Poor Law Commission, "feels that a great advantage would be gained if all the medical work in any one Union were performed by a sufficient number of assistant Medical Officers under the control of the Medical Superintendent of the infirmary of that Union, because by this means the treatment received by a patient before his admission and after his discharge would be in

domiciliary and the institutional treatment of the sick poor, so irrelevant from a medical standpoint, results, so far as we can learn, from nothing more rational than their medical attendance being, in both cases, regarded solely as "relief," and subject, as such, to the fundamental Poor Law classification of indoor and outdoor, which it seems a cardinal point of policy to keep entirely separate.

What is even more extraordinary is, from one end to the other of the Poor Law medical service, costly as it now is, the complete and absolute ignoring of the preventive aspect of State medicine. To the Relieving Officer it is officially a matter of indifference whether the applicant is most likely to recover, or to recover most rapidly or most completely, in the workhouse or in his own home. It is no part of his duty to consider whether the applicant's wife and children will suffer most in health by his removal to the infirmary, or by his struggling on in his avocation, with his lungs getting steadily worse, in order to avoid the stigma of pauperism. If a poor family takes measles or whooping-cough badly, and cannot afford competent medical attendance, it seems to the Board of Guardians a wanton incitement to pauperism to urge them to apply for the attendance of the District Medical Officer; though abstention may mean, through neglected sequelæ, the lifelong crippling of the health of one or more of the children. The prevalence of ophthalmia of the newly born, with its result of entirely preventable blindness, will not appear as any matter of reproach to those Poor Law Authorities which have managed to restrict their mid-

continuity with that which he underwent while in the infirmary." (Report of the Poor Law Commission, 1909, *Q.* 23303, par. 15.)

wifery orders. Nearly the whole of the children of a slum quarter may go on year after year suffering from adenoids, inflamed glands, enlarged tonsils, defects of eyesight, chronic ear discharges, etc.,[1] which will eventually prevent many of them from earning their livelihood, without inducing the Relieving Officer and the Board of Guardians to notice anything beyond the total sum coming in to the household of each applicant for a medical order or other relief. Even to the average District Medical Officer it does not seem so important to prevent the spread of disease, or its recurrence in the individual patients, as to relieve their present troubles. It is not from the District Medical Officers or in respect of their Poor Law patients that requests for the bacteriological examination of "swabs" or sputa are received at the local bacteriological laboratory. The provision of Poor Law dispensaries, and the consequent abandonment of half the domiciliary visiting, even implies the discouragement of that consideration of home environment and personal habits which not only helps diagnosis but would also justify the giving of hygienic advice of preventive character. Even the Poor Law infirmary—not allowed to receive students, with a staff too busily occupied for research, and seldom provided with a laboratory—can think only of discharging its patients as quickly as possible, without convalescent home or sanatorium to which to send them, and without an outdoor visiting staff to keep them under observation and give them the hygienic advice as to home management, for lack of which the phthisical patient will soon be back in the infirmary again. In short, from beginning to the end of a

[1] See *post*, p. 168.

Poor Law expenditure of over £4,000,000 annually upon the sick, there is no thought of promoting medical science or medical education, practically no idea of preventing the spread of disease, and little consideration even of how to prevent its recurrence in the individual. The question cannot fail to arise whether so large an expenditure on mere "relief," with so complete an ignoring of preventive medicine, can nowadays be justified.

Under these circumstances it is impossible to view with approval any extension of medical service by the Destitution Authority. It cannot be regarded as desirable for the Destitution Authority to undertake the urgently needed service of the treatment of tuberculosis in its early stages—still less that it should, as at Bradford, actually encourage persons to become paupers in order to be treated. It is impossible not to agree with the Senior Poor Law Medical Inspector of the Local Government Board in deploring the tendency for Boards of Guardians to "set up . . . expensive specialisation" in the treatment of the sick "for persons who qualify for its receipt by becoming paupers." [1] An equally pressing public need, urged upon the Poor Law Commission by every sort of witness,[2] is some power of compulsory removal to an institution of persons found lying neglected, dangerously sick or contaminating their surroundings. Yet so long as the institutions for the sick poor are in the hands of a Destitution Authority, with its stigma of pauperism, its deterrent machinery and its

[1] Report of the Poor Law Commission, 1909, *Q.* 23193.

[2] See, for instance, *ibid.*, *Qs.* 5162, 6635-6, 6936, 10412, 11129, 13946, 15888 (par. 13), 19555, 20117 (par. 15), 22535 (par. 3), 25264 (par. 8), 28796 (par. 10), and Appendices Nos. viii. (A), par. 30, x. (A), par. 45, xv. (A), par. 78, to vol. i. etc.

failure in many districts to provide anything better for the unwilling patient than the general mixed workhouse, no responsible Minister of the Crown could propose, and no Parliament would permit, the concession to an authority dominated by the idea of "relieving destitution" of any such power of compulsory removal. Thus, all the defects and all the shortcomings of the Poor Law medical service as it at present exists are inherent in its association with the Destitution Authority.

CHAPTER IV

THE TREATMENT OF THE SICK BY VOLUNTARY AGENCIES

It was represented to the Poor Law Commission that the whole provision for the sick now made by the Destitution Authority, alike in its domiciliary treatment and in its "hospital branch"—being legally confined to the destitute—is but the fringe of a more general provision for the sick made by other agencies; that these other agencies impinge upon the medical work of the Poor Law, and are themselves impeded by it; and that, if the Poor Law medical work were brought to an end or seriously restricted, they might with advantage undertake the whole service. These voluntary agencies in some cases provide their service gratuitously; others claim to be wholly self-supporting; whilst others again exact a partial contribution for their benefits. Across this classification runs the cleavage between those voluntary agencies maintaining residential institutions, and those supplying only domiciliary treatment.

A.—The Domiciliary Treatment of the Sick

To begin with the domiciliary treatment of the sick poor, we find overlapping the work of the District

Medical Officer (i.) the out-patient department of the voluntary hospital; (ii.) the free dispensary or "Medical Mission"; (iii.) the doctor's medical club, or the friendly society or other "contract practice"; (iv.) the Medical Provident Association, started by a combination of the local doctors, or the Provident Dispensary managed by a philanthropic committee. These four classes of agencies for domiciliary treatment of the sick poor differ widely from one another in their geographical extension, the doctor's medical club or contract practice being, for instance, widespread over town and country alike, and the out-patients' department being confined to the Metropolis and a few large towns. They differ also in the degree to which, in one place or another, they impinge upon or overlap the Poor Law.

(i.) *The Out-patient Department of the Voluntary Hospital*

The free dispensaries and "medical missions," on the one hand, and the out-patients' departments of the voluntary hospitals on the other, have in common the attribute of offering medical attendance and medicine gratuitously to those who come for it at prescribed times and places—sometimes without the slightest fee or formality, sometimes on presentation of a subscriber's letter, and sometimes on payment of a few pence for the medicine supplied. Started originally on a small scale, in order to afford relief to the suffering poor who had access to no other doctor, these centres of gratuitous doctoring now minister, in the Metropolis and in certain other towns, to literally hundreds of thousands of cases annually. Here, at

any rate, we have unrestricted access to medical treatment—a widely advertised gratuitous provision which to some extent mitigates the hardship of a restriction of Poor Law medical relief and which goes far to explain, in the Metropolis and the other towns in which it exists, the slow growth of any form of medical insurance. "In our great cities," states a great hospital authority, "and especially in the Metropolis, the vast out-patients' departments of the voluntary hospitals, with their ever-open doors, offering gratuitous treatment to all comers, are a standing obstacle to any efficient reform of the home treatment of the sick poor. No organisation of Provident Dispensaries or public Medical Service, no system of mutual insurance for medical attendance, no scheme based on thrift, supplemented by State-aid, can hope successfully to compete with the open hand and high prestige of the great voluntary hospitals."[1] This objection to the out-patient departments—that of preventing more self-supporting forms of medical treatment—will, however, not be conclusive to those who desire that the sick poor should have every possible access to medical assistance in their hour of need. What appears more serious is the assertion that the treatment afforded to the bulk of the patients is, from the standpoint of preventive or really curative treatment, wholly unsatisfactory. "These great institutions," continues the eminent physician of Guy's Hospital whom we have already quoted, "while preventing the proper development of other agencies, are quite unable efficiently to fill their places. They

[1] "The Future of the Voluntary Hospital and its Relation to a Reformed Poor Law Medical Service," by Dr. Lauriston Shaw, Physician at Guy's Hospital, *British Medical Journal*, 20th June 1908, p. 1472.

cannot carry their services to within reasonable distance of every patient's door, nor can they follow the patient to his home when too ill to attend at the out-patient department, and not ill enough, or suitably ill, for admission to the wards."[1] Indeed, from the necessarily hurried way in which the work has to be done, no less than from the crowding together of all sorts of sick persons—sometimes men, women, and children of all ages—with sores and ulcers, with coughs and expectorations, not infrequently with a case of zymotic disease among them, kept waiting for hours cooped up in dirty and insanitary waiting-rooms, we cannot help regarding these mammoth out-patients' departments as positive dangers to the public health.[2] Nor is this merely our own opinion. "As a matter of well-known fact," testified a medical practitioner of experience, "the out-patient department is so crowded that the work has to be done in a slipshod fashion, and unless the case happens to be an 'interesting' one, the patient is put off with the stereotyped 'How are you to-day?' 'Put out your tongue.' 'Go on with your medicine.' No one who knows the system can blame the doctors, as they are notoriously overworked. Many people go there who could well afford to pay for outside advice and whose complaints are of the most trivial character. The consequence is that cases which really require time and consideration frequently fail to get it from the overworked house-surgeon or physician."[3] However

[1] "The Future of the Voluntary Hospital," etc., *Brit. Med. Journ.* p. 1472.

[2] "The patient . . . runs some substantial risk of acquiring or giving infection in the waiting-rooms, particularly of children's hospitals." (Report of the Poor Law Commission, 1909, *Q.* 92534, par. 21; see also *ibid.* Appendix No. xlv. (par. 30) to vol. ix.)

[3] *Ibid.*, *Q.* 51859, par. 4. See also *ibid.*, *Qs.* 33210-45, 41888 (par. 10), 47202-3, 50873-4, 92534 (par. 21); "Hospital Reform," by T. Garrett Horder,

profitable may be the out-patients' department in attracting the subscriptions of the benevolent; however convenient it may be as a means by which the hospital can pick out "interesting" cases which are wanted inside; and however genuinely useful it may be as a preliminary diagnosis which promptly sifts out and admits the cases requiring institutional treatment, we are bound to conclude that, to a large proportion of the patients dealt with, it is, so far as any preventive or really curative effect is concerned, little better than a delusion. It is, indeed, difficult to take seriously in the twentieth century, as an organisation professing to treat disease, the typical arrangement under which an overworked and harassed house-surgeon gives a few minutes each to a continuous stream of the most varied patients; without knowledge of their diet, habits, or diathesis; without any but the most perfunctory examination of the most obvious bodily symptoms; without even the slightest "interrogation of the functions"; and without any attempt at domiciliary inspection and visitation. "At present," summed up one experienced medical practitioner, "the out-patient department of the voluntary hospital is to a great extent a shop for giving people large quantities of medicine."[1]

(ii.) *Free Dispensaries and "Medical Missions"*

We need not describe the Free Dispensaries and "Medical Missions" which abound in the slum dis-

p. 4, reprinted from *British Medical Journal*, 30th March 1907. Where "the home life" is not "properly attended to," sums up a medical witness, "the relief they get at the out-patient department" of the great hospital is "of very little value."

[1] Report of the Poor Law Commission, 1909, *Q.* 51896.

tricts of a few large towns. All the arguments against the gratuitous, indiscriminate, and unconditional medical attendance afforded by the out-patients' departments of the hospitals appear to us to apply, in even greater strength, to the free dispensaries and medical missions; with the added drawbacks, that they are not, as a rule, under responsible and specialised medical supervision, and that they are not able to offer immediate institutional treatment to those of their patients whom they find to require it. The "Medical Missions," in particular, were stated to be "the worst of the whole lot . . . mixing up medicine with religion," and seeking to attract persons to religious services by the bait of "cheap doctoring."[1] In our opinion, all these centres for the gratuitous, indiscriminate, and unconditional dispensing of medical advice and medicine, far from meriting encouragement, or offering opportunities for extension, call imperatively—at any rate where they involve the gathering of crowds of sick persons in halls and passages—for systematic inspection and supervision by the local Medical Officer of Health, in order to ensure that they are not actually spreading more disease than they are curing.

(iii.) *Medical Clubs*

We pass now to those agencies for domiciliary treatment which are based on contributions from the persons attended to, wholly or partially covering the cost of the service. The most widespread of these agencies is the more or less formally organised medical "club," or "contract practice"—it may be a

[1] Report of the Poor Law Commission, 1909, *Qs.* 33690, 33691.

regular friendly society giving also sick pay; it may, on the other hand, be merely a scratch enrolment of members got up by the doctor himself for his own convenience and profit—the members in either case paying a small sum weekly or quarterly whilst they are well, in order that, when they happen to be ill, they may obtain medical attendance and medicine free of charge. This "club practice," which has, in one or other form, greatly increased during the past few decades, has plainly some advantages. The poor pay something towards their own doctoring, and the feeling that they are themselves paying for it increases their independence and self-reliance. They pay for it, too, by the device of insurance, by which the cost of the years of sickness, being spread over a large number of persons, falls in effect upon the years of good health, when the small periodical instalments can be borne with the least inconvenience.

Notwithstanding these advantages, there is, we notice, a feeling of uneasiness among the medical profession,[1] and, we think, also among the clients of this club or contract practice, as to the real benefits of the arrangement. The contracts so extensively made by the organised friendly societies for medical attendance on their members are constantly producing strain and friction in the relations between the societies and the local practitioners whom they employ, breaking

[1] It has been represented to us that the great growth of these medical clubs and of "contract practice" in some districts has seriously undermined the remuneration of the local medical practitioners; and that a large part of the growth has been actually at their expense. In view of the facts that the work of the Poor Law Medical Officers has certainly not decreased, and that of the Public Health Authorities and voluntary hospitals has steadily increased, it appears probable that the increase in club and contract practice represents, in part, at any rate, an absorption of those who formerly paid fees as individual patients.

at intervals into open warfare. The doctors allege that the remuneration allowed to them is so insufficient as hardly to cover expenses, whilst many persons of substantial means take advantage of the society membership.[1] The members of the friendly societies, on the other hand, complain that they get only perfunctory attendance, that the doctor favours the committeemen or other influential members, and that he seeks to recoup himself by charging fees for all the other members of the family. We need not consider these mutual recriminations, except in so far as they reveal conditions inherently inimical to the cure and prevention of disease. We have it in evidence that "the club doctor is not infrequently regarded as an inferior kind of practitioner. I have known," says a Medical Officer of Health, "several cases where members of clubs, on the occurrence of serious illness in themselves or their families, have discarded the services of the club doctor and incurred the expense of employing a private practitioner. A few weeks ago I was asked by a workman whether I thought a 'club doctor' was competent to treat a case of scarlet fever. . . . From my own experience in club practice, I can testify to the extremely unsatis-

[1] A vivid picture of this friction and conflict was given in *The Battle of the Clubs*, by the Special Commissioner of the *Lancet*. Much of the conflict is waged round the so-called "income-limit." "Friendly societies," said a witness before the Poor Law Commission, "were originally started to afford sick pay and medical attendance to the class immediately above pauperism, that of artisans, labourers, etc., and the contributions were so arranged as to pay the doctor something, perhaps half of what he would have charged, taking an average; but they have now been taken possession of by a higher class which ought to pay better fees, and the contributions are utterly inadequate to pay for modern medical attendance, involving, as it does, estimation of opsonic index, bacteriological investigations of secretions, serum therapy, etc., and the performance of many operations which were unthought of when the rates were fixed." (Report of the Poor Law Commission, 1909, *Q*. 70631, par. 7.)

factory conditions under which it is carried on. The examination of a patient should be conducted on the principle laid down by Trousseau, 'Interrogate all the functions,' but in a busy club practice it is impossible to interrogate even one function with sufficient care."[1] But besides the adverse influence on the public health which medical attendance upon such conditions must necessarily exercise, the contract practice of friendly societies fails altogether to provide for some of the classes for whom the provision of medical aid is, in the public interest, most essential. Speaking broadly, the friendly societies do not provide medical assistance for any woman, whether married or single,[2] or for children. They do not, if they can help it, admit "bad lives," against which all friendly societies protect themselves by a medical examination prior to admission, or any persons suffering from constitutional defects, or incipient disease. Nor do they provide for persons, even if already admitted to membership, who suffer from venereal diseases or the results of alcoholic excess. Taken together these excluded classes must amount to more than three-fourths of the population.

Much the same objection applies to the private medical clubs established by doctors for their own profit. It is true that, unlike most of the friendly societies, they do provide for children and also for wives, though midwifery is not included. But the

[1] Report of the Poor Law Commission, 1909, Appendix No. xlv. (par. 29) to vol. ix.

[2] The friendly society contract for medical attendance habitually includes members only, not their dependents. Friendly societies for women are objected to. The doctors, we are told, "boycott female Courts." In one town the Medico-Ethical Society, to which all the best doctors in the town belong, has a rule that, "No female club be accepted by any member of the Society." (*Ibid.* Appendix No. ci. (par. 26) to vol. v.)

remuneration is practically never sufficient[1] to enable the doctor to devote the time and attention necessary for really curative work. There is the same exclusion of "bad lives,"[2] with the additional drawback that, in the doctor's own medical club, there is no obligation to continue the membership of any member who develops chronic disease, or even to continue the club at all if he thinks that the average sickness has become too great.[3] Needless to say there is no idea of prevention, or even of taking precautions against the communication of disease. "The long waiting in the crowded waiting-rooms at the doctor's surgery," we are authoritatively informed, "tends to spread infectious disease, to injure the health of the patient and to cause considerable loss of time, which in many cases inflicts inconvenience or even actual loss on the poor. Moreover the doctor should take account of the home conditions of the patient. In the home there are various influences which assist or retard

[1] "The amount paid by these clubs to medical men," said one witness, "is generally 3s. per annum per member, and as the doctor provides all medicines this does not give a living wage to the doctor, hence the work is often unsatisfactory." (Report of the Poor Law Commission, 1909, Appendix No. lxxxiii. (par. 15) to vol. iv.) "Club fees are so low," deposed a local secretary of the British Medical Association, "that the medical men cannot do justice to the patients; the fees vary from 3s. to 4s. a member per annum." (*Ibid.* Appendix No. civ. (par. 2) to vol. iv.) "I may state this with the greatest positiveness," stated a Medical Officer of Health, "that medical men would much rather be without any sort of contract practice than have it. They simply take clubs . . . in order to keep somebody else out." (*Ibid.*, *Q.* 38844.) "I . . . am opposed to them on principle," testified a hospital surgeon, "because . . . it means a sweating of the medical profession on the one hand, and a perfunctory and inefficient performance of duties on the other." (*Ibid.* Appendix No. lxxxvi. (par. 17) to vol. iv.; see also *ibid.*, *Qs.* 27908, 41717, 41888 (par. 10 (b)), 92534 (par. 20), and Appendix No. cxxxii. (pars. 7, 8) to vol. iv.)

[2] *Ibid.*, *Qs.* 74818-22. "They take very great care," deposed Sir William Chance, "only to take in cases they know will pay them." (*Ibid.*, *Q.* 29297.)

[3] *Ibid.* Appendix No. lxxv. (par. 13) to vol. vii.

recovery, and the doctor should make himself acquainted as far as possible with these conditions and endeavour to modify them in the interest of the patient. For instance, sanitary defects should be reported to the sanitary authority, and advice should be given as to the sanitary ordering of the home. The overworked club doctor, however, has time for none of these things. He reduces his domiciliary work as much as possible and encourages the patients to come up to his surgery for treatment, and it is extremely rare for him to report anything to the sanitary authority except cases of notifiable infectious disease."[1] There is the same temptation to supply only the cheapest medicines that we have seen to prevail where the Poor Law Medical Officer has himself to provide drugs. There is even a tendency, it is said, to pander to the medical superstitions of the sick rather than correct their bad hygienic habits. "To the poor people who crowd his surgery," as one overworked club doctor explained, "he must be equally subservient. They must not be allowed to grumble about the club medical man; and to ensure their goodwill it is best to treat them more in accordance with their palates than with their symptoms. To satisfy these patients it is necessary to give them a lot of medicine. It must be a dark medicine with a strong taste, preferably of peppermint."[2] Hence we are not surprised to be informed by a responsible medical witness that, to the respectable medical practitioner, "club practice is most distasteful. No practitioner remains a club doctor any longer than

[1] Report of the Poor Law Commission, 1909, Appendix No. xlv. (par. 29) to vol. ix.

[2] *The Battle of the Clubs*, by the Special Commissioner of the *Lancet*, p. 120.

he can possibly help. The disadvantages of club practice constitute a burning question for the medical profession at the present time. In various parts of the country practitioners are banding together to resist what are spoken of as the 'sweating' methods of the clubs, and the weapon of the strike (with the concomitant ostracism of the 'blackleg') is being freely employed by these associations of medical practitioners in their struggle for better conditions of club practice."[1] To quote the words used by a medical witness, himself a Poor Law Guardian, "the clubs are a failure, both for the patients and for the medical men."[2]

(iv.) *Provident Medical Associations and Provident Dispensaries*

It is, we think, impossible to avoid the conclusion that the spontaneous and competitive organisation of medical insurance—far from being in a position to supersede the Poor Law medical service—has, in all its varied forms, proved in practice to be inimical alike to the medical profession and to the public health. This result has gradually forced itself upon the conviction of philanthropists and the medical organisations. In certain provincial towns the local medical practitioners have combined to establish "Provident Medical Associations," on a plan which, after some hesitation, has received the endorsement of the British Medical Association.[3]

[1] Report of the Poor Law Commission, 1909, Appendix No. xlv. (par. 29) to vol. ix.

[2] *Ibid.* Appendix No. clix. (par. 9) to vol. iv.; see also *Qs.* 44618, par. 30.

[3] *Ibid., Qs.* 39153, etc.

These Provident Medical Associations differ from the medical clubs got up by individual doctors, and from the contract practice of the friendly societies, only in the fact that all the medical men of the locality who are willing to take part share in the practice and in the contributions, in exact proportion to the number of members who select each of them as their doctor. "We consider it undesirable," testified the representatives of the British Medical Association, "that there should be the existing monopoly in contract practices; we think they should be thrown open so that all the patients should have a choice of all the medical men in the district."[1] The provident dispensaries established by philanthropists in London and some other places are, for the most part, based upon the same plan of allowing the contributing member a choice of doctors, and sharing the contributions among all the doctors on the list in proportion to the number of patients whom they severally attract. These deliberately organised arrangements for combining medical insurance with free choice of doctors have made little headway;[2] owing, it is said, to the difficulty of inducing the doctors to combine,[3] and, in the Metropolis and other large centres of population, also to the rivalry of free dispensaries and medical missions and the out-patients' departments of the hospitals that we have already described.[4] But as it was suggested to the Poor Law Commission by responsible

[1] Report of the Poor Law Commission, 1909, *Q.* 39151.

[2] "Provident dispensaries have not been a success—not in London, at any rate." (*Ibid.*, *Q.* 77672.) "Somehow or other the provident dispensary system has not caught on." ("Hospital Reform," by T. Garrett Horder, p. 2, reprinted from the *British Medical Journal*, 30th March 1907.)

[3] Report of the Poor Law Commission, 1909, *Q.* 42643.

[4] *Ibid.*, *Q.* 33805.

witnesses[1] that charitable persons might be urged to foster the provident dispensaries and Provident Medical Associations; that Poor Law medical relief might be so restricted as to compel all poor persons to join them, as the only way by which they could obtain medical assistance in their hour of need;[2] and even that some such system of Provident Medical Insurance, with free choice of doctors, might well receive a state subsidy, and might actually be made to take the place of the outdoor Poor Law medical service, it became necessary to examine with some care both its results and its possibilities.

After careful consideration of the working and results of medical insurance in all its various forms, our conclusion is that we should hesitate before recommending to the charitable any deliberate extension of it, even at its best. "It must be borne in mind," observes a Medical Officer of Health, "that the 'self-supporting' character of existing forms of medical insurance is largely an illusion. There are many diseases that a club doctor does not attempt to treat. The vast majority of notifiable cases of infectious disease, lunacy, and an increasing number of cases of tuberculosis are treated in rate-supported institutions. Abdominal surgery, ophthalmic surgery, any surgical operation except the most trivial, and

[1] See, for instance, Report of the Poor Law Commission, 1909, *Qs.* 33115 (par. 6), 33177, 33487 (par. 49), 41558, 42509 (pars. 14, 15, 18), 51859 (par. 8), and Appendix No. xvi. (par. 15) to vol. v. This plan was also advocated by the Medical Investigator appointed by the Poor Law Commission. (Report on Poor Law Medical Relief, by Dr. J. C. M'Vail, Appendix, vol. xiv., pp. 158-62.)

[2] It is claimed that this has been done at Bradfield. By making Poor Law medical relief more irksome and even more costly to the recipient, than belonging to a medical club, it has been practically superseded by a great growth of such medical clubs. (Report of the Poor Law Commission, 1909, *Qs.* 29895, 29896.)

many other conditions are treated in hospitals that are supported by private charity. If these institutions were not available, clubs and provident dispensaries could not be conducted on their present conditions, and, therefore, it is true to say that, in a sense, these so-called 'self-supporting' medical agencies are partly supported by the rates and partly by private charity."[1] But even with regard to the kind of sickness with which they actually deal; the indigestions, the chronic catarrhs, the sores and eruptions, the palpitations, the dragging pains of the woman worker, the rheumatism and lumbago of the outdoor labourer—the quality of their ministrations leaves, as we have seen, much to be desired. In nearly all these cases, as was over and over again pointed out in evidence before the Poor Law Commission, what is needed is not so much "a bottle of physic" or an ointment, as some alteration in the unhygienic methods of living to which so many of the poor, whether from ignorance, from sheer poverty, or from lack of self-control, are unfortunately addicted. But this is just where all the forms of provident clubs or dispensary practice fail. To quote the words of an experienced physician, "they give people a bottle of medicine, but they do not do much else. They take no supervision of their home surroundings, and no supervision of the general hygiene, and they never provide anything in the way of food and nourishment. It is very often much more food that is wanted, for instance, with the children. The cost of feeding an infant alone is 3s. a week, and the people cannot always afford it. They all get an

[1] Report of the Poor Law Commission, 1909, Appendix No. xlv. (par. 31) to vol. ix.

attempt at food in the shape of cod-liver oil or something of that kind from the hospital."[1] "The amount of medicine consumed," deposed a medical expert with regard to perhaps the largest and most flourishing of the provident dispensaries, "is out of all proportion to the amount of advice taken."[2] All this applies with even greater force where, to the device of medical insurance, there is added a free choice of doctors. The medical practitioner who is chary with his drugs, but prodigal and plain-spoken in his advice about giving up bad habits and injurious excesses in eating and drinking, is seldom popular among the poor. To give either public encouragement or public aid to any system of medical attendance among the poor that was based on a free choice of doctors, and on their remuneration according to the number of patients that they severally attracted, could not fail, in our opinion, to perpetuate and intensify the popular superstition as to the value of medicine and the popular reluctance to adopt hygienic methods of life; and—as we fear we must add—could not fail also to foster the injurious medical demagogy to which, in the stress of competition, these popular feelings already give occasion.[3]

[1] Report of the Poor Law Commission, 1909, *Q.* 36946.

[2] *Ibid.* Appendix No. cxxxii. (par. 38) to vol. iv.

[3] To the Chancellor of the Exchequer the proposal to supersede the present Poor Law medical service by a system of State-subsidised medical insurance, involving free choice of doctors, will appear impracticable for quite other reasons. Any such system of provident insurance, coupled with the boon of free choice of doctors, must necessarily be offered simultaneously to the poor all over the country. The 3713 District Medical Officers in England and Wales, the 800 in Scotland, and the 845 dispensary doctors in Ireland hold definite salaried appointments, nearly always during good behaviour, from which they could not be displaced without the usual compensation. This, upon the customary basis, would involve a lump sum payment of about £5,000,000. On the other hand, the mere transference of these officers, at their existing emoluments, to a new or reorganised county medical service,

Apart from the general shortcomings of any system of medical insurance so far as its contributing members are concerned, it is, in our judgment, for other reasons quite impossible to employ it as a substitute for the Poor Law medical service. We note, to begin with, that neither the Medical Association nor the provident dispensaries have themselves had any hope of including in their membership those for whom the Poor Law medical service is provided, namely, the destitute. It has, however, been suggested that the Local Authority, instead of having a Poor Law Medical Officer, might enroll all the persons now or hereafter entitled to medical relief as members of the local Provident Association, simply by paying the requisite contributions in their names.[1] But, if this were done, or done whenever any case might prove to require medical aid, we fail to see what motive there would be for any person to pay his own contribution to the Association. One of the strongest inducements at present to join a medical club or otherwise to pay for one's own doctoring is said to be the free choice of doctors which is thus secured.[2] The poor, we are told, strongly resent having to go to one particular doctor whether or not they like him or have confidence in his treatment. But if the labourer who has neglected to contribute to the Provident Medical Association finds himself, when illness overtakes him, with just the same privilege of choosing his own doctor and of changing with equal facility from one doctor

which could take place simultaneously all over the country, leaving desirable readjustments to be made only as vacancies occurred, would involve no compensation.

[1] Report of the Poor Law Commission, 1909, *Qs.* 33118 (par. 6 (c)), 33177, 33610, 42525, 51859 (par. 8).

[2] *Ibid.*, *Qs.* 33734-7.

to another,[1] as if he had himself contributed, it is difficult to see why anybody should be at the pains of contributing at all. Thus the use of these Provident Medical Associations by the Destitution Authority, in order to provide for the paupers requiring medical treatment, would very shortly bring the self-supporting side of these associations to an end.

It has been suggested that the difficulty would be avoided if the Provident Medical Associations were fortified by a compulsory enactment, requiring every adult to become a member for himself and his dependents. The short answer to this suggestion is that it is in this country, under present conditions, totally impracticable. For the Government to extract any weekly contribution—let alone the substantial contribution that would be necessary — from the millions of unskilled and casually employed labourers of our great cities, from the hundreds of thousands of home-workers in the sweated trades, from the women workers everywhere, and from the tens of thousands of vagrants and their dependents, would be an impossible task. To bring the Government into the field as a

[1] It is an incident of the absurd popular belief in medicine, and the anarchy fostered by the full choice of doctors, that there is already any amount of overlapping. "It is quite possible," says a Medical Officer of Health, "that a Poor Law doctor, a club doctor, and the doctor in charge of the hospital out-patient department may attend the same patient at the same time. I once heard of a case where the patient had secured in this way three bottles of medicine from three different doctors, and took from one in the morning, from the second in the middle of the day, and from the third in the evening." (Report of the Poor Law Commission, 1909, *Qs.* 41888 (par. 8), 41921-3.) "It is common," testifies a District Medical Officer, "for people to use two institutions (for outdoor medical treatment) at the same time . . . and to throw away one or both lots of medicine." (*Ibid.*, *Q.* 43998, par. 50.) Apparently 11 per cent of all the out-patients at the voluntary general hospitals of London are, or have recently been, in receipt of poor relief. (Report on the Overlapping of the Work of the Voluntary General Hospitals with that of Poor Law Medical Relief, by Norah B. Roberts, p. 6.)

rival collector of weekly pence in the skilled trades—whether or not deducted by the employer from the wage—would excite the strongest opposition, not only from those doctors who have large medical clubs of their own, but also from the whole Trade Union movement, from all the friendly societies and from the tens of thousands of agents and collectors and the millions of policy-holders of the industrial insurance companies—an irresistible phalanx! Nor would such a method of levying the revenue required to pay for universal medical attendance be, in accordance with the classic canons of taxation, economically justified. It would, in short, be in the nature of a poll-tax; and England has not had a poll-tax since 1381. Finally, for the Government in this way to guarantee the revenue of these Provident Medical Associations would, we suggest, involve the Government in the necessity of guaranteeing the management. We should thus have got round again to a State medical service, but this time to one of gigantic dimensions.

We have left to the last the objection that seems to us the most serious against the proposal to supersede the Poor Law medical service by any system of medical insurance, whether voluntary or compulsory, which involves the free choice of doctors by the persons for whom the medical attendance is provided. In the treatment of poor persons, the problem is complicated by the frequent necessity for supplementing the medical attendance and medicine by "medical extras," that is to say, nourishing food and stimulants of one sort or another. It must necessarily be left to the doctor to recommend authoritatively in which cases this extra nourishment is required for curative treatment. If the patient can choose his doctor, he will

inevitably choose the one who is most addicted to ordering "medical extras,"[1] and the medical practitioner whose remuneration is dependent on the number of patients whom he attracts will be under a constant temptation to recommend, at the cost of the rate-payer, for any person who looks anæmic, the additional food or stimulant for which all poor patients have a craving. To give to the destitute, at the cost of the rates, not access to the particular medical treatment that their ailments really require, but the power to choose, and to enrich with their fees, that one among all the doctors of the town who most commends himself to them would be, we suggest, most disastrously to aggravate all the existing temptations to medical demagogy.[2] To expect this freely chosen doctor to give, not the "strong medicine" beloved by the poor, or the appetising "medical extras" for which they crave, but the stern advice about habits of life on which recovery really depends—to look to him to speak plainly about the excessive drinking or the unwise eating which cause two-thirds of the ill-health of the poor; or to stop the overcrowding and bad ventilation that encourage tuberculosis; to insist, in measles or whooping-cough, on the troublesome precautions against infection which may check the spread of these diseases; or to press for the removal of his patients to an institution whenever he believes that they would be better cured there—would clearly be chimerical.[3] What would tend to be provided under

[1] This has been the experience of the Provident Medical Associations at Birmingham. (Report of the Poor Law Commission, 1909, *Q.* 44126.)

[2] It was given in evidence before the Poor Law Commission that any plan of letting the pauper choose his own doctor "would be very bad because the pauper would not be under proper discipline." (*Ibid.*, *Q.* 34179.)

[3] The lack of connection in the public mind—even the divorce in the minds

such a system would be, not preventive or curative treatment or hygienic advice, but, in the literal sense of the words, medical *relief*, and that wholly without conditions. On all these grounds, the proposal to supersede the Poor Law medical service by any system of universal medical insurance appears to us, not only politically impracticable, but also entirely retrograde in policy, and likely to be fraught with the greatest dangers to public health and to the moral character of the poor.

B.—The Institutional Treatment of the Sick

We have still to consider the institutional treatment of the sick provided by voluntary agencies. This is practically confined to the endowed and voluntary hospitals, and of these, fortunately, the merits are so well known as to enable us to be brief. They are already made use of freely by the very poorest, and Boards of Guardians everywhere transfer suitable cases to them from the workhouse infirmary, usually making, as is recommended by the Local Government Board, a contribution towards the cost of maintenance either of these particular patients or of the institution

of medical practitioners themselves—between the medical treatment of an ailment, and "the cure of the bad . . . habits" (*ibid.*, *Q.* 38758, par. 28) which are actually producing that ailment, seems to us, from the standpoint of Public Health, one of the strangest anachronisms of the present day. Some medical practitioners actually declared, in one and the same statement, that the arrangements for the medical attendance of the poor left nothing to be desired, and that the infants were dying in numbers; that no further medical attention was required, and that the people were living most unhealthy lives. "The poor," says one doctor, "do not suffer from insufficiency of medical attendance. . . . [There is] an utter want of knowledge . . . of the ordinary rules of health and treatment of minor ailments. The treatment of babies by young mothers from ignorance is appalling." (*Ibid.* Appendix No. lxxxii. (pars. 8, 9) to vol. vii.)

as a whole.[1] But the endowed and voluntary hospitals are very far from sufficing for the needs of the sick poor.[2] They appear to provide in the aggregate little more than 25,000 beds, which is only about one-fourth of the number of sick beds already actually occupied in the workhouses and workhouse infirmaries. Moreover, instead of being distributed geographically as required, the voluntary hospitals, whether general or special, are mainly concentrated in London and the sixty or seventy larger or more ancient provincial towns, where physicians and surgeons and their students love to congregate. The selection of the diseases which these hospitals are willing to admit for treatment is, alike from the standpoint of preventive medicine and from that of the needs of the poor, equally arbitrary. It was because the voluntary hospitals refused to provide for zymotic diseases, or for any epidemic, that the municipal hospitals arose. It was because they would not deal with cases of chronic disablement that the Poor Law had to develop its "hospital branch." "No general hospital," stated a Local Government Board Inspector, "will admit a man suffering from delirium tremens: hence the Poor Law infirmaries are charged with such cases."[3] "All cases of venereal disease," says a Poor Law Medical Officer, "are now practically debarred from the general hospitals, to the great detriment of the com-

[1] Report of the Poor Law Commission, 1901, *Qs.* 268, 737, 930, 5046, 6019, 7938, 8994, 11044, 18653, 18753, 20888, 21335, 21378, 21383, 21494, 23384, 32608-10, 32805-7, 37921, 42237, 45586, 47501, 50468, 50856, 51107, 52533, 52577-87, and Appendices Nos. lxv. (par. 4), lxxxvi. (par. 10), xciii. (par. 14), cxxii. (par. 13), cxxxii. (par. 33), cl. (par. 23 (a)) to vol. iv.; Report on Poor Law Medical Relief, by Dr. J. C. M'Vail, Appendix, vol. xiv. pp. 61-2; Report of Departmental Committee on Poor Law Medical Relief (Scotland), 1904, p. 86.

[2] Report of the Poor Law Commission, 1909, *Q.* 2887.

[3] *Ibid.* Appendix No. xxvi. (A), par. 41, to vol. i.

munity."[1] To-day there is no sign of any development of medical charity competent to provide institutional treatment all over the country for the two gravest national diseases, tuberculosis and syphilis. In fact, what the voluntary hospitals like to deal with is the acute case and the unique or "interesting" case—just those which are least prevalent and which, in all probability, are, to preventive medicine, the least important. Moreover, even where voluntary hospitals exist, and even in those diseases which they select for treatment, their provision, excellent as it is so far as it goes, has the capital drawback of disconnection with domiciliary inspection and supervision before and after the acute stage of the illness. In fact, as it has been paradoxically put, the voluntary hospital is not concerned with the treatment of disease; what it treats and treats so magnificently is collapse from disease. Until the patient is so ill that he cannot continue at his employment, he does not enter the hospital. As soon as he is well enough to be discharged, his case disappears from the ken of the hospital staff. And it has been given in evidence that this tendency to get rid of a case as soon as the acute stage is passed, or as soon as it is apparent that the disease is a chronic or incurable one, is leading more and more to the prompt transfer of such patients from the hospital to the Workhouse or Poor Law infirmary.[2] Thus, whilst it may be foreseen that the Local Authority dealing with the sick poor will, under proper conditions as to

[1] Report of the Poor Law Commission, 1909, *Q.* 37927, par. 10.

[2] *Ibid.*, *Qs.* 32618, 32675-7, 32757-63, 33380, 49171 (par. 10), 49192, 51119, 98105; see also Report on Poor Law Medical Relief, by Dr. J. C. M'Vail, Appendix, vol. xiv. p. 42; Report on the Overlapping of the Work of the Voluntary General Hospitals with that of Poor Law Medical Relief, by Norah B. Roberts, pp. 13-14; Report of Departmental Committee on Poor Law Medical Relief (Scotland), 1904, p. 24.

payment, be able to make increasing use of the voluntary hospitals for the treatment of the acute stages of certain diseases, and especially for operative surgery, these hospitals, far from rendering unnecessary "the Hospital Branch" of the Poor Law medical service, will, on the contrary, tend more and more to reject or to transfer all other cases to rate-supported institutions of one kind or another.

CHAPTER V

THE TREATMENT OF THE SICK BY THE PUBLIC HEALTH AUTHORITIES

THE voluntary agencies treating the sick poor are not the only rivals whose work overlaps or surrounds that of the Poor Law medical service. It was formally brought to the notice of the Poor Law Commission by the Medical Officer of the Local Government Board for England and Wales,[1] by the Medical Member of the Local Government Board for Scotland,[2] and by the Medical Commissioner of the Local Government Board for Ireland,[3] as well as by the Medical Officer of the Board of Education for England and Wales,[4] that, ubiquitous and expensive as is the Poor Law medical service, it is not the only one maintained out of the rates. Every part of the United Kingdom is now provided with an equally ubiquitous, quite as highly qualified, and nearly as costly a service of public Medical Officers,

[1] Report of the Poor Law Commission, 1909, *Qs.* 92531-93029; see also Dr. Newsholme's "Memorandum by the Medical Officer of the Local Government Board on the Unification of the Official Medical Services," *ibid.* Appendix No. liv. to vol. ix.

[2] Report of the Poor Law Commission, 1909, *Qs.* 56605-57036, 61904-62080.

[3] *Ibid.*, *Qs.* 99821-100019; see also Dr. Stafford's "Some Notes on Public Health, and its Relation to the Poor Law in Ireland" (Appendix, vol. x.).

[4] *Ibid.*, *Qs.* 94283-628.

maintained by the local Sanitary Authorities. To mention only England and Wales, under the various Public Health Acts the Municipal and Urban District Councils on the one hand, and the Rural District Councils on the other, are charged, under the supervision of the County Councils, with explicit responsibility for the health of their several districts —that is to say, for the maintenance in health of all the inhabitants thereof. To this end the Councils have been granted elaborate statutory powers, both of regulation and provision, some of them optional and some obligatory. The responsible heads of the medical departments above mentioned, as well as numerous Medical Officers of the Local Authorities concerned, described the very extensive functions which those Authorities are now fulfilling in the treatment and cure of the sick poor, amounting, in fact, to the provision of medical advice, attendance, or medicine, in one way or another, for possibly nearly as many patients—certainly as many acutely sick patients—as are under the care of the Poor Law medical service. And it was given in evidence by the responsible heads of the Departments concerned, as well as by the Medical Officers of Health themselves, that neither in legal theory nor in practical administration are the destitute sick excluded from their ministrations. We have, in fact, in every part

[1] The medical service of the Public Health Authorities has, apparently, not hitherto been made the subject of systematic description. We have compiled the following inadequate description from many sources, principally the statements and evidence furnished to the Poor Law Commission (especially those of Dr. Newsholme, Dr. Newman, Dr. Cooper-Pattin, Dr. Butler, Dr. Meredith Richards, Dr. S. Davies, Dr. McCleary, Dr. Cameron, Dr. Niven, Dr. Beatty, and Dr. Leslie Mackenzie); the reports of the health committees and Medical Officers of Health of the principal Municipal Corporations and District Councils; and Burdett's *Hospitals and Charities Annual*.

of the Kingdom two public medical authorities legally responsible for, and in many cases simultaneously treating, the same class of poor persons, sometimes even for the same diseases. So extensive and costly an overlapping, as yet not commonly known, compels us to describe at length the various developments of the Public Health as well as of the Poor Law service.[1]

(A) *Municipal Hospitals*

Starting from the provision of temporary isolation hospitals for cholera patients and then for those attacked by smallpox, the Public Health Authorities now maintain over 700 permanent municipal hospitals, having, in the aggregate, nearly 25,000 beds,[2] or nearly as many as all the endowed and voluntary hospitals put together. These vary in size and elaboration, from the cottage or shed with two or three beds set aside for an occasional smallpox patient, up to such an institution as the Liverpool City Hospital, divided into seven distinct sections in as many different parts of the city, and having altogether 938 beds, served by six resident and

[1] We omit from this survey the most extensive of all the hospital services of the country, that for the treatment of mental diseases. There are now nearly 100,000 persons of unsound mind in the asylums of the County Councils and County Borough Councils (and those of the Metropolitan Asylums Board). It is a peculiar anomaly that although these asylums are administered (except the last named) by Public Health Authorities, they are provided almost entirely for paupers, the cost of whose maintenance is mainly recovered from the several Boards of Guardians.

[2] We regret that no official return of these municipal hospitals has been published; and that no more complete list is available than that given in Burdett's *Hospitals and Charities Annual*, or that which may be compiled from the return of deaths in public institutions in the Annual Report of the Registrar-General of Births, Deaths, and Marriages in England and Wales.

seven visiting doctors, and treating nearly 5000 patients a year, for an average period of seven or eight weeks.[1]

The Manchester Town Council maintains the Monsall Fever Hospital, with 415 beds, which makes no charge whatever to the patients; another at Baguley, with 100 beds, and a third at Clayton Hill for smallpox cases.[2] The Birmingham Town Council has a couple of hospitals, having together 610 beds.[3] The Leeds Town Council provides a series of hospitals and isolation dwellings, principally for scarlet fever, diphtheria, and smallpox, accommodating over 600 persons, where "patients are admitted without any charge whether they belong to the families of rate-payers or of paupers."[4] These towns are typical of many others. Mention must here be made of the hospitals of the Metropolitan Asylums Board, because, though administered by a body largely made up of representatives of Boards of Guardians, and actually maintained out of the poor rates,[5] they have become, both by statute and by Local Government Board decisions, practically public health institutions. The dozen great hospitals thus maintained for smallpox, scarlet fever, enteric fever, and diphtheria now admit all cases recommended by any medical practitioner, irrespective of the patient's affluence.[6] The mainten-

[1] Report on the Health of the City of Liverpool during 1905, by the Medical Officer of Health.

[2] Report of the Poor Law Commission, 1909, *Q.* 38380, par. 37.

[3] *Ibid.* Appendices Nos. cxxxvii. (par. 1 (a)) and cxxxviii. (par. 2) to vol. iv.

[4] *Ibid.*, *Q.* 41489, pars. 2-5.

[5] *Ibid.*, *Qs.* 64-9, 23253-6, 24155-499, and Appendix No. xvi. to vol. ii.

[6] "All classes in the borough," says the Medical Officer of Health for Woolwich, "make use of the fever hospitals [of the Metropolitan Asylums Board], the middle class less so than the working class, but it is by no means

ance and treatment, once made matter of charge, is now by virtue of the Public Health (London) Act, 1891, universally free. The inmates, originally exclusively paupers, are now explicitly declared to be not pauperised, the treatment, and even the maintenance, being (by the Diseases Prevention Act of 1883) expressly declared not to be parochial relief and to involve no stigma or disqualification whatsoever. The 3000 to 6000 patients in these hospitals, costing nearly £1,000,000 a year, may, therefore, be reckoned, though under a Poor Law Authority, as virtually patients of a Public Health Department, and they are accordingly excluded by the Local Government Board from the statistics and computed cost of pauperism. The municipal hospitals of the provincial towns, provided in the first instance usually for smallpox, have had their spheres extended to scarlet fever, enteric fever, and usually diphtheria; in addition to any stray cases of plague, cholera, or typhus that may turn up. But they do not stop there. The Public Health Acts do not prescribe the kind of disease to be treated in the hospital which they authorise,[1] and whatever may have been the primary object for which it was established there is nothing to prevent the Local Authority from admitting any sick patients whatsoever.[2] Hence,

unusual for the professional and well-to-do classes to send their children to these hospitals." (*Ibid.* Appendix No. xliv. (par. 1) to vol. ix.) Another Medical Officer of Health states, however, that such use by the professional and well-to-do classes, though not unknown, is "exceptional."

[1] Report of the Poor Law Commission, 1909, *Qs.* 37989, 39302, and Appendix No. xxxviii. (par. 10) to vol. iv. It is only the Isolation Hospitals Act of 1893, permitting combinations of Public Health Authorities to establish hospitals for infectious diseases, that is limited to notifiable diseases. There is equally no limitation in Scotland under the Public Health (Scotland) Acts, 1867 and 1890.

[2] It is somewhat remarkable that there is neither systematic governmental

although it is generally assumed that these so-called "Isolation Hospitals" are for infectious cases only, the list of diseases dealt with is steadily growing. In most towns of any size the municipal hospitals are willing to deal with puerperal fever (as at Crewe)[1] and with serious erysipelas. Cases of chickenpox are occasionally found in them; children suffering from scabies and pediculosis are occasionally admitted for temporary treatment;[2] and the door is now being opened to the two most deadly diseases of children beyond infancy. The Liverpool Town Council has decided to receive in its municipal hospitals "infants suffering from whooping-cough and measles . . . together with the mother or other natural guardian of the child if necessary,"[3] so far as there is room; and since it is recognised that "the isolation of the infectious sick in hospital is important and necessary," special steps have been taken to make room. "Provision of hospital accommodation for a limited number of cases," reports the Medical Officer of Health, "has now been made for measles."[4] Moreover, "isolation for a limited number of [whooping-cough] cases has

inspection nor central audit of these municipal hospitals. In the absence of this inspection and audit, the Town Councils are, in practice, quite free. Beyond sanctioning the loans for hospitals under the Public Health Acts, the Local Government Board, we understand, has no other official knowledge of this branch of civic activity than it can glean from the Local Taxation Returns, and from reading the Annual Reports of the 1800 Medical Officers of Health, with which it is supplied, but which it does not, for publication, summarise or review statistically. There appears to be no official statement how many sanitary authorities, or what proportion of the whole, either maintain their own hospitals, or make arrangements to use other hospitals, or make no provision at all.

[1] Report on the Health of Crewe, 1905, by the Medical Officer of Health, p. 39.

[2] Report of the Poor Law Commission, 1909, *Q.* 92531, par. 4 (A (i.)).

[3] Report on the Health of the City of Liverpool during 1905, by the Medical Officer of Health, pp. 19, 37.

[4] *Ibid.* p. 35.

been found."[1] At Liverpool, indeed, the municipal hospitals admitted and treated during the year 1905 nearly 200 cases, and in 1906 between 500 and 600 cases, of other diseases, including gastro-enteritis, pneumonia, tubercular meningitis, bronchitis, tubercular peritonitis, cystitis and nephritis, erythema, influenza, varicella, septicæmia, abdominal tumour, empyema and tubercle, psoas abscess, tetanus, syphilis, tonsillitis, laryngitis, pharyngitis, angina ludovici, and appendicitis, besides four cases of poisoning.[2] It appears to us difficult to believe that these can all be explained as being cases of mistaken diagnosis.

The assumption that the power of the Public Health Authority in the provision of hospitals is limited to contagious or infectious disease is, indeed, a mistake, though a common one. There are no such words of limitation in the sections of the Public Health Acts dealing with the matter.[3] For a long time, however, probably influenced by the common impression that their powers applied only to infectious diseases, no Public Health Authority sought to establish anything but an isolation hospital. In 1900 the Barry Urban District Council (which sends its infectious cases to a joint isolation hospital at Cardiff, and provides home nurses for such of them as are not moved), established, with the express sanction of the Local Government Board, a free municipal hospital exclusively for non-infectious cases, intended principally for accidents and urgent surgical cases. This municipal hospital has a medical staff of

[1] Report on the Health of the City of Liverpool, etc., p. 37.
[2] *Ibid.* pp. 202-9.
[3] Report of the Poor Law Commission, 1909, *Qs.* 22940-42.

eight visiting surgeons and physicians, an organised nursing staff, and seven beds in daily use.[1] The Widnes Urban District Council, which runs a fever hospital and a temporary smallpox hospital, was definitely informed by the Local Government Board that it was free to start also an accident hospital, and accordingly did so.[2]

But the greatest recent development has been in the provision for tuberculosis. The Brighton Municipal Hospital in 1906 actually dealt with more cases of phthisis than of any other disease, they forming a third of its whole number of patients, and amounting to nearly two per 1000 of the entire population of the town. The object of their admission is not so much immediate cure as treatment with a view to instruction in good hygienic habits. They are therefore admitted preferably at an early stage, before being invalided, and they are retained only a few weeks, passing then to their homes, where they are periodically visited. About half of all the known consumptives in Brighton have already been thus through the municipal hospital, with the result, it is believed, of great prolongation of life.[3] Special hospital provision for tuberculosis, primarily with educational objects, is accordingly now being made, one way or another, by many Public Health Authorities. At Manchester, the Town Council not only pays for beds at the Delamere and Bowden Sanatoria, but has for several years

[1] Report of the Poor Law Commission, 1909, *Qs.* 22942, 49222 (par. 1), 49231, etc., and Appendix No. xxv. (par. 24) to vol iv.; Report on Poor Law Medical Relief, by Dr. J. C. M'Vail, Appendix, vol. xiv. p. 43, and Appendix No. xvi. p. 288.

[2] Report of the Poor Law Commission, 1909, *Qs.* 10728, 10729, 22942.

[3] *Ibid.*, *Qs.* 92534, par. 4 (iii.), 92541-605; and Annual Report on the Health . . . of Brighton for . . . 1906, by Arthur Newsholme, p. 26.

opened special phthisis wards at its Clayton Vale Hospital.[1] At Leicester, the Town Council has set aside a special hospital block for curable cases, no charge being made for maintenance and treatment during the first month. They may stay for a second, a third, and even a fourth month, on payment of 10s. a week.[2] In Scotland it has even been definitely laid down by the Local Government Board that it is for the Local Health Authority to treat all cases of phthisis; and that sufferers from this disease should not come under the Poor Law at all.[3]

(B) *Municipal Treatment of Cases otherwise than in Hospital*

It is, however, not only by admission to hospital that the Public Health Authorities now treat individual cases. In certain instances, and for particular purposes, individual cases of disease are dealt with out of hospital. Alike in numbers and in degree this municipal outdoor medical service is rapidly growing.

(i.) *Notification and Disinfection*

We may notice first the notification of disease, the inspection as to isolation, the treatment of "contacts," and the arrangements for disinfection. This organisation, at first dependent on voluntary,

[1] Report of the Poor Law Commission, 1909, *Qs.* 38380 (pars. 38, 39), 38437, 38438, 38445-8; see also Report on the Health of the City of Manchester, 1905, by James Niven, pp. 168, 169.

[2] Report of the Poor Law Commission, 1909, Appendix No. cxliv. (par. 3) to vol. iv.

[3] *Ibid.*, *Qs.* 53286-9, 54029-35, 62676 (par. 24).

and only subsequently on obligatory, notification, has been extended from disease to disease, until it now covers not only plague, cholera, and typhus; erysipelas, puerperal fever, smallpox, scarlet fever, enteric, and diphtheria; but also, in one town or another, for this or that period, influenza, measles, and chickenpox. Puerperal fever, too, has become in a sort of way also separately notifiable by midwives. Arrangements for the voluntary notification of phthisis have been made in numerous towns (including Liverpool, Blackburn, Brighton, Northampton, Southwark, Finsbury), a payment of 2s. 6d. being made for each case. At Sheffield and Bolton this notification of phthisis has been made obligatory by a Local Act. Scotland has gone still further. Under the Public Health (Scotland) Acts, as amended in 1907, phthisis is compulsorily notifiable in Edinburgh and a large part of the country, including the whole of Lanarkshire outside Glasgow. And now, throughout England and Wales the Local Government Board has ordered the Poor Law Authorities everywhere to notify to the Local Health Authorities every case of phthisis that is observed in the pauper population.

Arrangements are also made by direction of the Board of Education for the Medical Officer of Health to receive weekly notifications, from the head teachers of all the public elementary schools, of all cases in which the children stay away on account of such diseases as measles, whooping-cough, chickenpox, mumps, ringworm, scabies, etc.[1] A Board of Guardians has strongly urged that ophthalmia

[1] See, for instance, Report of the Poor Law Commission, 1909. Q. 37605, pars. 26-8.

should be made compulsorily notifiable.[1] Medical Officers are now suggesting that not only pneumonia, influenza, and diarrhœa, but also cancer should be added to the list of notifiable diseases.[2] "As the result . . . of recent additions to our knowledge of cancer," reports one Medical Officer of Health (and this is only an echo of similar proposals made at Finsbury and elsewhere during the past decade), "I am of opinion that it is a disease which calls for public health measures; not, indeed, of a stringent nature, but dealing more with the necessity of destroying the dressings of cancerous ulcers, and for issuing warnings that persons dressing these cases should be careful to protect cuts or wounds of the hands, and to boil sheets and pillow-cases used by patients."[3]

(ii.) *Supply of Medicines and Antitoxin*

The importance, in certain diseases, of the prompt administration of specific remedies has led the Public Health Authorities to supply these gratuitously to all who will accept them; just as vaccination has, since 1840, been performed by the Poor Law Authorities, free of charge, on all who will submit to it. The Manchester Town Council, and various other bodies, distribute bottles of diarrhœa mixture to any one

[1] Kensington Board of Guardians to Kensington Borough Council, 1900; Monthly Report of Medical Officer of Health for Kensington, October 1909, p. 109.

[2] Report on the Health of the County of Dorset for 1905, by the various Medical Officers of Health (Sherborne Report), p. 28; Report of the Poor Law Commission, 1909, *Qs.* 37605 (par. 46), 37914.

[3] Report on the Health of Southend-on-Sea for 1905, by the Medical Officer of Health, p. 59.

in need of them, using all the police stations as distributing agencies.[1] But the remedy usually distributed gratuitously is the antitoxin serum for diphtheritic cases. The extreme importance of promptitude in the administration of this remedy, and the great saving of expense implied by the prevention of the spread of diphtheria, have led very many Public Health Authorities, sometimes after a vain attempt to enlist the co-operation of the Board of Guardians,[2] to supply it gratis, on demand, to any medical practitioner; sometimes, as at Blackburn and Stockport, through the police stations among other agencies.[3] In some cases the Municipal Authorities have gone further, and have paid Poor Law doctors and private medical practitioners to use it. Thus, the urban district council of Fenton, in Staffordshire, decided in October 1905, on the advice of the Medical Officer of Health, and as being less costly to the ratepayers than institutional treatment, to undertake the domiciliary treatment, so far as the injection of antitoxin was concerned, of all diphtheritic patients, and of all who had come in contact with them. For this purpose every medical practitioner in the district, including the District Medical Officers of the Board of Guardians, was, in effect, made, temporarily, an additional officer of the Urban District Council as Public Health Authority, and was paid a fee for each case so treated—amounting, for the next few months, to three or four per week.[4]

[1] Report of the Poor Law Commission, 1909, *Q.* 38380, par. 40.

[2] As at Norwich; see *ibid.* Appendix No. xlvi. (par. 6) to vol. ix.

[3] *Ibid.*, *Qs.* 37605 (par. 14), 38758 (par. 9).

[4] Report on the Health of Fenton, 1905, by the Medical Officer of Health, p. 49.

(iii.) *Municipal Out-Patients' Departments*

Another direction in which the Public Health Authorities have extended their treatment of individual cases is by opening an out-patients' department. At Willesden, finding that from 25 to 50 per cent of the cases were without any sort of medical treatment, the Public Health Authority, on the recommendation of the Medical Officer of Health, has established an out-patients' department at its isolation hospital for persons suffering from ringworm, impetigo, scabies, or ophthalmia.[1] At Newcastle-on-Tyne, where the Town Council subscribes 100 guineas a year to the dispensary, something like eight hundred "letters" are, in return, placed at the disposal of the Municipality. These "letters" each entitle the bearer to two months' gratuitous treatment, including domiciliary visits where required, and, in practice, recommendations for admission to various voluntary hospitals, etc., if institutional treatment is necessary. At present these "letters" are distributed by Town Councillors. The Town Council also maintains salaried Health Visitors, who go round the town under the direction of the Medical Officer of Health, and who thus discover many cases of disease, but have, at present, no organised method of securing medical attendance. "The Medical Officer of Health himself has . . . recently suggested to the Corporation that they should increase their subscription to the Dispensary . . . with the object of getting more

[1] Report of the Poor Law Commission, 1909, Appendix No. xliii. (par. 17) to vol. ix. The establishment of similar out-patients' departments or "dispensaries" for the treatment of phthisis, is, we believe, under consideration in various towns.

letters, *and that these letters should be distributed by the Health Visitors.*"[1]

(iv.) *Pediculosis and Scabies*

For the particular bodily affections of pediculosis and scabies—which, as being morbid conditions of the body susceptible of treatment and cure, must be classed as diseases—Parliament has expressly authorised gratuitous provision, which is not to be deemed parochial relief or charitable allowance.[2] "Baths and disinfecting chambers for the cleansing and purifying of the bodies and clothing of persons infested with vermin or parasites" are now provided by various municipal authorities. "No charge is made for the use of these facilities, and applicants will be treated with every consideration."[3] This small "attempt in the treatment of certain skin diseases," as it has been apologetically described, represents, it is admitted, "a departure from the principle of not treating disease, but it has its justification in the contagious nature of such disease"—a justification which would carry us far. But even for pediculosis only one Public Health Authority (that of Marylebone) has successfully treated 32,500 patients in seven years.

(v.) *Medical Care of School Children*

The supervision of the health of the children in

[1] Report of the Poor Law Commission, 1909, *Qs.* 51466 (pars. 12, 14, 18), 51511, 51601-7.

[2] The Cleansing of Persons Act, 1897.

[3] Public notice by the Medical Officer of Health for Hackney, April 1905. Similar facilities are afforded by the Metropolitan Borough Councils of Marylebone, Woolwich, etc., whilst that of Finsbury pays the Board of Guardians to perform the service. (Report on the Health of Finsbury, 1907, by the Medical Officer of Health, p. 193.)

the public schools is opening up another range of individual treatment by the Public Health Officers. Many of the children attending the public elementary schools were found to be suffering from lack of medical attendance and treatment: they had upon them untreated cuts and sores; they had adenoid growths requiring surgical removal; their glands and tonsils were swollen and inflamed; they had incipient curvature needing remedial drill; their eyesight was often defective, sometimes rapidly degenerating for lack of proper spectacles; they had discharges from the ears, and inflamed eyelids, and skin diseases of various kinds—to say nothing of such gravely contagious conditions as ringworm and favus, and "dirty heads."[1] In the large towns of Scotland the condition of the children in these respects was found to be, if anything, even worse than in England.[2] These tens of thousands of children were, from one cause or another, plainly destitute of the medical attendance that was necessary for them. According to law, it

[1] We may give two testimonies out of many. At Wimbledon, which is not a "slum" district, the Medical Officer of Health found, in 1904, "out of an average attendance of 5430 in the total of schools, 358 cases of defects of sight have been detected in the year . . . 216 affections of the nose, throat and ear . . . and the total number of notifications sent to parents in the year from the 5430 is 852, which works out at 15·6 per cent of the total number of children." (Report of Inter-Departmental Committee on Medical Inspection and Feeding of Children attending Public Elementary Schools, 1905, vol. ii. Cd. 2784, *Q*. 5582.) Out of 2378 children in Worcestershire schools examined by the schools' Medical Officers under the new Act, 1660 were in such a condition that it was necessary to call the attention of their parents: 545 had neglected heads; 254 had neglected teeth; 279 had enlarged tonsils and adenoids; there were 44 cases of external eye diseases; 120 cases of defective eyesight; 70 children were consumptive; and 115 were anæmic.

[2] See the reports of Dr. Leslie Mackenzie and Dr. Hay in the Report of the Royal Commission on Physical Training (Scotland), 1903, vol. i.; also *Qs*. 56943, 56945-50; Report on the Physical Condition of Fourteen Hundred School Children, by the Edinburgh Charity Organisation Society, 1906; and Report of Dr. Leslie Mackenzie and Captain Foster on the Physical Condition of the Children of Glasgow, 1907.

was the duty of their parents to provide this medical attendance, and, in case of inability to pay for it, to apply to the Relieving Officer for a Medical Order. It was the duty of the Board of Guardians to grant that Medical Order whenever necessary, and to prosecute the parents under the Prevention of Cruelty to Children Act if they failed to apply. But, so far as we can ascertain, the Guardians do not seem either to have taken any steps to furnish the medical treatment; nor yet, in the vast majority of cases, to act upon their statutory duty of proceeding against the parents who were thus guilty of neglect of their children.

Owing to this widespread failure of the Destitution Authorities in England and Scotland alike to relieve the destitution of children in the matter of medical attendance, and to the equal failure of voluntary agencies,[1] we find the duty gradually undertaken—even to the stretching of their legal powers[2]—by one of two other authorities. In the smaller boroughs we see the Public Health Authority permitting the Medical Officer of Health to accede to the express or implied invitation of the Local Education Authority to institute a medical examination of all the children in the public elementary schools; sometimes on the plea of detecting infectious disease, sometimes frankly to discover physical defects rendering the children

[1] Report of Inter-Departmental Committee on Medical Inspection, 1905, vol. i. Cd. 2779, par. 7, p. 2; Report of Royal Commission on Physical Training (Scotland), 1903.

[2] As lately as 1905 it could be said that "there is no specific statutory provision for Local Education Authorities to conduct the medical inspection of the children attending the Public Elementary Schools." (Report of Inter-Departmental Committee on Medical Inspection, 1905, vol. i. p. 2.) School doctors and school nurses were appointed as being "necessary officers" to schools, under the general powers of the Education Act. (*Ibid.* vol. ii. Q. 99.)

unfit to profit by the instruction. In town after town we see the Medical Officer of Health advising on the children's diseases, as well as on the defective eyesight and hearing, sometimes systematically weighing and testing all the children.[1] We see the Town Council's Health Visitors following the children back to their homes, and giving advice to the parents how to treat the defects discovered.[2] Occasionally a special nurse is engaged by the Town or District Council,[3] to visit the homes, in order to offer her services gratuitously for actual treatment of the cases as well as to advise the mothers how to remedy the trouble and prevent its recurrence. In this way the Local Health Authority has, in many towns, undertaken a large amount of the medical relief of poor children, which the Destitution Authority, dominated by its desire at all hazards to restrict its work, had failed to provide.[4]

In London and the larger boroughs we see the work which the Destitution Authorities refused or neglected to do undertaken by the Local Education Authorities[5] themselves. School Medical Officers and

[1] Thus at Salford, we learn, "children suffering from ringworm are excluded from school, and parents [are] advised what to do. . . . Children suffering from pediculosis are pointed out to the teachers, who interview the children and give instructions as to treatment. Where the teacher's influence is insufficient, the parents are seen by the Medical Officer. In this way a considerable improvement has been effected." (Annual Report of Medical Officer of Health, Salford, 1904, p. 9.)

[2] Thus, to give one example out of many, at Liverpool, the female Inspectors of the Public Health Authority "visit children suffering from ringworm, sore eyes, sore heads, skin diseases, etc." (Annual Report of Medical Officer of Health for Liverpool, 1905, p. 89.)

[3] As at Widnes and Wimbledon (Report of Inter-Departmental Committee on Medical Inspection, 1905, vol. i. p. 6; vol. ii. pp. 161-6).

[4] For the extent to which the Medical Officers of Health had, even by 1904, carried the medical inspection and treatment of school children, see *ibid.* vol. i. pp. 89-99.

[5] In the County Boroughs the Education Authority is identical with the Public Health Authority.

school nurses have been appointed, whose business it is to examine all the children; to discover all physical defects; to test eyesight and hearing, and advise what steps should be taken as to treatment; to instruct the mothers how to remedy the evils; to supply gratuitously or at a nominal charge the spectacles required by the child's defective eyesight;[1] and, in not a few cases, even systematically to provide the treatment required.[2] "In Liverpool . . . over 50,000 dressings have been done in the course of 1904. In Birmingham there have been in four schools over 20,000 dressings in twelve months. . . . At Reading a nurse is employed . . . to attend to the heads of verminous children where the parents fail to do so."[3] In 1907, by statute and by order of the Board of Education, these duties were not only sanctioned, but were even made obligatory on all Local Education Authorities, with regard to all the children in attendance at public elementary schools.[4] Nor are the Local Education Authorities to stop at mere inspection. "It is important," declares the Board of Education,

[1] Report of the Poor Law Commission, 1909, *Qs.* 38758 (par. 8), 38766.

[2] Report of Inter-Departmental Committee on Medical Inspection, 1905, vol. i. pp. 89-99; see also *Q.* 3744 of vol. ii. of the same. At Croydon the Local Education Authority itself cures ringworm, free of charge to all children attending the public elementary schools, by the Röntgen-ray process, at an expense of about £100 a year. (Evidence before the Commission, *Q.* 22952; Annual Report of Medical Officer of Health for Croydon, 1905, p. 90; Annual Report to the London County Council of the Medical Officer (Education) for 1906-7, p. 34.) In various towns, as at Glasgow (under its Police Act), and in several of the Metropolitan boroughs, verminous children are treated free of charge by the Local Health Authority, under the Cleansing of Persons Act, 1897. (Annual Report of Medical Officer of Health for Glasgow, 1905, p. 132.)

[3] Report of Inter-Departmental Committee on Medical Inspection, 1905, vol. i. p. 6.

[4] Education (Administrative Provisions) Act, 1907, Sec. 13; Memorandum on Medical Inspection of Children (Board of Education Circular, No. 576), November 1907; Report by Medical Officer to the Board of Education, 1910.

"that Local Education Authorities should keep in view the desirability of ultimately formulating and submitting to the Board for their approval under Section 13 (1) (*b*) of the Act, schemes for the amelioration of the evils revealed by medical inspection, including, in centres where it appears desirable, the establishment of school surgeries or clinics, such as exist in some cities of Europe, for further medical examination, or the specialised treatment of ringworm, dental caries, or diseases of the eye, the ear, or the skin." [1] Under this encouragement the three hundred Local Education Authorities are now nearly everywhere organising medical treatment in one way or another; at Bradford and Cambridge already setting up school clinics. [2]

Unlike the medical treatment provided by the Destitution Authority, the medical examination and treatment of school children by the Local Education Authority (or by the Local Health Authority at its instance) is never of the nature of "relief," but rather of hygienic discipline. It is systematically applied without any implication of pauperism to all children who are found to need it, without waiting for application to be made. It is continued so long as is found necessary, whether or not the parents actively desire it. And it always takes the form, to a very large extent, of hygienic advice, obedience to which is strongly pressed both on the child and on the parent. This medical inspection has actually a tendency to increase parental responsibility. When, for instance, under the London County Council, the

[1] Memorandum on Medical Inspection of Children (Board of Education Circular, No. 576), November 1907.

[2] Annual Report of Medical Officer of the Board of Education (as to Medical Treatment), 1910.

school nurse visits a school to put in force the cleansing scheme, "she examines every child, noting all that have verminous heads. The parents are notified by a white card, on which is also printed directions for cleansing. . . . At the end of a week, if not cleansed, the child is made to sit separately from the rest of the class, and the School Attendance Officer serves a more urgent warning 'red card' at the home. The nurse, too, often visits to offer advice; and then, if in another week the child is still unclean, it is excluded, after having been seen by the Medical Officer; and the parent is prosecuted for not sending the child in a fit state to school."[1] Under the influence of such a system, the obligations of the parents in this one matter of cleanliness have, in the course of the last few years, been so greatly increased that the proportion of verminous children has, through the exertions of the mothers, steadily diminished. The expenditure incurred from public funds, far from being "relief" to the parents, has been actually the means of compelling the less responsible among them to devote more time and money to their children's welfare.

(vi.) *The Supervision of Birth and Infancy*

The continuance of a high rate of infantile mortality, in spite of a steadily falling mortality among persons of other ages, has, within the last two decades, forced itself upon the attention of the Local Authorities. Whilst the general rate of mortality

[1] Report of Medical Officer (Education) to London County Council, 1905, Appendix iii. p. 17. During the year 1906-7, 81,629 children were thus examined, 12,975 white cards were issued, 6090 red cards, and there were 277 prosecutions, at which fines were imposed. (*Ibid.* for 1906-7, pp. 32, 33.)

has fallen in the United Kingdom during the past forty years by at least one-sixth, the proportion of deaths under one year per thousand births has, until lately, remained almost undiminished.[1] The result has been a great outburst of sanitary activity in new directions. "The question of how we are to prevent so large an infantile mortality," says a recent report, "is now engaging the attention of every Medical Officer of Health throughout Great Britain, and more or less of every sanitary authority, and the great factors . . . which they are to combat are ignorance, carelessness, and neglect of the hygienic laws. It therefore becomes necessary to instruct the people in these matters."[2] At first, "the efforts of Health Committees" were "directed chiefly towards reducing the deaths among infants from epidemic diarrhœa." But "statistics have clearly shown that the practice of feeding infants with artificial food is chiefly responsible for the terrible wastage of life at present

[1] "It may safely be said that the health of the community at large, especially that of adults, depends upon many factors, some of which have been beneficially influenced by Public Health legislation ; but the health of the infant population depends chiefly upon home and maternal influences, *i.e.* upon the mode of feeding, clothing, etc., which Public Health legislation has only slightly touched. The general mortality reacts most quickly to sanitary measures of a municipal character, the infant mortality to domestic hygiene, and this, in my opinion, is the explanation of the different behaviour of the general death-rate and the infantile death-rate during the last half-century. The fact is that personal and domestic hygiene, and in this I include all that relates to the proper care of infants, has been neglected in the past ; it may be said in this respect we are very little better on the whole than a quarter of a century ago. With the exception, perhaps, of a nebulous idea that when an individual is known to be suffering from an infectious disease, such person should be separated from those who are healthy, the public, especially in crowded localities, may be said to possess no ideas on domestic hygiene, with the result that the community at large still suffers from an unnecessarily and preventably high infant death and sick rate." (Report of the Medical Officer of Health, on Hackney, for 1905, p. 105.)

[2] Report on the Prevention of Infantile Mortality, by Alfred E. Harris (Medical Officer of Health for Islington), 1907, p. 30.

going on."[1] Thus the Local Health Authorities have found their work taking the novel forms of giving advice to mothers how to treat their babies—advice which it was difficult to distinguish from that given by the private practitioner or the District Medical Officer; and in some places of actually supplying the mothers with suitable food for their babies—food that might otherwise have been sought as outdoor relief from the Destitution Authority.

(*a*) *Provision of Midwifery*

We must first notice a small and, we think, undesigned responsibility assumed by the Local Health Authority in some places, in connection with the provision of medical attendance on women in child-birth, who are destitute of the means of providing it for themselves. We have already[2] drawn attention to the varying practice of the Boards of Guardians with regard to the payment of the fees of the medical practitioners whom midwives are now required to have sent for in cases of difficulty or danger. It has been argued that Borough Councils have power to pay these fees under Section 133 of the Public Health Act, 1875, and in some places (as at Manchester, Liverpool, St. Helens, and Cardiff) the Town Council is, with the approval of the Local Government Board, making the payments under this Act.[3] There is nothing to prevent both Local

[1] Report upon the Infantile Death-Rate at Newport, by J. Howard-Jones, M.D., D.Sc., Medical Officer of Health for Newport (Mon.), 1907.

[2] See *ante*, p. 62.

[3] Report of the Poor Law Commission, 1909, *Qs.* 36931 (par. 2), 37103, 38380 (par. 42), 38573-82, 39475, 49493 (par. 10), 49511. In the Metropolis the London County Council addressed both Guardians and Borough Councils, inquiring whether they would be prepared to pay the

Authorities paying for the same service. For instance, both the Manchester Town Council and the Manchester and Chorlton Boards of Guardians have actually resolved to make such payments under certain conditions.[1] On the other hand, in other places, the doctor fails to get his fee from either Local Authority.

(b) *Provision of Hygienic or Medical Advice*

Whilst the provision of midwifery by the Public Health Authorities is, at present, occasional only, the provision of hygienic or medical advice for infantile ailments has already become an organised service. The most remarkable feature of this development has been its educational aspect. The Local Health Authority found the bulk of the poor mothers—those in receipt of outdoor relief no less than the others—totally unaware how to rear their babies in health. They were both unable and unwilling to pay for the private practitioner's advice, at any rate so long as the babies were not actually ill, and the Destitution Authority provided no instruction even for the mothers whom it was relieving. It was argued by the Local Authorities that " no education in school is likely to have much practical result in lessening the vast amount of preventible mortality and sickness among young infants. Very few of the mothers in the working classes have either the time or the ability to understand books or leaflets on the

fees; the Public Health and Housing Committee of the London County Council thought the Guardians should discharge this duty.

[1] Report of the Departmental Committee on the Midwives Act, Cd. 4822 and 4823, 1909.

management of children. What is required is that they should have actual practical instruction from some properly trained and tactful visitor soon after the child's birth, who would be able to show them that it would save them trouble in the long run if they spent a little pains in preparing for their child's food, in the event of their not being able to nurse it themselves." [1] The result has been the creation of a remarkable organisation, partly paid and partly voluntary, by which the Medical Officer of Health attempts to keep under observation during the whole of the first year of life, all the babies born in the poorer families, including those who are on the outdoor pauper roll of the Destitution Authority, and those among them who are actually under the attendance of the District Medical Officer. This organisation has already gone very far. It may be said that Parliament has sanctioned the new development by expressly legalising the appointment of paid Health Visitors by the Metropolitan Borough Councils; [2] and by passing the Notification of Births Act of 1907, [3] the avowed object of which was "to give Sanitary Authorities the opportunity of effecting improvements in infant and domestic hygiene by means of Health Visitors." [4] Accordingly, at the

[1] Report of Medical Officer of Health for Margate, 1905, pp. 14, 15.

[2] London County Council (General Powers) Act, 1908.

[3] 7 Edward VII. c. 40.

[4] Report upon the Infantile Death-Rate at Newport (Mon.), by J. Howard-Jones, M.D., D.Sc., Medical Officer of Health, Newport, 1907. "The Local Government Board, as stated in their Circular of 27th September last, to the Councils of the Metropolitan Boroughs, however, are of opinion 'that there is no occasion for imposing upon parents and others the obligation of notifying births, unless steps are taken to carry out the ultimate object of the measure, viz. the giving of advice and instruction to those who have charge of the infants, and in ordinary circumstances they would not be prepared to consent to the adoption of the Act unless it appeared that

present time, in the poorer districts of many towns of Great Britain, every house at which a birth occurs (even those at which the District Medical Officer is in attendance) is visited by an officer from the Medical Officer of Health's Department—in some places by a lady volunteer, in others by a semi-philanthropic paid agent, in others, again, by a trained professional Health Visitor, qualified by a sanitary certificate or a nurse's experience. Including the organised volunteers, there are already more Health Visitors than there are Relieving Officers in England and Wales.[1] At Huddersfield and elsewhere some of these Health Visitors are even qualified medical practitioners. They interview the mother and inspect the baby; they advise how it should be fed, washed, clothed, and generally treated; they criticise what is being done wrong or unskilfully; they keep a sharp eye for the presence of disease to be reported to the Medical Officer of Health; they suggest hygienic improvements in the household; if the baby is ailing they are often able to suggest the cause and remedy; and, finally, if the case looks serious, they urge the obtaining of further professional advice, either by calling in a private practitioner, or by application to the Relieving Officer for the attendance of the District Medical Officer.[2] The adoption

arrangements would usually be carried out by local agencies under the Medical Officer of Health. The Board trust the Council will consider the question of adopting the Act, and of co-operating with any agency that may exist, so as to secure its successful operation.'" (Report on the Prevention of Infantile Mortality, by Alfred E. Harris (Medical Officer of Health for Islington), 1907, pp. 31, 32.)

[1] There appear to be already between 200 and 300 salaried Health Visitors in the United Kingdom and at least ten times as many regularly engaged volunteers.

[2] Report of the Poor Law Commission, 1909, Appendix No. cxxxviii. (par. 2) to vol. iv. (as to Birmingham); *Qs.* 37605 (par. 29), 37616-18,

of this system of domiciliary "health visiting," as applied to the 2·45 per cent of the population which is under one year of age, has apparently resulted in a great improvement in the health of those visited; although the proportion of these to the total population has not yet risen to a sufficient height to have any marked statistical result on the whole.[1]

Three features stand out in this expansion of the work of the Local Health Authority, all of them in significant contrast with that of the Destitution Authority. The first is its humanising and educational character. The poverty-stricken mother, tempted to regard the newly born infant only as an additional burden, finds herself reminded of the importance of the child's life, finds its welfare a matter of interest to the visitor, and finds herself

37801, 37802 (as to Blackburn); *Qs.* 95100 (pars. 17-20), 95121-34 (as to Glasgow); Appendices No. lvi. to vol. iv., and xlv. (par. 22) to vol. ix. (as to Huddersfield); *Qs.* 41685-9, 42546 (as to Leeds); *Q.* 41888, par. 1 (d) (as to Sheffield). In Huddersfield, for instance, all "newly-born children are visited as soon as possible by the official Health Visitors. Each Saturday a list of the cases in her district is sent to a Lady Superintendent, who distributes the cases among her lady-helpers. These keep the cases under observation, and, where it appears necessary, invoke the aid of the Department. Great care is exercised to avoid touching upon the domain of the family doctor, and also to avoid any action which even might have the appearance of diminishing parental, and particularly maternal, responsibility." (Report of the Medical Officer of Health of Huddersfield for 1905, p. 30.) In particular, the Health Visitor keeps a "watchful guard over the illegitimate children who are nursed in the District, much to the advantage of these little unfortunates." (Report of Medical Officer of Health for Walthamstow, 1905, p. 5.)

[1] After attaining the age of twelve months the infants are not, at present, medically inspected in any town, so far as we have been able to ascertain, unless infectious disease is notified. To this, the only exception appears to be that of the child "farmed" out by the parent. These so-called "baby farms" have, under the Infant Life Protection Act (now the Children Act, 1908), to be regularly inspected in the Metropolis by the Public Health Department of the London County Council, though, curiously enough, outside the Metropolis this service has to be performed by the Boards of Guardians.

gradually acquiring a higher standard of child-rearing. The second significant feature of the work is the extensive use made of volunteers in an altogether new relation to the official machinery. Such volunteers, numbering in towns like Huddersfield several scores, visit the poor in a friendly unofficial way, and yet serve systematically as the eyes and ears of the Local Authority, working always under the supervision, guidance, and control of the responsible salaried officer and his representative Health Committee. The third feature is the stimulus given by the action of the Local Authority to parental responsibility, personal self-control and regularity, and self-help. The Destitution Authority, grudgingly giving its dole of outdoor relief to the destitute mother, leaves her not only without instruction how to make the best use of it, but also quite free to neglect her infant, to endanger its life by irregular hours, and to let it starve quietly to death if she chooses. What the Local Health Authority does is to persist in inquiring after the health of that baby; to send its Health Visitors to see its condition; to make the mother feel that she is being helped; to induce her to take some pride in the infant's thriving; and to show her how she can make it thrive. The Poor Law Commission was much impressed by the evidence afforded of the beneficial results of this kind of State action in positively increasing self-respect, a sense of personal responsibility and maternal care.[1]

[1] Report of the Poor Law Commission, 1909, *Qs.* 41687-9, 42664-9, 44096-101, 56933, 56934, 56961-4, 94589.

(c) *Provision of Milk*

In a dozen towns (St. Helens since 1899; also Liverpool, Battersea, Finsbury, Lambeth, Woolwich, Glasgow, Dundee, Leicester) the Medical Officer of Health has gone a step further. He provides a municipal milk depot, or rather a "milk dispensary," at which babies requiring artificial feeding are supplied with pure milk (and hygienic feeding teats) on payment of a small sum.[1] At Liverpool this has developed into an elaborate organisation with branch depots in various parts of the city, supplying "humanised sterilised milk" of seven different grades, for infants of various ages (in addition to the babies brought to the depots), to many hundred families by direct delivery. But the special interest of the "milk dispensary" to the sanitarian is the personal supervision which it enables the Medical Officer of Health to exercise over these ailing babies. At Finsbury the supply of the milk was made conditional on the babies being brought regularly for inspection, accurate weighing, and hygienic advice. Those who could not be brought were visited in their homes. At Glasgow a qualified medical practitioner (lady) visits

[1] As to these municipal milk dispensaries, see *ibid.*, *Qs.* 94287 (pars. 23 (h), 25 (h)), 94335-43 (for Finsbury); *Qs.* 95100 (pars. 13-16), 95106-16, 95228-43 (for Glasgow); *Qs.* 41489 (par. 35), 41492-514, 41585, and 41700 (for Leeds); *Qs.* 47191, 47266, 47501, and Appendices Nos. cxvi (par. 3), cxliv. (par. 5), and cl. (par. 1) to vol. iv. (for Leicester); and Appendix No. xliv. (par. 8) to vol. ix. (for Woolwich). Small as is the sum charged, it is sufficient to prevent the poorest mothers (those in receipt of outdoor relief) from obtaining the advantage of the municipal milk depot. At Liverpool and Finsbury we have been informed that attempts have been made by the Health Committee to get the Boards of Guardians to give orders for the milk, in lieu of other food, where there are young or delicate children; but so far with little success. At Battersea the Board of Guardians sometimes gives orders for milk instead of money.

every home as a matter of course. Practically, though not avowedly, the Medical Officer of Health becomes the medical attendant of each of these infants; to whom, indeed, he not infrequently supplies the milk gratuitously rather than let them die or compel the destitute parents to "go through the rigmarole" of obtaining Poor Law relief for them.[1] "During the hotter portion of the year," reports the Medical Officer of Health for Norwich, "and to a lesser extent since, with the sanction of the Health Committee, I have distributed [through the lady Health Visitor] a considerable quantity of dried milk powder to necessitous mothers and, on the whole, have been well satisfied with the results."[2] "It is clear," says Dr. Newman, now Chief Medical Officer to the Board of Education, "that such a specialised milk supply does not meet the whole problem of infant mortality. . . . Nevertheless it is true that a *properly equipped and controlled* Infants' Milk Depot is part of the solution at the present time and under present conditions and is a practical step in the right direction."[3]

[1] It must be remembered that a Relieving Officer seldom gives milk to an infant, even when, in cases of sudden and urgent necessity, he may give relief in kind. Even if an infant is ill, the Relieving Officer usually gives milk only upon a recommendation of the District Medical Officer. The Medical Officer of Health for Kensington refers to "the malnutrition of the nursing mother as a principal cause of the malnutrition of the infant. Thus it happens that, when mothers get up and about, the little milk they had disappears or becomes almost valueless as food for their offspring. . . . Appeals to the Relieving Officer for out relief in such cases, unless the District Medical Officer is in attendance, result in the 'offer of the house,' of which mothers of families are unwilling to avail themselves." (Monthly Report of Medical Officer of Health for Kensington, 1905, p. 59.)

[2] Report on the Health of Norwich, 1905, by the Medical Officer of Health, p. 10.

[3] Report of the Medical Officer of Health on the Infants' Milk Depot, Finsbury, 1905, p. 7.

Here, too, as with the advice given to the mothers by the Health Visitors, the most prominent features of the work are the education of the persons aided, and the stimulus to their sense of responsibility. When the baby has to be regularly brought to be inspected and weighed, the mother's interest in its physical condition is not allowed to slacken; there is praise and approval if the baby goes on well; there is blame and warning if it sickens. The connection between irregular hours, dirt, carelessness about the food and other forms of neglect, and the ups and downs of the baby's physical development are brought home to the most ignorant and apathetic of mothers. In marked contrast with the practice of the Poor Law, the actual gift of material relief is made only an incident—for the most part only an occasional incident—in the process of education and inspection. The self-respect, the power of will, the sense of personal responsibility, instead of being weakened, as they are under outdoor relief, are, with a milk dispensary, actually strengthened.

(vii.) *Health Visiting*

The system of "health visiting" now adopted in some scores of towns is, of course, not confined to newly born infants and children in "baby farms." The Health Visitors go at once to every house at which either an infantile death or a death from phthisis or any infectious disease is notified, with a view of inquiring into the sanitary condition of the premises, ensuring the execution of any necessary disinfection, and (with regard to deaths of infants

under two years old)[1] also obtaining elaborate particulars as to the method of feeding, source of milk supply, etc. The Health Visitor goes also to any house in which sanitary defects are complained of. She follows up "contacts." She visits all the cases reported from the public elementary schools of children staying away or excluded on account of measles, whooping-cough, ringworm, etc. She investigates cases of erysipelas for the Medical Officer of Health. She visits the patients discharged from the municipal hospital, and exercises a certain amount of supervision over them.[2] She may even, so far as time permits, visit from house to house in blocks or districts in which special sanitary care is for any reason required. Wherever she goes, she makes such inspection of the inmates as she can; she is able to report to the Medical Officer of Health where and what diseases exist, and which cases are without medical attendance; she gives hygienic advice; she makes known the facilities with regard to phthisis; and she advises the calling in of a medical practitioner where necessary. Her advice is found specially useful in those children's ailments which are so often treated lightly without medical aid.[3] "The Medical Officer of Health for Warwickshire points out in one of his reports (1903) that the work of the Health

[1] "The dead baby," writes a Medical Officer of Health, "is next of kin to the diseased baby, who in time becomes the anæmic, ill-fed, and educationally backward child from whom is derived later in life the unskilled casual who is at the bottom of so many of our problems." In the Annual Report of the Medical Officer of the Education Committee of the London County Council for 1906, Dr. Kerr gives statistical grounds for concluding that physical defects are more marked in children born in years of high infantile mortality than in years of low infantile mortality.

[2] Report of the Poor Law Commission, 1909, Appendix No. xlvi. (par. 11) to vol. ix.

[3] *Ibid.* Appendix No. lvi. (par. 5-8) to vol. iv. pp. 675-676.

Visitor does not trench on the work of the Sanitary Inspector, that she is not an inspector in any sense of the word, and that her functions are those of friend to the household to which she gains access. He also states that although at first there may have been some opposition on her entering a house, it rapidly died away, and in numerous instances she has been asked to return and aid the family by her help and counsel. He also believes that in this new departure of carrying sanitation into the home, we have not only an important, but almost the only, means of further improving the health of the people, and that in the future, although Sanitary Authorities, by providing water supply, drainage, and decent houses, have done much in the past, the most important advance will come from an appreciation by the people themselves of the value of good health."[1]

(viii.) *Municipal Home Nursing*

In addition to the work of the Health Visitors and school nurses, some Public Health Authorities have begun a system of domiciliary treatment of the adult sick by municipal home nurses. At Brighton, for instance, under a Local Act, the Town Council employs a trained nurse, who is employed in attending at home on cases such as puerperal fever or erysipelas in which removal to hospital is not considered desirable.[2] Nurses are also provided "in special cases of infectious disease" by the Barry

[1] Report on the Prevention of Infantile Mortality, by Alfred E. Harris (Medical Officer of Health for Islington), 1907, p. 31.

[2] Report of the Poor Law Commission, 1909, *Qs.* 92534, par. 4 (iv.), 92762-5.

Urban District Council.[1] Even more interesting is the action of the Health Committee of the Worcestershire County Council, which maintains a staff of nurses for the domiciliary treatment of the sick poor in certain of the sanitary districts within the county, in which the Local Authorities do not, either in their capacity of Guardians of the Poor or in that of Rural District Councillors, make adequate provision for home nursing.[2]

(ix.) *Diagnosis*

One of the most important branches of the Public Health medical service is that of diagnosis. The bacteriological laboratory of the Medical Officer of Health, or that at the municipal hospital, frequently undertakes the investigation of "swabs" for diphtheria or of sputum for tuberculosis for all the medical practitioners of the district. But the service does not stop here. The Medical Officer of Health frequently acts himself as diagnostician in individual cases, being called in (without payment) by the medical practitioner to suspected cases of smallpox, etc. In times of epidemic the active Medical Officer of Health goes even further, and himself spontaneously visits the common lodging-houses and other suspected centres in order to search out cases of smallpox which are not being medically attended at all, and to hurry them off to the municipal hospital. The services of the Medical Officer of Health as diagnostician are rapidly extending. Not only in diphtheria and tuberculosis cases, but also in typhoid fever, in

[1] Report of the Poor Law Commission, 1909, *Q.* 49222, par. 1.

[2] Annual Report of the Medical Officer (Worcestershire County Council).

cerebro-spinal-meningitis, in affections of the throat, and in the whole realm of opsonic treatment, he is more and more coming to serve as the general consultant of the district. It is he who considers "suspects" and "contacts" and "carriers," who, not being themselves ill, are not remunerative patients. Yet it may be upon their prompt treatment that the health of the district depends.[1]

(C) *Chargeability and Compensation*

It is sometimes imagined that the maintenance and medical treatment afforded by the Public Health Authorities is always gratuitous, whilst that of the Poor Law medical service is legally recoverable, either from the patient himself, or from the relatives liable to maintain him. This is not the case. The whole question of chargeability for institutional treatment is one of inextricable confusion. We may notice first that by far the largest class of patients, viz. the 100,000 in the lunatic asylums of the County Councils and County Borough Councils,[2] are technically paupers, and their relatives are required to pay a weekly contribution towards the maintenance and medical treatment—a contribution which in some cases covers the whole cost. Patients suffering from other diseases in the hospitals of the Public Health Authorities are not, as such, paupers. They are not subject to any political or other disability—not even as regards voting for the members of the council which relieves them. The Public Health Authority may, however, if it chooses, under certain clauses of the Public

[1] Report of the Poor Law Commission, 1909, *Q.* 92534, par. 4 (ii.) (vi.).

[2] Like those in the idiot asylums of the Metropolitan Asylums Board.

Health Acts and Isolation Hospitals Acts, make a charge for maintenance in its hospitals, for which it can sue the patient. But it is a personal charge only; the relations of the patient come under no liability.[1] If the patient is a minor it does not appear that any such charge is legally recoverable; and if the patient dies it seems doubtful whether the charge could, in the absence of any agreement, be enforced against his estate. Under these provisions of the Public Health Acts and the Isolation Hospitals Acts all sorts of arrangements are made by different authorities for the recovery from the patients of a part or the whole of the cost of their maintenance and medical treatment. In a few towns, in the cases of some or all the patients, the patient himself, or the father or other responsible person, is invited to enter into an agreement for the payment of various sums, any such special contract being in all cases only voluntary. In some towns the patient, without a contract, is charged according to his ability to pay, the rough test being the rateable value of his domicile; under £25 a year free, or a nominal sum; £25 to £50 a year a substantial contribution; over £50 a year the whole cost. This scale is, however, criticised as logically inequitable, those patients who are large ratepayers already contributing in larger proportion to the municipal expenditure than those who pay less in rates. Hence some Public Health Authorities prefer to take income as the test of ability to pay, admitting, for instance, ratepayers getting less than £1 a week free of charge; those earning between 20s.

[1] It has been definitely held that the patient alone was chargeable; a parent is not even chargeable for his child. (*Selections from the Correspondence of the Local Government Board*, vol. i. 1880, p. 18.)

and 30s., at half-a-crown a week; those between 30s. and 40s., at 5s. a week; those between 40s. and 50s., at 7s. 6d. a week; those between 50s. and 60s., at 10s. a week; those between 60s. and 80s., at 15s. a week; whilst those over 80s. are charged £1 a week. Others, again, make a discrimination between local ratepayers and strangers or "visitors"; the latter, as at Romney Marsh, "being asked to pay the entire cost of their maintenance and treatment"; or, as at Bridlington, being charged from 10s. to 40s. according to circumstances, as may be decided by the committee.[1] In another town it is usual to make no charge to local residents having incomes under £2 per week. In the great majority of instances, however, no charge whatever is made, either for medical treatment or for maintenance, in the general wards of the municipal hospitals. Experience soon showed that if it was desired to get these hospitals generally used—and this was most keenly desired in the case of smallpox and other demonstrably dangerous diseases—it was necessary to make them absolutely free. Accordingly, with the approval of the Local Government Board, all attempt to make a charge has been generally abandoned.[2] "The more enlightened sanitary authorities," says a Local Government Board Inspector, "make no charge for patients in the isolation hospitals, and

[1] Scale of charges of Municipal Sanatorium at Bridlington (Yorkshire), 1905.

[2] Thus, in the municipal hospital of Newcastle, out of 502 patients admitted, 501 came in free, whilst one only was paid for, and that not by himself, but by a private guarantor. (Report on the Health of Newcastle-on-Tyne, 1905, by Medical Officer of Health.) "There was," it is given in evidence, "in Huddersfield an attempt at one time to recover the cost, or to make the people pay. I was always personally strongly against it. My reason was that if people were segregated for the benefit of the community, the community ought to pay for it. It was tried for a short time and given up at last." (Report of the Poor Law Commission, 1909, *Q.* 41526.)

this is the proper line to take. The cases are not removed as a matter of relief, but for the protection of the public health. All classes of the community are made to contribute to the support of the hospitals, and all classes are entitled to the benefits they confer. Directly a payment is imposed an influence adverse to the use of the hospital is introduced. The great object in view is to do everything possible to get all the cases which cannot be effectively isolated at home into hospital at the earliest possible date. It is by this means that the patients stand the best chance of favourable treatment, and that the spread of disease is stopped at once."[1] Parliament has expressly sanctioned this view, so far as the Metropolis is concerned, first by a provision in the Diseases Prevention (London) Act of 1883,[2] and then, in 1891, by omitting from the Public Health (London) Act of that year[3] all provisions as to making a charge or recovering any contribution. On the other hand, a few Town Councils make charges for the use of their municipal hospitals at such prohibitive rates as to cause them to remain practically empty. Thus, at Shrewsbury the Town Council admits persons suffering from infectious disease to its isolation hospital, the only one in the whole county, upon terms of their finding their own doctor and nurse, providing their own food and other necessaries, and paying, in addition, 20s. per week during their stay by way of rent. The result is

[1] Thirty-third Annual Report of the Local Government Board, 1903-4, Appendix B, p. 179, Mr. Fleming's Report.

[2] 46 & 47 Vict. c. 35.

[3] 54 & 55 Vict. c. 76. By a curious anomaly, the cost of each patient, although not a pauper, is still charged to and paid by the Board of Guardians of the Union in which he resides; and the amount is then repaid to the Board of Guardians from the Common Poor Fund. (Report of the Poor Law Commission, 1909, *Qs.* 24155 (par. 17), 24223.)

that the hospital usually stands empty ; and cases of scarlet fever and enteric fever, like diphtheria and measles, have to be treated at home, however little possibility of isolation there may be. Even the local Board of Guardians (that of Atcham) has to treat paupers suffering from infectious disease in the General Mixed Workhouse, "in the midst of a community of four or five hundred, many of whom are children,"[1] rather than comply with the prohibitive terms by which the Shrewsbury Town Council chooses to nullify the intention of the statute.

The more usual adoption of the principle of gratuitous admission to the municipal hospitals does not mean that none of the inmates contribute to their maintenance. At the Brighton Town Council's Sanatorium for Consumption there are among the patients some paying as much as 30s. a week. These are allowed private bedrooms. In other cases even more may be charged, in return for particular privileges, such as a special nurse. The Town Council of Eastbourne reserves four of the pavilions of its hospital for the Eastbourne schoolmasters' and schoolmistresses' associations, for the admission of the pupils of their expensive private boarding-schools, in return for retaining fees of £150 and £180 per annum respectively.[2] What is most remarkable is that the Town Council often obtains payment for the admission to its hospitals of precisely the very poorest class of patients. The Local Government Board has advised that the Public Health Authority is under no obligation to provide hospital accommodation for

[1] Report of the Poor Law Commission, 1909, *Qs.* 70186 (par. 3), 70193-201.

[2] Report on the Health of Eastbourne, 1905, by Medical Officer of Health, pp. 3, 10.

the not inconsiderable proportion of the inhabitants of its district who happen to be destitute. For these persons, whether already in receipt of poor relief or not, it is the duty of the Board of Guardians to provide what is necessary, even in cases of infectious disease.[1] Accordingly, some Public Health Authorities refuse to admit to their hospitals workhouse inmates (including occupants of the casual ward) suffering from infectious disease.[2] In other cases they have agreed to receive such patients only on payment by the Board of Guardians.[3] The status of the patient so admitted, his liability to refund the cost of his maintenance, and the obligation of his relations to

[1] "When a person suffering from illness, including infectious disease, is destitute, it is the duty of the Guardians, or, in the interval between their meetings, of the Relieving Officer, to give such relief as the case may require, and if necessary to give an Order for the admission of the patient to a hospital in which he can be properly treated. . . . The test of the Guardians' duty in the matter is the destitution of the patient, and this will not necessarily depend upon his being on the actual receipt of poor relief, but may consist in his being unable to obtain at his own cost the requisite medical attendance, nursing and accommodation. Where it devolves upon the Guardians to deal with cases of infectious disease which require hospital accommodation, they are not restricted to providing for the treatment of such cases in the Workhouse. On the contrary, the Board consider it very desirable that the Guardians should arrange with the Sanitary Authority for the reception into their hospital, when necessary, of any destitute persons suffering from infectious disease upon such terms as may be mutually agreed upon between the Guardians and the Authority, and that this arrangement should include cases occurring among the inmates of the workhouse." (Local Government Board to Holbeach Board of Guardians, 15th March 1905.)

[2] The Departmental Committee on Medical Relief in Scotland reported in 1904 "two instances where local authorities do not appear to deem it their duty to admit to their infectious diseases hospital any cases from a combination poorhouse situated within their district." (Report of Departmental Committee on Medical Relief (Scotland), 1904, p. 27.)

[3] For example, at Liverpool, Merthyr Tydvil, Gateshead, and Hartlepool. (Report of the Poor Law Commission, 1909, *Qs.* 37927 (par. 7), 48888 (par. 3), 51849 (par. 2), 52840 (par. 3).) At Blackburn the Local Health Authority charges the Guardians a guinea a week for cases of smallpox removed from the workhouse, but admits cases of other infectious diseases free. (*Ibid.*, *Q.* 37728.)

contribute in default, as we have already mentioned, all depend, in law and in practice, on the particular character of the voluntary arrangement entered into between the Poor Law and Public Health Authorities. In those Unions in which the Boards of Guardians prefer to pay a fixed annual sum, which ranges in fact from £2 (as at Yeovil) to £300 (as at Bristol)—as also in those Unions in which the Public Health Authority admits the Poor Law patients, like others, free of charge—the pauper admitted to the municipal hospital thereupon instantly ceases to be a pauper; and neither he nor his relations are liable for any part of his cost, or subject to any stigma or disqualification. On the other hand, in those Unions in which the Board of Guardians pays at a rate per head—sometimes as much as 7s. per diem—the pauper patient, lying in the general ward among non-pauper patients who are admitted free, remains a pauper; he is liable to repay the full cost of his maintenance; he is disqualified for the franchise; and his relations are liable to contribute. Thus, we have the paradox that, under the present conflicting jurisdictions of the Poor Law and Public Health Authorities, it is in respect of the most destitute of its patients that the Public Health Authority recovers the most; whilst when such most destitute patients or their relations contribute—being perhaps the only patients who contribute at all—they nevertheless remain paupers, subject to a stigma and to disqualifications from which those patients who are maintained and treated wholly free of charge are entirely exempt.

With regard to the growing amount and variety of domiciliary treatment of cases by Public Health

Authorities, whether in respect of the supply of medicine, hygienic advice, diagnosis, nursing, or actual medical treatment, there is nowhere any question of making a charge to the patient or his relations. All this development has been, without hesitation or cavil, placed on the same footing as sanitary inspection and disinfection.

But the cash nexus between the patient and the Public Health Authority is not always one of payment by the patient. The medical treatment of the Public Health Authority in cases of infectious disease does not stop at merely relieving the patient or admitting him to hospital. The utmost possible disinfection of the surroundings, with a view to prevent new cases of the disease, is an integral part of its medical service. In this process of disinfection it does not hesitate to destroy property so infected as to be dangerous to health; and in such instances it pays compensation for the property so destroyed. Thus, the stock of food, etc., in small shops, which may have been handled by the patients is bought up and destroyed. Bedding and clothing is frequently burnt, and its value paid to the owner in a lump sum, even although the owners are paupers in receipt of outdoor relief, as is constantly found to be the case. At Liverpool the same principle has been extended to the verminous clothing of children of poverty-stricken homes. With the co-operation of a charitable association (the Police-Aided Association for clothing Destitute Children) the verminous clothes are destroyed, as being detrimental to health; and the new clothing required is, we are informed, paid for by the Town Council as compensation under the Public Health Act.

Possibly more important, in its future development, is the practice of Local Health Authorities of granting free lodging and an alimentary allowance, to "contacts," or persons (whether dependents or not) who have been in contact with a patient suffering from infectious disease. In order to prevent new cases of disease these "contacts" are often segregated and kept under medical observation. It then becomes necessary to provide for the maintenance of the persons thus prevented from working. The Leeds Town Council has "frequently paid part wages of those who, though not themselves apparently ill, have at request remained away from work on account of having been exposed to contagious disease. . . . The practice has been to pay half the wages, and to maintain the contacts in . . . cottages . . . under medical observation."[1] They may, however, in other cases remain at home but abstain from working, receiving allowances for their maintenance. This practice is followed as a matter of course in cases of suspected plague or cholera, and frequently for smallpox. With regard to other infectious diseases, the state of things is chaotic, and great hardship arises. One such case was brought specially before the Poor Law Commission. A widow working as a laundry woman had a child ill with fever, who was removed by the Local Health Authority to its hospital. The Local Health Authority, apparently, in the public interest, stretching its legal powers, peremptorily ordered the widowed mother not to go to work, it being a penal offence to spread infection. The widow being thus rendered destitute applied to

[1] Report of the Poor Law Commission, 1909, *Qs.* 41489 (par. 8), 41515-23, 41531-4.

the Relieving Officer, who refused to give outdoor relief, and referred her to the Local Health Authority; from which, however, she received no maintenance allowance. The Board of Guardians thereupon indignantly reported the matter to the Local Government Board and to the Poor Law Commission, demanding legislation to make it obligatory on the Local Health Authority to grant aliment to heads of families so prevented from working, owing to their having come in contact with infectious disease.[1]

The question of allowing aliment to "contacts" forced, in the public interest, temporarily to suspend work is, however, comparatively simple. The practice of the Local Health Authorities brings them up against the far more serious problem presented by the necessity of granting aliment to the dependents of patients admitted to the municipal hospitals or sanatoria. The Poor Law Authorities in many places grant outdoor relief freely for the families of men in hospital. This, however, involves the stigma of pauperism, and accordingly (as is actually intended and desired by the Boards of Guardians) many respectable wage-earners struggle to continue at work in gradually failing health, and put off entering the hospital as long as they possibly can. In cases of tuberculosis, especially, this delay, besides spreading the disease, militates against a cure; and makes, in fact, in the vast majority of cases, all recovery hopeless.[2] In this

[1] Resolution of Kingston Board of Guardians, 2nd July 1906.

[2] See *ante*, pp. 75, 76. "In a large number of cases the disease was in an advanced state when notified, the sufferers continuing to work for the support of their families, and having refused to see a doctor until absolutely compelled. The longer we work the more are we impressed with the need of a sanatorium to which the sufferers could be removed in the early stage of the disease, which, however, cannot be brought about without provision being made for the support of the families during the period devoted to isolation." (Report

dilemma the Bradford Board of Guardians, as we have seen,[1] like the Brighton Town Council, seeks actually to induce and persuade the man with phthisis to come into its sanatorium at an early stage of the disease when he can still earn wages. This particular "workhouse" is clearly run almost on the lines of a municipal hospital, with the added advantage that the Board of Guardians is able to induce people to take advantage of it by proffering liberal outdoor relief to their families. Some Public Health Authorities now want to use the same inducement. The Medical Officer of Health for Manchester explained to the Poor Law Commission the importance of the Health Committee of the Town Council being free to provide aliment, without the stigma of pauperism, for the dependents of patients suffering from incipient phthisis, whether removed to hospital or treated by the municipal doctor in their own homes. "It is to my mind very plain," says Dr. Niven, "that this would be an economic expenditure. One of the great means of combating phthisis would be to raise the nutrition of the families in presence of the disease. The family falling into a state of poverty, the rest of the family are exposed to infection just in that condition which lays them open to attack, and if we are to deal really effectually with the prevention of consumption I feel sure that it is necessary to improve the nutrition of the families in presence of the disease." Dr. Niven explained that he would put it on the same plane as money given in plague or cholera cases.[2] Hitherto Local Health Authorities

of lady inspectors, in Report on the Health of Kensington for 1905, by Medical Officer of Health, p. 51.)

[1] See *ante*, p: 113.

[2] Report of the Poor Law Commission, 1909, *Qs.* 38412-56.

have limited any such grant of aliment to cases connected with plague, cholera, and smallpox, and have always coupled it with complete isolation of the patient. There does not, however, appear to be any legal limitation to their power to grant such aliment, at any rate as regards all notifiable diseases. This incipient development of a second public body granting what is virtually outdoor relief to the sick poor appears to us to demand the most serious consideration.

(D) *The Characteristics of the Public Health Authority's Treatment of Disease*

All treatment of the individual patient by the Public Health Authority has for its object, not the relief of immediate suffering, but the prevention of disease. It is plain that this involves the treatment and cure of existing diseases in the individual patient, because, as one Medical Officer of Health remarks, "the cure of a sick person tends to prevent disease in that person."[1] But, unlike Poor Law medical practice, even of the best type, it involves much more. In the obviously communicable diseases, such as plague, cholera and typhus, smallpox, scarlet fever and enteric, it involves the securing of complete isolation of the patient, and even the isolation and medical observation of healthy "contacts." In other infective cases, such as phthisis, trachoma, and chronic ear, throat, and skin affections, it involves the education of the patient in a method of living calculated

[1] Report of the Poor Law Commission, 1909, Appendix No. xlv. (par. 28) vol. ix.

to minimise the recurrence or spread of the disease.[1] But the special sphere of the Public Health Authority in the treatment of disease is not that of infectious or contagious but of *preventable* disease. It was, indeed, not to stop the spread of disease from individual to individual, but to prevent its arising from dirt and filth, that the Poor Law Commissioners first made their public health investigations, and importuned the Government to give the Local Authorities public health powers. It was preventable disease which Chadwick found to be so great a cause of unnecessary pauperism. It was for the reduction to a minimum of this preventable disease that the Public Health Act of 1848 was passed; and it is to preventable disease, whether communicable or not, that the powers and duties of Public Health Authorities to-day extend. The accident of the widely published advance of bacteriological science since 1848 has tended unduly to concentrate attention on the zymotic diseases, which, taken altogether, cause only 11 per cent of the deaths, and account, probably, for only a twentieth or a thirtieth of the persons ill at any one time. But as the Medical Officer of Health for Coventry remarks: "It is a great mistake to suppose that it is only infectious diseases that are

[1] It is worth noting how extensive is now the class of legally recognised infectious diseases. "The Local Authority for Public Health," says Dr. Leslie Mackenzie, "may legally deal with the following well-known and common infectious diseases: anthrax, cerebro-spinal fever, chickenpox, cholera, diphtheria, dysentery, endocarditis (infective), enteric fever, enteritis (infective), erysipelas, gangrene (acute infective), German measles, influenza, measles, mumps, osteomylitis and periositis (acute infective), phagedæna, plague, pneumonia, pyæmia, pyrexia of uncertain origin, relapsing fever, rheumatic fever, scarlet fever, septicæmia, smallpox, tetanus, tuberculosis, whooping-cough—thirty orders of disease. These are taken from the official Nomenclature of Diseases, 1906. For special reasons I have omitted the venereal group." (Report of the Poor Law Commission, 1909, *Q.* 566[illegible]5, par. 12[illegible].)

preventable."[1] "Our activity as health officers," writes another Medical Officer of Health, "cannot be limited to the infectious diseases. There are indeed greater opportunities of preventing illness among the non-infectious ailments, *e.g.* ailments of the digestive system, almost, than in the case of infectious illnesses." To the long list of common infective diseases already given, we must add as plainly preventable: "Infectious eye diseases, such as conjunctivitis in most of its forms (trachoma, etc.); infectious ear diseases (abscesses, etc.); infectious nose and throat diseases; abscesses of all kinds not due to tuberculosis; parasitic skin diseases, and some others. To these again we may add as due to immediate environment, and preventable, the occupational (non-infectious) diseases; chronic arsenical poisoning, chronic lead poisoning, chronic phosphorus poisoning, mercury poisoning, coal-miner's lung, steel-grinder's lung, the diseases due to dusty occupations, skin diseases, lung diseases, bowel diseases, and many others due to special manufactures, as rubber works, chemical works, dry cleaning, rag works, etc., etc. . . . Similar reasoning can be legitimately applied to chronic bronchitis, which can usually be prevented if the acute stage is properly treated; to catarrhal pneumonia, which is often the precursor of phthisis; to the heart diseases that are due to acute rheumatism; to chronic kidney disease, which often follows neglect of acute kidney disease; to some forms of cancer, which are curable if operation is early enough."[2]

But besides the preventable diseases brought about

[1] Report on the Health of Coventry for 1905, by the Medical Officer of Health, p. 109.

[2] Report of the Poor Law Commission, 1909, *Q.* 56605, pars, 129-30, 133.

by environment, and by neglect of acute diseases, there are those now recognised to be caused by bad hygienic habits of the individual himself. "The chief factor in disease production," says Dr. Newman, "is personal rather than external."[1] To quote the epigram of a distinguished doctor: "We have pretty well removed the filth from outside the human body; what we have now to do in order to lower the death-rate is to remove the filth from inside." "Diseases spread not alone by infection and contagion," says another Medical Officer of Health. "The habits and practices of people are responsible in even greater measure for the continuance of diseases. These cannot be combated by the popular panacea of a bottle of medicine."[2] It may be said, in fact, that "the public health method of treatment is superior to that of the Poor Law because it is largely educative and for the future." Nor is this merely a matter of cleanly living and the avoidance of excess. The prevention of disease, which, as the Medical Officer of Health always remembers, "is far more effective and infinitely less costly than the treatment of disease that is accrued," may depend on the adoption of a particular mode of life. Incipient phthisis, in particular, may be thus curable. "Such conditions as diabetes, granular kidney and aneurism," says another authority, "are not necessarily diseases. If the condition is recognised early, and the patient adopts the proper regimen, the symptoms which really constitute the disease may be postponed for a considerable period."[3] We come even to the study of

[1] Report of the Poor Law Commission, 1909, Q. 94287, par. 26.

[2] *Ibid.* Appendix No. xliii. (par. 30) to vol ix

[3] *Ibid.* Appendix No. xlv. (par. 28) to vol. ix.

individual proclivity or diathesis, as a branch of preventive medicine. "Thousands, nay, hundreds of thousands, of young men and women with hereditary or acquired tendencies to various diseases are, *owing to want of knowledge*, brought up, enter upon occupations, and lead modes of life which inevitably result in disease and early death."[1]

Thus, the special characteristic of the treatment of disease by the Public Health Authority is, not to wait until the patient is so ill that he is driven to apply, but positively to search out every case, even in its most incipient stage. "An active Medical Officer of Health," sums up one of them, "attempts anything and everything which promises to reduce death-rates or to prevent disease." The one recurring note of all the statements and oral evidence of the Medical Officers of Health is the vital importance of "early diagnosis." "I am satisfied," writes Dr. Newman, "that much illness is prolonged quite

[1] *The Prevention of Diseases other than Infectious Diseases*, by Roger M'Neill, Medical Officer of Health for the County of Argyll (1896). Dr. Newsholme, in his Paper at the 1907 Meeting of the British Medical Association, gave the following tabular classification of deaths in England and Wales:—

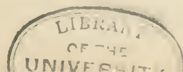
Caused by	Per cent
Acute notifiable infectious diseases	2·39
Acute non-notifiable infectious diseases, including pneumonia and rheumatic fever	18·58
Chronic infectious diseases, including tuberculosis	11·21
Accident	2·99
Preventable non-infective diseases	3·31
Partially preventable non-infective diseases	17·63
All other diseases	43·89
	100·00

(A Discussion on the Co-ordination of the Public Medical Services, by Arthur Newsholme in *British Medical Journal*, 14th September 1907; Report of the Poor Law Commission, 1909, *Q.* 92534, par. 11 (c).) Thus, nearly two-thirds of all the deaths are due to diseases which can be classed either as "infectious" or as otherwise "preventable."

unnecessarily, and that there is a lamentable and disastrous amount of failure to deal with the *beginnings of disease.* Neglect of such things leads to mortality more than any other factors."[1] The disastrous effects of failure to seek early treatment, in consumption, diphtheria, and other diseases, are continually coming to the notice of medical men. It is a necessary condition of the Public Health medical service that there must be no delay in searching out and discovering all the cases; there must be no delay in securing the necessary isolation; there must be no delay in applying the necessary treatment; there must be no delay in the adoption of the appropriate hygienic habits. It is the consciousness of the importance of this "early diagnosis," the immense superiority in attractiveness of the incipient over the advanced "case," the overwhelming sense of the dire calamities that may come from a single "missed case," that mark the characteristic machinery of the Public Health medical service—its notification; its birth, death, and case visitation; its bacteriological examination; its school intimations; its house-to-house visitation; its domiciliary disinfection; its medical observation of "contacts," and its prolonged domiciliary supervision of "recoveries" and patients discharged from institutions in order to detect the "return case."

This all-pervading principle of "early diagnosis" and immediate treatment has important corollaries. The existence of preventable or communicable disease is of equal importance to the Medical Officer of Health, whether it is among the rich or among the poor. "In all this," to use the words of the Royal Commission

[1] Report of the Poor Law Commission, 1909, Q. 94287, par. 28.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on Hospitals of 1882, "we suggest no distinction between rich and poor, pauper and non-pauper cases, except that between persons who can and those who cannot be isolated at their homes or in some place approved by the proper authorities—an exception which, of course, will not extend to the official notification of disease. In default of which isolation the hospital authority (however constituted) should, we conceive, be bound and empowered to remove to the hospital every patient capable of removal without risk to life or serious aggravation of the disease."[1] "The Public Health Acts," says a high authority, "are not conditioned in their operation by any such irrelevant consideration as the possible patient's poverty or destitution. The authorities are bound to do what is possible to prevent disease whatever be the economic condition."[2] Equally irrelevant to them must necessarily be the assumed Poor Law distinction between indoor and outdoor treatment which always implies some superiority in the indoor over the outdoor, as applying a deterrent test. And it is just because the Medical Officer of Health aims at dealing with every case in its incipient stage—even before the patient himself, or his family, recognises that he is ill, and long before the drug or the knife becomes requisite—that we find, in the public health curative treatment, the largest part played by hygienic advice, so that some of the more naïve witnesses before the Poor Law Commission declared that it was not medical treatment at all!

[1] Report of the Royal Commission on Hospitals, 1882, p. 11.

[2] Report of the Poor Law Commission, 1909, *Q.* 56605, par. 131, evidence of Dr. Leslie Mackenzie, Medical Member of the Local Government Board.

It is an interesting practical result from the foregoing characteristics of the Public Health Medical Service—in marked contrast to the Poor Law Medical Service — that scientific investigation and research occupy a large part of the intellect and activity of the Medical Officer of Health. We see him observing and recording the location and circumstances of diseases; we find him applying the logical methods to the discovery of the causes of the local outbreaks; he is great at statistical verification of hypotheses. He calls to his aid the microscope and chemical analysis. It is in the department of the Medical Officer of Health that (outside the hospital or the university) we find the bacteriological laboratory, with all its potentialities of scientific diagnosis. We are inclined to think that, in England to-day, there is far more scientific research into the cause and treatment of disease done by the medical men of the Public Health Service, in proportion to their numbers (not to say their financial resources), than in any other branch of the medical profession.

Passing from the characteristics of the Public Health medical service to its effects on its patients, there comes to light an interesting contrast with the Poor Law medical service. It has been strongly urged upon the Commission that Poor Law medical relief is not merely "deterrent" but that, when accepted, it breaks down the independence of the recipient and leads him frequently to become a chronic pauper. It is alleged that the labourer who begins by asking the Relieving Officer for a midwifery order or for medical attendance on his ailing infant is easily led on to apply for a Medical Order for himself and presently for outdoor relief. No such allegation

is made with regard to submission to medical treatment by the Public Health Authority. On the contrary, there is absolute uniformity of testimony, from all sorts of witnesses in all parts of the country, that the medical attendance and medicine of the Public Health Department has no pauperising tendency. The fever-stricken patient who is removed to the isolation hospital, or the mother who receives hygienic advice about her infant, are not thereby induced to find their way to the Poor Law. Indeed, it has been repeatedly given in evidence by witnesses with practical experience that the essential characteristic of the Public Health medical service—that it is rendered in the interest of the community and not in order merely to relieve the suffering of the individual —actually creates in the recipient an increased feeling of personal obligation, and even a new sense of social responsibility.[1] This sense of obligation is, we are informed, seen in a new responsibility as to not creating nuisances or infecting relations and neighbours; in a deliberate intention to remain healthy, and therefore to control physical impulses; and in an altogether heightened parental responsibility in the matter of the conscientious fulfilment of the daily—even the hourly—details of family *régime* necessary for the rearing of the infant or the recovery of the invalid. The very aim of sanitarians is to train the people to better habits of life. The object of health visiting is to make the people understand that prevention is better than cure.[2] It has, indeed, been

[1] See, for instance, the striking evidence of Dr. Leslie Mackenzie, Medical Member of the Local Government Board for Scotland, before the Poor Law Commission, 1909, *Qs*. 56927-34.

[2] "I look," stated the distinguished sanitarian who was recently Medical Officer of Health for Finsbury, and is now the Medical Officer to the Board

strongly urged that actual experience of public health administration indicates that universal medical inspection, hygienic advice, and the appropriate institutional treatment of those found out of health might have as bracing an effect on personal character, by imposing a new standard of physical self-control as it would have on corporeal health. Nor is this a mere figment of the imagination. "The form in which medical aid would be given," states Dr. Newsholme, the Medical Officer of the Local Government Board, in the light of his actual experience with the hundreds of phthisical patients whom he has treated, "would be such as constantly to enforce on the minds of the patients their duty to the community and to themselves in matters of health. Though they would pay nothing, they would not be merely passive recipients of advice and attention. The influence of the doctor would demand from them habits of life and even sacrifices of personal taste in the interest of the health of the community, their families and themselves, which would leave them conscious of a sensible discharge of duty in return for the attention which they received. The discipline of responsibility into

of Education, "to a betterment of the personal factor as likely at the present time (now that environment has reached a high standard of excellence) to be most effectual in the betterment of physical life. I would, if I could, bring to bear upon the homes of the people of Finsbury more suitable health visitation, by which we should gain: (*a*) information as to the occurrence of illness; (*b*) information as to sanitary conditions; (*c*) advice on domestic hygiene, dietaries, cleanliness, etc.; (*d*) direction and advice on the whole question of infancy and children; (*e*) counsel in the carrying out of medical treatment; (*f*) special health work in the direction of phthisis prevention, physically defective children, invalid children, and so on. Such health visitation would act as a deterrent to malingering and unsupportable complaints of which we now receive a large number. They might also assist in providing some check on school non-attendance, employers' certificates in relation to infectious diseases, etc." (Report of the Poor Law Commission, 1909, *Q.* 94287, pars. 27, 28.)

which the system would educate them should, in my judgment, suffice to avoid the loss of self-respect liable to arise from the merely passive receipt of gifts; and it would introduce into the national life an attitude towards matters of personal health that would have an indirect influence on conduct while directly restricting disease."[1]

But the Public Health medical service, as it exists to-day, has grave defects. Though nominally co-extensive with the kingdom and applicable to all preventable disease, it exists, over a large part of the country, merely in skeleton outline. So far as we have been able to ascertain, positively a majority of the 650 Rural Sanitary Authorities of England and Wales, and not a few of the smaller Urban Sanitary Authorities, have no hospitals even for the most infectious diseases, no domiciliary visitation for the searching out of disease, and nothing more in the way of a Medical Officer of Health than a scrap of the time of a private practitioner, to whom the small fee of a few guineas comes with instructions "not to be meddlesome." Some sanitary districts are far too small for efficiency, there being even "urban districts" with less than 1000 population. It is true that there is provision for voluntary combinations of districts, and such exist; but they are difficult to arrange, and not permanently satisfactory. Even in many considerable urban districts the Local Authorities have not

[1] Report of the Poor Law Commission, 1909, *Q.* 92534, par. 36. "Most people," says the Medical Officer of Health for Manchester, "can pay something; if they cannot pay in money they can pay in care and trouble in carrying out instructions, in seeing to the cleanliness of the home, and in taking those measures of precaution which the public authority considers advisable, in looking to the welfare of the children, and in seeing that the children are properly clothed." (*Ibid.*, *Q.* 38532.)

yet realised the importance either of extending their isolation hospitals to anything but the "seven chief zymotics," or of any sort of supervision of infantile ailments. A large town like Norwich was, in 1906, making "no provision for the treatment of other infectious ailments, such as measles, German measles, whooping-cough, chickenpox, and mumps; nor for the tuberculous diseases, nor for such contagious diseases as scabies and the other pediculi, nor for venereal diseases."[1] The varied activities that we have described have, in fact, often emanated from the zeal and energy of the Medical Officer of Health himself. It is a further drawback that the apathy of the Local Authorities is not systematically exposed by any regular inspection by the Local Government Board,[2] and that the zeal and enterprise of the best among them meets, so far as published documents go, with little official recognition or encouragement. Even in the largest provincial centres of population, where the Public Health medical service is most fully developed, the systematic medical observation of the children is limited to the entirely arbitrary period of the first twelve months; there is no regular inspection or house-to-house visitation for children between one and five, during which ages measles and whooping-cough are most deadly; any systematic medical supervision of pupils at school is, notwithstanding

[1] Report of the Poor Law Commission, 1909, Appendix xlvi. (par. 7) to vol. ix.

[2] It is surprising how little is known, even to the Local Government Board, of what the several Local Authorities are doing, or leaving undone, in the domain of public health. Even the Poor Law Commission was unable to obtain any statistical or other information for the kingdom as a whole as to municipal hospitals, health visiting, the treatment of phthisis, the campaign against infantile mortality, the extent and the diseases to which voluntary notification is in operation, and many other points.

the recent introduction of medical inspection, in most places practically restricted to those whom the teachers report as absent through infectious disease; there is as yet hardly anywhere any systematic treatment of their affections of the eyes, ears, nose, teeth, throat, and skin—not to mention incipient curvature; there is no study of diathesis in order to advise as to occupation; and there is no regular system of observation of the "children of larger growth"—not even of the pregnant mothers of the race. After infancy, in fact, the activity of the most public-spirited Medical Officer of Health is—but for the nascent service of school hygiene—limited practically to particular diseases, to such, in fact, as the Local Authority may choose to consider sufficiently infectious. The most energetic are no further advanced than, following the lead of Dr. Niven at Manchester and Dr. Newsholme at Brighton, to have begun to include tuberculosis, and to provide for a tiny proportion of the cases—usually the advanced cases—of phthisis in their districts; though "between the ages of fifteen and thirty-five more than one-third of all deaths are due to this cause."[1] None of them, so far as we have been able to ascertain, deal with venereal diseases. In short, the Public Health medical service, though excellent in its aims and results, and demonstrably successful in a few zealous districts, for such diseases as it has there touched, is, from a national standpoint, in 1910, still suicidally deficient in its volume and geographical extension.

[1] Report of the Poor Law Commission, 1909, *Q.* 38380, par. 63.

CHAPTER VI

THE NEED FOR A UNIFIED MEDICAL SERVICE

It is, we think, impossible, after surveying the whole field, to avoid the conclusion that what is before all else needed, with regard to the curative treatment of the sick poor, is the establishment of one united County Medical Service, in which the medical services of the Poor Law and the Public Health Authorities would be merged. It has been abundantly proved that "at the present time the question of treatment of sickness is in a state of chaos and confusion entailing a great deal of overlapping and unnecessary expense."[1] "There is," we are told, "considerable waste of energy and money. Two sets of officials visit the same houses, one for one object, the other for another. Neither completely attains his object —the cure of the social bad habit—and neither has much hope of doing so under existing circumstances. Much of this waste of money and energy would be saved by amalgamation of Poor Law and Sanitary Authorities."[2] In consequence of this overlapping and confusion, the community is at present spending an untold amount of public money—apparently as much as seven or eight millions sterling annually—

[1] Report of the Poor Law Commission, 1909, *Q.* 37927, par. 56 ([illegible]).

[2] *Ibid.*, *Q.* 38758, par. 28.

on the curative treatment of the sick by the rival authorities. In return for this large expenditure we have two conflicting Public Medical Services, both rate-paid, overlapping in their spheres, practically without communication with each other, working on diametrically opposite lines, and sometimes positively hindering each other's operations. Between them, it was given in evidence, they fail to provide for a large proportion of the illness—even of the preventable illness—of the community. The number of cases of sickness—even of dangerous infective sickness—that go entirely without medical attendance of any sort, private or public, is demonstrably enormous. The proportion of uncertified deaths, indicating a total lack of any sort of medical attendance even in the most advanced stages of disease, rises, as the Registrar-General warns us, in certain towns in England to 4 or 5 per cent, in certain counties of Scotland to 20 and even 30 per cent, in some islands to as many as 60 or 70 per cent.[1] But to the community it is of less importance that people should die without medical attendance than that they should live without it. What is above all deplorable is the enormous amount of incipient disease that exists—undiscovered, untreated, and unchecked—in the infants, school children, and young persons who constitute one-half of the entire population, and upon whose health the productive power of the next generation depends. Even in the Metropolis, where hospitals and free dispensaries abound, and where the Poor Law medical relief is specially well organised, it is evident that a large proportion of the 18,000 infants

[1] Report of the Poor Law Commission, 1909, *Q.* 56605, par. 111; Report of Departmental Committee on Medical Relief (Scotland). 1904, pp. 71-2.

who die annually in the first year of life are medically attended, if at all, only in the last days or hours of their brief existence—often merely in order to avoid trouble with the coroner or the insurance company. Among the 1,000,000 or more older children in the Metropolis, some 40,000 of whom are probably ill at any one time, thousands of the cases of measles and whooping-cough are not medically attended at all. The married woman, left without medical or even midwifery attendance at her first childbirth, is not infrequently injured for life, both as mother and as industrial worker. The young artisan with the seeds of tuberculosis in him goes on, for lack of medical inspection and advice, in habits of life which presently bring him, too late to be cured—after, perhaps, he has infected a whole family—to the sick ward of the workhouse. Scarcely less important to the nation are the ravages of venereal disease, which now goes almost entirely untreated, either by the Public Health medical service or by the Poor Law medical service (except when advanced cases enter the workhouse as destitute), whilst the sick clubs and provident dispensaries definitely or by implication exclude treatment of such cases. Yet it is proved that, owing to lack of medical treatment or to insufficient medical treatment, such diseases as syphilis and gonorrhœa are eventually responsible for a very large proportion of the pauperism of disease and insanity.[1] For all

[1] We gather from the reports of Dr. Mott, F.R.S., Pathologist to the Claybury Asylum of the London County Council, that it now seems that syphilis is responsible for more insanity than alcoholism ; and especially that it is the cause of practically all the general paralysis of the insane and locomotor ataxy. It leads, as the Departmental Committee on Physical Degeneration reports, to "insanity, idiocy, diseases of bones producing deformity and disfigurement, diseases of the eyes producing blindness, diseases of the ear producing deafness, disease of the internal organs

these cases, so vital to the interests of the community, the Poor Law medical service—costly though it be—is, with its stigma of pauperism, its deterrent tests, its consequent failure to get hold of incipient disease, its total ignoring of the preventive aspect of medicine, its lack of co-ordination between domiciliary inspection and institutional treatment, practically useless. Medical "relief" may even be regarded, for all its attempted palliation of individual suffering, from the standpoint of national health (at any rate in a large proportion of cases), as worse than useless. In so far as it encourages in the patient faith in the taking of medicine instead of reliance on hygienic regimen—wherever the District Medical Officer dispenses physic rather than advice—it positively counteracts the efforts of the Public Health medical service in the promotion of personal hygiene. And when the District Medical Officer, conscious that his physic will not avail, orders "medical extras," he provides the fatal introduction of the patient to reliance on the food or money doled out by the Relieving Officer. On the other hand, the existence of a separate Poor Law medical service, with its hundreds of thousands of patients under medical treatment in the course of each year, gives the Public Health Authority an excuse for not—except for this or that particular disease, or for infants under twelve months old—acting upon what are actually its statutory powers to provide hospital accommodation for all, and temporary medical attendance and medicine for the poorer classes.[1]

producing defective nutrition and deficient development, disease of the nervous system producing insidious forms of paralysis, locomotor ataxy, etc." (Report of the Departmental Committee on Physical Degeneration, 1904, p. 77.)

[1] The Local Sanitary Authority is even induced, though the tramp on

As we have shown, the conflict and confusion between the two rival public medical services has already reduced the question of recovery, from the patient or his friends, of the cost of his treatment and hospital maintenance, to a state of chaos, almost ludicrous in its paradoxes. The more destitute a patient is, the more frequently he is liable to have the cost of his treatment charged to himself and recovered from his relatives; and it is just in those cases in which such a charge is made and the amount recovered that he is most frequently subjected to the stigma of pauperism and disqualified from exercising the electoral franchise. In those cases in which the patient is maintained in hospital and treated free of charge, without the stigma of pauperism or electoral disqualification, the rich man may take advantage of the rate-provided service as freely as the starving tramp. No less incongruous is the distinction made between different diseases. Patients who have so neglected the elementary duties of personal cleanliness as to become infested with lice are treated free of charge, their clothing is disinfected gratis, and it may even (as at Liverpool) be destroyed and replaced at the public expense—all without any stigma of pauperism. On the other hand, the person suffering

discharge may infect a whole town, to refuse to treat the most infectious or communicable diseases when these occur in destitute paupers. At Bristol, between 1886 and 1894, the Board of Guardians itself provided isolation hospital accommodation for all the destitute infectious sick, whilst the Town Council provided similar (only far superior) accommodation for the non-destitute infectious sick. The results of this administrative duplication were so injurious (smallpox twice becoming epidemic in the city), the friction and delays were so great, and the total expense was so unnecessarily increased that after eight years' trial the Board of Guardians ceded the whole service to the Town Council, which has since dealt alike—but only for these particular three or four diseases—with the destitute and the non-destitute. As regards all other kinds of disease the conflict continues, and the results, although not so dramatically obvious, may be no less disastrous.

from an occupational disease incurred in the earning of his daily bread, under circumstances over which he has no control, has, unless destitute, nowhere any right to public medical aid; and in the majority of places no public medical attendance is provided for him under any conditions unless he becomes destitute. The wife who, in the public interest, is compulsorily removed from her home as a dangerous (or merely a publicly disagreeable) lunatic becomes (in England) a pauper, makes her husband a pauper, and subjects him to the liability of having to repay to the Guardians the whole cost of her maintenance. On the other hand, the Barry dock labourer or the Widnes chemical worker who breaks his leg in a drunken spree gets hospital maintenance and the best of surgical attendance provided for him out of the rates without conditions, without charge, without stigma of pauperism, and without electoral disqualification. Nor does the presence or the degree of danger to the public afford any certainty that there will be any public provision for medical treatment. The most dangerous of all diseases to the public health—syphilis—is, owing to "deterrent" tests, at present not usually dealt with at all—and practically never in its most contagious phase—by either the Public Health or the Poor Law medical service. Tuberculosis, which, we believe, stands second in public danger, is, in its incipient stages when treatment is of some use, publicly provided for only in a few towns to a small extent; and even in its advanced stages, when it is most communicable, it is nearly everywhere treated by a public authority only when the patient is destitute, and is then scarcely ever treated in a way calculated to promote recovery.

Finally, through the chaos into which the whole subject of public medical attendance has been allowed to fall, we have the beginnings of what might easily develop into a new national danger, namely, the irresponsible grant of "relief in kind," and even a weekly dole of money, by the Public Health Authorities, intent only on the prevention of disease and heedless of the perils of a system of indiscriminate outdoor relief. On the other hand, we discover enlightened and progressive Boards of Guardians, in their anxiety to check the disease that reduces so many to dependence on the poor rate, boldly trespassing into the domain of Public Health administration, and actually pressing all and sundry wage-earners, in whom incipient tuberculosis is detected, to enter a Poor Law institution and incur all the taint of pauperism and a dangerous familiarity with Poor Law relief, in order that, in the public interest, they may be shown how to live healthily.[1]

It is, we think, clear that the united Public Medical Service, in which those of the Poor Law and Public Health Authorities will have to be merged,

[1] It is quite another kind of anomaly that two of the most important instruments of the Public Health medical service, the registration of births and deaths and vaccination, have no connection whatever with the Public Health organisation, but are attached, more or less closely, to the Poor Law. The nomination of local registrars of births and deaths, who receive authentic information of what is essential for the Medical Officer of Health to know, by the Board of Guardians, and their almost complete lack of connection with the Local Health Service, is explicable only on historical grounds. The same is true of the vaccination doctors and officers who now administer at enormous expense a specific medical treatment, free to all alike, destitute or non-destitute, in order to prevent the ravages of a disease that has now been made far less disabling to the individual and far less destructive to the community than either tuberculosis or syphilis. The desirability of transferring this function from the Poor Law to the Public Health Authority was urged by many witnesses before the Poor Law Commission (Report of the Poor Law Commission, 1909, *Qs.* 36690, 38631 (pars. 7-11), 44173-5, 47882, 48888 (par. 20), 52434 (par. 7), etc.)

must be established on the lines of scientific prevention of disease and the appropriate treatment at the earliest possible stage of such disease as is not prevented—its medical practice, in short, must be based upon Public Health rather than upon Poor Law principles. We might have hesitated to express so definite an opinion on such a subject as the proper basis of organisation of the Public Medical Service of the State—vitally connected as it must be with the prevention and treatment of destitution and pauperism—were it not for the fact that the Poor Law Commission was led to investigate this part of its subject-matter with special thoroughness, and that the weight of testimony, both administrative and medical, appears to us to be overwhelming. A certain number of the doctors who were consulted, including private practitioners and Poor Law doctors, and even some Medical Officers of Health, expressed themselves, indeed, like many of the Poor Law officials, as inimical to a unified Public Medical Service,[1] either because they were, through long habit, not conscious of the defects in the existing arrangements, or because they could not see how a united service would work. Some of these—forgetting, we think, the large amount of actual treatment of disease now carried on by the Public Health Authorities—urged that it was positively advantageous for preventive work to be carried out by one department and curative work by another.[2] The Poor Law Commission was, however, naturally impressed by

[1] See, for instance, Report of the Poor Law Commission, 1909, *Qs.* 34206, 42549-50, 47757-9, 50281 (par. 9), and Appendices Nos. xx. (par. 6), lxv. (par. 18), lxxxiii. (par. 7), xci. (par. 8), xciv. (par. 3), civ. (par. 22) to vol. v., and cxix. (par. 12) to vol. vi. (statement of Dr. J. M. Ross).

[2] *Ibid.*, *Qs.* 37605 (pars. 43, 44), 47745 (pars. 10, 11).

the wide concurrence in the recognition of the superior advantages of a united State Service expressed by those who had given thought to the subject.[1] The Medical Investigator appointed by the Commission specially to inform them on this subject found himself, as he relates, irresistibly driven to the same conclusion.[2] What is perhaps even more convincing is the fact that the imperative need for unifying the present competing Public Medical Services is felt by the heads of all the four public departments concerned. "I think it was unfortunate," says the Medical Commissioner of the Local Government Board for Ireland, "that Public Health did not precede Poor Law, and that the medical relief of the poor, both indoor and outdoor, was not organised as a Public Health Service. A Health Service having for its first and great aim the prevention of disease,

[1] Amongst these we may mention, in particular, Dr. Nathan Raw (Report of the Poor Law Commission, 1909, *Q.* 37927, par. 57); Dr. Bygott (*ibid.*, *Qs.* 43998 (par. 54), 44088); Dr. Burnett (*ibid.*, *Qs.* 44124, 44588); and Dr. Longbotton (*ibid.* Appendix No. lxxxiii. (pars. 18, 19) to vol. iv.), of the Poor Law medical service; Dr. Meredith Young (*ibid.*, *Q.* 38758, pars. 15-18); Dr. Barlow (*ibid.*, *Q.* 38631 (par. 20), 38723); Dr. M'Cleary (*ibid.* Appendix xlv. (par. 28) to vol. ix.); Dr. Richards (*ibid.* Appendix No. xlvii. (pars. 25-9) to vol. ix.); Dr. Cooper-Pattin (*ibid.* Appendix No. xlvi. (par. 31) to vol. ix.); Dr. Davies (*ibid.* Appendix xliv. to vol. ix.); Dr. Chalmers (*ibid.*, *Q.* 95100, pars. 30-51); Dr. Gould (*ibid.* Appendix No. xxxviii. to vol. iv. pars. 14-19); and Dr. Morrison (*ibid.*, *Q.* 52434, par. 8), of the Public Health Service; and Dr. M'Alister Hewlings (*ibid.*, *Q.* 47501, par. 45-9); Dr. Lea (*ibid.*, *Qs.* 36982, 37062); Dr. Reid (*ibid.*, *Q.* 50912), and others, who are private practitioners.

[2] "Should the control of all the health conditions of the poor be put under a single Health Authority? . . . Should this Health Authority supervise the work of the District Medical Officers, or, on the other hand, should there be two medical services supported by the State? . . . Having no previous knowledge of the English Poor Law, I believe I approached the question with an open mind. . . . As my inquiry progressed, however, the conclusion has forced itself on me that transference of functions should take place if that be practicable." (Report on Poor Law Medical Relief, by Dr. J. C. M'Vail, Appendix, vol. xiv. p. 153.)

embracing the present Public Health, Medical Charities, and Poor Law Hospital Services, and, in fact, charged with the prevention and treatment of disease among the poor would, I consider, particularly if managed as a State Service, be a forward step of immense benefit to the public health and poor of the country. Everything points to the fact that the future of all medicine, but particularly of Poor Law medicine, lies in the adoption of preventive measures; the time has passed when the principal function of the Poor Law Medical Officer is merely to dispense drugs."[1] The need for union of the rival medical services has been equally urged by Dr. Newman, formerly Medical Officer of Health for Finsbury and for the County of Bedford, and now Medical Officer of the Board of Education. "My experience," says Dr. Newman, "convinces me that from a medical point of view further co-ordination is imperatively necessary . . . between Public Medical Services, and if practicable a unification under one authority. . . . Personally I am disposed to think that the medical part of the Poor Law Services might suitably be organised, partly or wholly, in conjunction with the Health Authorities. . . . By some such unification the Medical Service would be more economical as well as more efficient and effectual."[2] Striking testimony to the same effect is borne by Dr. Leslie Mackenzie, the Medical Member of the Local Government Board for Scotland, as to the urgent need for a complete provision by the community for all cases

[1] "Some Notes on Public Health and its Relation to the Poor Law in Ireland," by Dr. T. J. Stafford, and "Poor Law Dispensary Relief in Ireland," by the same; see also Report of Poor Law Commission, 1909, *Q.* 99882, and Appendix, vol. x.

[2] *Ibid.*, *Q.* 94287, par. 31; see also *Qs.* 94367-70, 94379, 94380, etc.

of sickness.[1] Most emphatic and impressive of all has been the evidence in confirmation of Dr. Newsholme, given first as Medical Officer of Health for Brighton, and then on wider and fuller information, officially repeated by him as Medical Officer of the Local Government Board for England and Wales. "Under the present conditions of treatment of sickness for the poor," says Dr. Newsholme, "diagnosis is usually belated, treatment is curtailed, and its efficiency is correspondingly diminished. . . . I entertain little hope of success [in respect of measles and whooping-cough] until more efficient medical attendance is promptly available in the homes of the very poor. . . . The divided responsibility as to cases of puerperal fever and erysipelas needing institutional treatment at the present time leads to inefficient arrangements for such cases, and to much suffering and some loss of life. . . . Such instances represent only a small part of the mischief caused by the division of responsibility and powers." And he sums up significantly "that the present division of medical duties is gravely mischievous to public health and the unification suggested is very desirable."[2] Such testimony, we feel, cannot be disregarded.

Turning now to the supervision of the work of the

[1] Report of the Poor Law Commission, 1909, *Q.* 56605, pars. 126-41, 155-62.

[2] Memorandum by the Medical Officer of the Local Government Board on the Unification of the Official Medical Services for the Poor. (*Ibid.* Appendix No. liv. to vol. ix. ; see also *Qs.* 92531-93029.) This consensus of weighty testimony is supported by the definite recommendations of the Vice-Regal Commission on the Irish Poor Law, in favour of the complete separation of all medical relief from the Poor Law, and the organisation, under the County and County Borough Councils, of a unified system of hospitals, dispensaries, and domiciliary treatment. (Report of the Vice-Regal Commission on Poor Law Reform in Ireland, 1906, vol. i. pp. 21-34.)

Local Authorities by the Central Authority, it is, we suggest, essential that this unified County Medical Service should have the guidance and control of a single Central Department, having the supervision of everything relating to the public health. Representations were even made before the Poor Law Commission in favour of the establishment of a separate Ministry of Public Health with a representative in the Cabinet. Leaving aside, however, this larger question, it is surprising to find that notwithstanding the strong recommendation of the Sanitary Commission of 1869, there does not exist to-day even a self-contained Division of the Local Government Board dealing with the subject. The supervision and control of the public provision for the prevention and cure of disease—a service on which the nation is spending altogether many millions sterling annually—is scattered among no fewer than five Divisions or Departments of the Local Government Board, each having its own staff, its own experience of administration, its own expert consultants, its own views of policy, and its own permanent head responsible for advising the Permanent Secretary and the President of the Board. Thus, all questions relating to the Poor Law infirmaries and the isolation hospitals of the Metropolis go to the Poor Law Division; and about these the Secretary and President are advised as to policy by Mr. J. S. Davy, C.B. The isolation hospitals everywhere else, and the vaccination business of the Boards of Guardians (though not their administration of the Infant Life Protection Act), are dealt with by another Division; and the Secretary and President are advised as to policy

by Mr. F. J. Willis. But this Division, called the "Public Health, Local Finance, and Local Acts Division," also deals with Public Libraries and Canal Boats, and is encumbered, curiously enough, with the entire subject of Local Finance, including rates, assessments, loans, and the accounts of Municipal Corporations. It is also responsible for the supervision of water supply, rivers pollution, and the purity of food and drugs. The whole activity of Local Authorities under the Public Health Acts and the Gas and Water Facilities Act is looked after by yet another Department, the "Sanitary Administration and Local Areas Division," which also deals with Housing, Drainage, Roads, and Burial; and on all these matters the Secretary and President are advised as to policy by Mr. N. T. Kershaw, C.B. On the other hand, the vital question of bylaws under the Public Health and other Acts, and of regulations as to water supply and milk, as well as those relating to motor cars — together with the whole administration of the Unemployed Workmen Act of 1905, and, curiously enough, also of the Old-Age Pensions Act of 1908 — is in the hands of yet another Division, under Mr. Jerred, who has the responsibility of advising the Secretary and President as to the policy to be pursued with regard to these heterogeneous services. Apart from all these Divisions, with a department of his own, stands the Chief Medical Officer of the Board, Dr. A. Newsholme, who, as we have learned from the complaints of his distinguished predecessor, Sir John Simon,[1] may or may not advise the President with regard to these health matters, according to whether or not the other

[1] *English Sanitary Institutions*, by Sir John Simon, 1890, pp. [illegible].

Divisions, which are charged with one or other of the fragments of the Public Health Service, send the papers to his department.

It seems clear that there can be neither adequate control of expenditure nor efficiency of service, whether on the side of the Poor Law medical service or on that of the Public Health medical service, so long as this illogical and demoralising distribution of the central control among five rival divisions or departments of the Local Government Board continues to prevail. To-day, as it was authoritatively stated in 1869, "the causes of the present inefficiency of the Central Sanitary Authority are obvious:—

(1) Its want of concentration. . . .

(2) The want of central officers, there being, for instance, no staff whatever for constant, and a very small one for occasional, inspection.

(3) The want of constant and official communication between central and local officers throughout the kingdom.

The new statute, therefore, should constitute, and give adequate strength to, *one Central Authority* . . . not to centralise administration, but, on the contrary, to set local life in motion—a real motive power, and an Authority to be referred to for guidance and assistance by all the Sanitary Authorities for Local Government throughout the country."[1] The historian cannot help attributing to the scattering of the knowledge, the power, and the responsibility among five different heads of Departments, all offering advice to the Permanent Secretary

[1] Second Report of the Sanitary Commission, 1871, pp. 30-31.

and to the President of the Board, the lack of any strong and consistent policy with regard to the public provision for the prevention and treatment of disease, the terrible want of co-ordination among the several parts of this service, the failure even to keep the work of the Local Authorities under supervision by any systematic medical inspection of the various public hospitals and infirmaries, the absence of medical statistics of their work, and the lack of guidance of the manifold activities and frequent omissions of the Local Authorities in the whole domain of Public Health, with which, as we have seen, the work of the Boards of Guardians is so closely connected. The time has surely come when the responsibility for the supervision, guidance, and control of the Local Authorities in all their action in the prevention and treatment of disease, including the administration of the Grants-in-Aid[1] in respect of this service, should be placed upon a single Public Health Department, whether that Department be represented by a Minister of its own, or form the principal Division of the Local Government Board. To this Public Health Department—which should be self-contained and complete in itself, with its own specialised legal and architectural experts—there would naturally fall the supervision of all public hospitals and infirmaries, whether now administered by Boards of Guardians or by Town Councils, etc.; of all domiciliary medical inspection and treatment,

[1] It is remarkable that the Local Health Authorities in England and Wales, vital as is their work to the community as a whole, receive, at present, the stimulus and assistance of practically no Grants-in-Aid, the only exception being less than £100,000 annually towards the salaries of Medical Officers of Health, Inspectors of Nuisances, and Registrars of Births and Deaths, and the payments to Public Vaccinators.

whether by the District Medical Officers or the Medical Officers of Health; of all developments of vaccination and the use of antitoxins; of all the provision made for infants under school age including the administration of the Infant Life Protection Act, now re-enacted in the Children Act, 1908; of all the institutional provision made for the aged; of the measures taken to secure the wholesomeness or purity of milk, meat, and other food, and of drugs; of the bylaws and regulations relating to matters of health; and of water supply, drainage, and house sanitation. The Department would, of course, have its own staff of qualified Inspectors; among which there would, no doubt, be developed a Hospital Inspection Branch, dealing systematically with all the institutional provision for the sick, to which the present "Medical Inspectors for Poor Law Purposes" would bring their valuable experience.

Such a Public Health Department would, of course, need more than one Assistant Secretary; would have, as its immediate permanent head, an officer combining administrative with Public Health experience, and would include among its administrative staff (and not merely as consultants) men of medical qualifications. It might well be considered whether the office of Chief Medical Officer should not be combined, if not with that of the permanent head, at all times with that of one of the Assistant Secretaries (just as the office of Chief General Inspector is now combined with that of Assistant Secretary for the Poor Law Division), in order that—as is already the case in Scotland and Ireland, to the great advantage of the Public Health Service—the Chief Medical Officer may, on the one

hand, be in direct communication with the Local Authorities, and, on the other hand, be directly responsible for advising the Permanent Secretary and the President of the Local Government Board as to policy in all matters relating to Public Health.

CHAPTER VII

STRAIGHTENING OUT THE TANGLE

We do not think that any one who has seriously considered the position can avoid the conclusion that the continued existence of two separate rate-supported Medical Services in all parts of the Kingdom, costing, in the aggregate, six or seven millions sterling annually—overlapping, unco-ordinated with each other and sometimes actually conflicting with each other's work—cannot be justified.

It is, we think, clear that the very principle of the Poor Law Medical Service—its restriction to persons who prove themselves to be destitute—involves delay and reluctance in the application for treatment; hesitation and delay in beginning the treatment; and, in strictly administered districts, actual refusal of all treatment to persons who are in need of it, but who can manage to pay for some cheap substitute. These defects, which we regard as inherent in any medical service administered by a Destitution Authority, stand in the way of the discovery and early treatment of incipient disease, and accordingly deprive the medical treatment of most of its value. We regard it as demonstrated beyond all dispute that the deterrent aspect which the medical branch of the Poor Law acquires through its associa-

tion with the Destitution Authority, causes, merely by preventing prompt and early application by the sick poor for medical treatment, an untold amount of aggravation of disease, personal suffering, and reduction in the wealth-producing power of the manual working class. The operations of the Poor Law Medical Service, being controlled by Destitution Authorities and administered by Destitution Officers, inevitably take on the character of unconditional "medical relief"—that is, relief of the real or fancied painful symptoms—as distinguished from remedial changes of regimen and removal of injurious conditions, upon which any really curative treatment, or any effective prevention of the spread or recurrence of disease, is nowadays recognised to depend. The decision as to whether any case of illness should be treated at home, or removed to an institution, is to-day made, for the most part, on grounds irrelevant to the medical aspects of the problem. We think that whilst domiciliary treatment of the sick poor is appropriate in many cases, it ought to be withheld :—

(i.) Where proper treatment in the home is impracticable.

(ii.) Where the patient persistently malingers or refuses to conform to the prescribed regimen ; or

(iii.) Where the patient is a source of danger to others.

It has become imperative in the public interest that there should be, for extreme cases, powers of compulsory removal to a proper place of treatment. Such powers cannot, and in our opinion should not, be granted to a Destitution Authority. On the other hand, where the Destitution Authorities cease to

abide by the limitation of their work to persons really destitute, or pass beyond the dole of " Medical Relief," their attempt to extend the range or improve the quality of the Poor Law Medical Service brings new perils. It is impossible to regard with favour any action which, in order to promote treatment, openly or tacitly invites people voluntarily to range themselves among the destitute; or which tempts them, by the prospect of getting costly and specialised forms of treatment, to stimulate destitution. Nor do we think that an Authority charged with the relief of destitution, whatever its method of appointment or whatever the area over which it acts, or any Authority acting through officers concerned with such relief, whatever their official designation, can ever administer a Medical Service with efficiency and economy.

With regard to the suggestion that the medical treatment of the sick poor should be left either to provident medical insurance or to voluntary charity, it has now been demonstrated that these offer no possible alternative to the provision for the sick made by the Public Authority. With regard to domiciliary treatment, the evidence as to medical clubs, "contract practice," provident dispensaries, and the out-patients' departments of hospitals is such as to make it impossible to recommend, in their favour, any restriction of the services at present afforded by the District Medical Officers and Poor Law dispensaries. Nor can any one be warranted in giving support to the proposal that the whole of this outdoor medical service of the Poor Law should be superseded by a publicly subsidised system of letting the poor choose their own doctors. Any such system would lead, not only to a most serious inroad upon the work and

emoluments of the private practitioner, but also to an extravagant expenditure of public funds on popular remedies and "medical extras," without obtaining in return for this enlarged "Medical Relief," greater regularity of life or more hygienic habits in the patient. With regard to institutional treatment, no one can ignore the inestimable services rendered to the sick poor by the hospitals, sanatoria, and convalescent homes supported by endowments or voluntary contributions. The use now made of these institutions by Public Authorities is of the greatest value; and it may well be that many more suitable cases than at present might, on proper arrangements as to payment, be transferred from rate-maintained to voluntary institutions. But it is clear that such institutions provide only for a small fraction of the need, and that they leave untouched whole districts for some cases, and whole classes of cases everywhere, which there is no prospect of their being able or willing to undertake.

Turning now to the Medical Service of the Public Health Authorities, which now extensively treats disease, and actually maintains out of the rates a steadily increasing number of the sick poor, it is plain that it is based on principles more suited to a State Medical Service than those of the Poor Law. These principles, which lead, in practice as well as in theory, to searching out disease, securing the earliest possible diagnosis, taking hold of the incipient case, removing injurious conditions, applying specialised treatment, enforcing healthy surroundings and personal hygiene, and aiming always at preventing either recurrence or spread of disease—in contrast to the mere "relief" of the individual—furnish, it would

to-day be argued, the only proper basis for the expenditure of public money on a Medical Service. Such compulsory powers of removal in extreme cases, as have been asked for, are analogous to those already exercised, with full public approval, by the Public Health Authorities; and the proposed extension of such powers can properly be granted only to an authority proceeding on Public Health lines.

It is therefore difficult, we suggest, not to agree with the responsible heads of all the four Medical Departments concerned—the Chief Medical Officer of the Local Government Board for England and Wales, the Medical Member of the Local Government Board for Scotland, the Medical Commissioner of the Local Government Board for Ireland, and the Medical Officer of the Board of Education—in ascribing the defects of the existing arrangements fundamentally to the lack of a unified Medical Service based on Public Health principles. In such a unified Medical Service, organised in districts of suitable extent, the existing Medical Officers of Health, Hospital Superintendents, School Doctors,[1] District Medical Officers, Workhouse

[1] The question has been raised of the relation in which, with a unified Medical Service, the nascent medical activities of the Local Education Authorities should be placed. The question is one to be determined, in our opinion, by the dominant characteristic of the service. Within the limits of school age, the predominant service should be that of education; and the responsibility for the normal child should rest with the Local Education Authority. The case is different with the mentally defective child, for which the new Local Authority for the mentally defective will have the responsibility; and with the child withdrawn from school for definite illness, for which the Local Health Authority will be responsible. But when the child, without being so ill as to be withdrawn from school, requires the services of a doctor—as, for instance, in school medical inspection, in medical examination for scholarships, and in the treatment of minor ailments—we suggest that, where the two Authorities are Committees of the same Council, the Local Education Authority should not set up a medical staff of its own, but call in the Local Health Authority as its agent; just as it does already with regard to inspecting and certifying the drainage of the school building. On

and Dispensary Doctors and Medical Superintendents of Poor Law Infirmaries—the clinicians as well as the sanitarians—would all find appropriate spheres; that one among them being placed in administrative control, as County Medical Officer, who has developed most administrative capacity. The establishment of a unified Medical Service on Public Health lines does not necessarily involve the gratuitous provision of medical treatment to all applicants. It is clear that, in the public interest, neither the promptitude nor the efficiency of the medical treatment must be in any way limited by considerations of whether the patient can or should repay its cost. But there is no reason why Parliament should not embody, in a clear and consistent code, definite rules of Chargeability, either relating to the treatment of all diseases, or of all but those specifically named; and of Recovery of the charge thus made from all patients who are able to pay. With regard to the relation between central and local administration, experience shows it to be essential that a Grant-in-Aid should be made to the Local Health Authorities in respect of all the work now or hereafter entrusted to them. The institution of such a Grant-in-Aid would make more than ever anomalous the fact that, notwithstanding the enormous importance and steady expansion of the Public Health work of the Local Authorities, there exists, in England and Wales,

the other hand, where the children in the hospitals and sanatoria of the Local Health Authority are in need of education (a point now often neglected), we suggest that the Local Health Authority should not have its own teachers, but should call in the Local Education Authority as its agent. The case may be different where (as at present in England and Wales, outside the County Boroughs) the two Authorities are not Committees of the same Council, and do not serve the same areas. But even here arrangements could usually be made on similar lines.

no Department, and not even a distinct and self-contained Division of a Department, responsible for their supervision, guidance, and control in this important service, and for maintaining in it a definite and consistent policy—the work of dealing with the questions as they arise being intermixed with the business of other services and scattered among five different Divisions of the Local Government Board; none of them having, under its control, any staff of inspectors for the systematic visitation of all the Local Health Authorities, or the administration of any Grant-in-aid of the services of those Authorities; and none of them being charged with the duty of formulating and maintaining a consistent policy for the service as a whole. It would clearly be imperative that a separately organised and self-contained Public Health Department should be created, whether this is organised as a distinct Department under a Minister for Health, or whether (by the breaking up of the Poor Law into its component services, and the consequent transfer of functions to the Board of Education, the Lunacy Commissioners, the Central Pension Authority, and the Minister for Labour) the Local Government Board itself becomes concerned with Public Health exclusively.

The foregoing conclusions were embodied in the Minority Report of the Poor Law Commission, which has, since its publication in February 1909, secured such widespread support among administrators as well as medical practitioners.[1]

[1] The National Committee for the Prevention of Destitution, formed to advocate the adoption of the Minority Report, had, at the end of its first year, over 26,000 individually enrolled members in England alone, with 4000 in Wales and Scotland.

Its far-reaching but on the whole simple scheme of reform emerged, during the three years' investigation of the Poor Law Commission, from two streams of facts in the survey of the whole country that was made by the Commissioners. In town after town it was discovered that the old idea of the sphere of a Public Health Service—namely, that it confined itself to measures of general provision, and did not treat the individual patient—was no longer correct. The recent developments of the Public Health Service—its 700 municipal hospitals crowded with patients, opening their wards to one disease after another, and even adding out-patients' departments and dispensaries; the growing staffs of "health visitors" (who are occasionally qualified medical practitioners), giving "hygienic advice"; the organisation, here and there, of domiciliary nursing; the active supervision of midwives; the "milk dispensaries"; the medical inspection and treatment of school children; the "school clinics"; the official acceptance of the specifically pauperising disease of phthisis as part of the sphere of the Public Health Authority—were rapidly encroaching on the domain of the Poor Law doctor and the Poor Law infirmary, and were bringing about a hopeless confusion of principle as to what was the public and what the personal responsibility for sickness. Secondly, it had to be admitted that these developments of the Public Health Service were not to be ascribed merely to the over-zeal of local authorities or to the muddle-headedness of Parliament, but that they were the necessary outcome of a half-conscious realisation that the principles of the Public Health Department afforded a better basis for State medicine than those

of the Poor Law Medical Service. This, as the Commission fully recognised, was not the fault of the Poor Law doctor himself. What appeared to the Commission the grave defect of the whole system of Poor Law medical relief—on which the community is spending something like five millions a year—was not any failure in skill or humanity on the part of the 4000 Poor Law medical officers concerned, but the fact that they were condemned to stand helplessly by when their ministrations would have been most effective. They have to let the preventable disease occur, to see it develop and get worse whilst the patient is slipping slowly down the hill of poverty, and only come in towards the end when pecuniary destitution has set in. By the very nature of the Poor Law the ministrations of its medical service are inevitably confined to those persons in whom sickness has gone so far as to make them unable to earn their livelihood, and in which disease has reduced them to pecuniary destitution. By the very nature of the case the ministrations came, therefore, too late in the vast majority of instances to amount to much more than "medical relief." In short, what the Poor Law Medical Service was instituted for, what it still aims at, and what it secures is the diminution of individual suffering. It does nothing, and by its very nature can do nothing, to prevent the occurrence of disease. On the other hand, the Public Health Service, whilst at least as effective in preventing individual suffering, aims at preventing the very occurrence of disease, or at any rate preventing its recurrence in the same or any other patient. The Public Health doctor can deal with the case in its incipient stage, irrespective of whether the patient is or is not too ill to go to

work. Unlike the Poor Law Medical Service, the Public Health Service is not limited to the treatment of the individual patients, still less of such individual patients only as are so far gone as to have become pecuniarily destitute. It has at its command the devices of notification and searching out, of the provision of acceptable hospital accommodation and even in bad cases of compulsory removal, of house-to-house inspection and domiciliary nursing, of a continuous supervision of practically all the infants and the school children, and of large measures of alteration of the sanitary environment. Above all, there is an important difference between the Poor Law and the Public Health Department in the psychological reaction. Here we come to the supremely important "moral factor," the effect on personal character. The irony of the Poor Law Medical Service is that the better it gets the more harm it does to the character of those whom it seeks to benefit. For every increase in its efficiency, every growth of humanity in the Poor Law doctor, every expensive improvement in the Poor Law infirmary is a standing temptation to men and women to become "destitute," or to pretend to be destitute, in order to qualify for the treatment which the State provides only for the most thriftless or the most unfortunate of the working class. And the temptation is, in too many cases, irresistible. As a Northumbrian miner once put it, "If you have owt you get nowt; if you have nowt you get owt, and a very gude owt too."

Apart from this, however, we have the fact that the Poor Law Medical Service, restricted as regards each patient to the period in which he remains "destitute," can exercise no kind of moral pressure

or disciplinary supervision before and after treatment. It can do nothing to induce the person who is just beginning to go down in health to adopt those habits of personal hygiene which alone would prevent him from becoming ill and therefore becoming destitute; it can do nothing, after the patient takes his discharge, to keep him under observation and bring pressure to bear on him so to live as not to have the relapses that will bring him again and again to the workhouse, until he comes in for the last time to die. In this way, by making elaborate and comfortable provision for the destitute sick, just because and just when they are destitute, without doing anything to prevent them from becoming destitute, the Poor Law Medical Service is in a cruel dilemma. For by all the humane treatment that it provides for the girl about to have a baby, for the drunkard in his bouts of delirium tremens, for the prostitute in her attacks of venereal disease, for the wretched man or woman who comes in periodically to be fed up and cleansed from vermin, the very humanity and professional excellence of the Poor Law infirmary—divorced as it necessarily is from any preventive influence over the patients' lives before they become paupers and after they cease to be paupers—unfortunately constitute elements in the breaking down of personal character and integrity, and may even be said actually to subsidise licentiousness, feeble-mindedness, and disease.

The Minority Commissioners asserted that this evil psychological reaction, characteristic of all the operations of the Poor Law—and of any Poor Law, whatever its designation—is not a necessary accompaniment of public provision. It is, for instance, not

seen in the operations of the Post Office or the public elementary school, or in the provision of scholarships to the universities. It is, in fact, inherent only in the operations of a Destitution Authority. We know from actual experience that the Public Health Service, in its relation to sickness, not only has no "pauperising" effect, but, on the contrary, positively promotes physical self-control, stimulates self-maintenance, and increases the consciousness of parental responsibility. No one is tempted to become destitute or to simulate destitution in order to obtain the valuable treatment (often including maintenance) afforded by the Public Health Department, any more than citizens are tempted to become destitute or to simulate destitution in order to enjoy the rate-maintained libraries, parks, and pavements, the journeys on the municipal tramway, the water supply from the municipal reservoirs, the consumption of the municipal gas, or the education in the municipal schools. This is the enormous psychological and sociological advance that has been made by "taking out of the Poor Law" one service after another, and so getting rid of the qualification of "destitution." Moreover, the curative treatment of individual patients by the Public Health Service—undertaken as it is for the good of the community, and not merely out of a desire to relieve individual suffering—happens always to be accompanied by hygienic advice and requirements as to personal conduct, which (as seen, for instance, in infectious disease injunctions, health visiting, and the practice of "milk clinics") amount to a constant stream of moral suasion, and, where necessary, disciplinary supervision, to promote physical self-restraint and the due care of offspring. This is, indeed, admitted.

The only complaint that is made against the Public Health Service, from the standpoint of those concerned for the maintenance of a sense of individual responsibility, is that this bracing influence on personal conduct is not always combined with a pecuniary charge. Here there seemed to the Minority Commissioners to be room for a deliberate reconsideration by Parliament, with regard to all branches of the public service, of the whole question of charge and recovery of cost, or, as it is more correctly designated, the propriety of "special assessments" on individuals for services specifically rendered to them over and above the services enjoyed equally by all ratepayers. That gratuitous treatment is not necessarily connected with public provision for specific complaints, quite independently of the qualification of destitution, has been conclusively proved by the large amounts actually recovered year by year in respect of the maintenance of lunatics. The Minority Commissioners not only propose that Parliament should definitely prescribe which services should be made the subject of special assessments and which should be done for all gratuitously, and what should be the scale of family income that should be deemed ability to pay; they have also devised and for the first time promulgated a carefully thought out plan and the necessary machinery for enabling these special assessments to be made and enforced, wherever there is ability to pay, without hampering the Public Health Department in its preventive and curative work.

Let us now attempt to make clearer these proposals of the Minority Report by a summary description of what happens in the present chaos, and what will happen in the order of the future, as

regards birth and infancy, sickness and permanent invalidity.

At present it is not easy to say what public authority is responsible for enforcing parental obligations, for stopping gross neglect, and for ensuring as a minimum that at any rate such provision is made for maternity, and for the nurture of infants up to school age, as is imperatively required in the interests of a healthy community. The Poor Law Authorities are legally bound to give gratuitous treatment and maintenance to any woman who is destitute and chooses at the time of child-birth to claim such aid. As a result, nearly 15,000 babies are born in the workhouses of the United Kingdom every year.[1] The Poor Law Authorities, though they may provide costly maternity wards, are, by their very nature as Destitution Authorities, inherently and necessarily incapable of exercising any supervision over the health or the conduct of these women before they choose to come in to be confined, or after they choose to take their discharge. A girl may go out and let her infant quietly die; she may come in again a year hence, and let the second infant die; what is worse for the community, she may from poverty, ignorance, or wilful carelessness so neglect her infant in its earliest years as to saddle us with a rickety, stunted, and permanently diseased citizen; she may repeat this process as long as nature permits, without the Poor Law medical officer or the representatives of the ratepayers having any power to insist on or to ensure proper conditions for this torrent of babies brought into the world at the public expense. Against this

[1] Minority Report of Poor Law Commission, 1909, Part I. chap. iii. (Birth and Infancy).

mass of poverty and parental neglect the Public Health Authority is now bestirring itself to fight, and, with insufficient legal powers, and without practically any co-operation from the Poor Law Medical Service, is organising its service of health visiting and milk dispensaries. Meanwhile, the Local Education Authority, which has been tempted to subject infants of three to the discipline of the schoolroom, because there was nowhere else for them to go, is beginning to exclude all children under five, and in doing this it is receiving the sanction of the Board of Education. But as the Consultative Committee of the same Government Department lately reported, "There is no doubt that the absence of public provision for children under five, so far as the poorest classes are concerned, is a crying evil."[1] The Minority Report proposes that the whole responsibility for enforcing parental obligation, preventing neglect and ensuring at any rate the necessary minimum of provision for maternity and infant nurture up to school age, shall be placed upon the Local Health Authority, which could combine for this purpose the present scattered services of birth notification, infant visitation, midwifery supervision, the milk dispensary and school for mothers, and the control over abortifacients. What it would take over from the Board of Guardians are birth registration, vaccination, and (outside the Metropolis) the inspection of baby-farming —all three anomalous excrescences on the Poor Law —together with the maternity ward, the workhouse nursery, and the power to give domiciliary treatment (including the necessary home aliment) to mothers

[1] Report of Consultative Committee upon children below five. Cd. 4259 of 1908, p. 127.

and infants. Under such a system the girl expectant mother (already presumably within the supervision of the health visitor under the chief medical officer), who might come into the maternity ward for her confinement, would remain under the same supervision after her discharge, and, in fact, throughout the infancy of her child, and would, if certifiable as feeble-minded, be reported to the Town or County Council committee dealing with the mentally defective. On the other hand, the respectable married woman might obtain midwifery assistance in her own home, with or without payment, according to scale of income, with no more stigma of pauperism than if she were a scarlet fever patient. Who can doubt that, if the chief medical officer of every town or county were empowered to organise such a systematic service for birth and infancy, on the lines of what is already being done in a partial way by the most progressive Health Authorities, the result would be a vast improvement in the conditions of birth (including the virtual abolition of *ophthalmia neonatorum*), and an almost incredible diminution of the mortality among new-born infants and children under five, together with a most beneficent increase in the consciousness of parental obligation and in the performance of parental duties on the part of the mothers, and a far more general enforcement of pecuniary responsibility against the fathers—the whole at a cost to the community that would be more than saved in the diminution of the expense now so unwillingly incurred over the defective, the blind, the crippled, and the diseased who result from our present neglect.[1]

[1] An interesting example of the hopeless tangle into which we are getting through the overlapping and competition between the Poor Law and the

In no branch of the subject is the question of overlapping of work and duplication of machinery between the Poor Law Medical Service and the Public Health Department becoming more acute than in the actual clinical treatment of sick patients; and yet there exists, at the same time, a disastrous amount of untreated disease. There are still some people, thinking themselves educated, who believe that the spheres of the two co-existing rate-maintained medical services are distinct and clearly

Public Health Service is afforded by the present position of the medical practitioner under the Midwives' Act, administered by the Town or County Council. The medical man whom the law, in effect, requires the midwife to send for in cases of difficulty is held by public opinion to be under a moral obligation to go; and yet there is still, after years of delay, no provision for the payment of his fee. In a few cases the midwives have paid it themselves. In a few towns the Town Council has paid it under section 133 of the Public Health Act, 1875. In other places the Boards of Guardians have very grudgingly paid under the general powers of section 2 of the Poor Law Amendment Act, 1848. In many cases the unfortunate medical man has failed to get his fee.

The Poor Law Division of the Local Government Board finds no better solution than to recommend the Board of Guardians to pay. At the same time, it is recommended that the Local Health Authority should be responsible for preventing collusion between midwives and doctors. Thus, the best arrangement the Local Government Board can suggest is that the doctor should go whenever he is called, but that his chance of getting his fee from the Poor Law Authority is to depend, not on the gravity of the case, or even on the absence of a fraudulent collusion between the midwife and himself, but on whether the Board of Guardians may subsequently choose, without possibility of appeal, to class the woman as destitute. If the Board of Guardians is to be required to pay (as was actually suggested by clause 17 of Lord Wolverhampton's abortive bill of 1910), it will mean making the patient compulsorily into a pauper, with all the abhorred inquiries of the Relieving Officer and the stigma of pauperism. (See Report of Departmental Committee on the Working of the Midwives' Act, Cd. 4822 and 4823, 1909.) Any such attempt to make people compulsorily into paupers will be strenuously resisted. Under the proposals of the Minority Report, both the control of the certified midwives and the payment of fees to the medical men whom they are required to call in, would be in the hands of the Health Committee of the Town or County Council, and its chief medical officer; whilst the recovery of the cost from the patient or her husband, in case of ability to pay according to the statutory scale, would be enforced by the special department of the Town or County Council entrusted with this duty.

defined—who believe, in short, that the Public Health Service has nothing to do with the clinical treatment of the individual patients. Such persons close their eyes to the 700 hospitals of the Public Health Service —actually having more beds than all the voluntary hospitals put together—treating at the present time something like 100,000 separate patients every year; no longer confining themselves to smallpox and enteric, but taking in an ever-lengthening list of diseases, diphtheria, measles, various forms of tuberculosis, and many accident cases—in two towns (Barry and Widnes) actually specialising exclusively in non-infectious cases. It is, in fact, now only a matter of chance and locality whether a sick person, or a person who meets with an accident, will be removed to a voluntary hospital, a Public Health hospital, or a Poor Law hospital; and (whether or not he repays the cost of his maintenance) it will equally depend on chance whether or not he becomes thereby a pauper, and whether or not he or any of his relatives come under liability for repayment. This rivalry between the competing rate-supported hospitals and medical staffs is becoming daily more serious and more acute in the vast range of tuberculosis. The Local Government Board for England and Wales, like the Local Government Board for Scotland, is definitely ranging the provision of adequate treatment of tuberculosis within the sphere of the Public Health Department. In Scotland this has been done by explicit order. In England and Wales a phthisical man will now be alternately a pauper and a public health patient. Neglected and untreated whilst his disease is still curable, as soon as he becomes too ill to earn a living he can go into the

workhouse whenever he chooses; as soon as he insists on taking his discharge, his case is officially notified to the medical officer of health, who thereby becomes responsible for looking after him and for preventing him infecting his family, but who is only here and there able to find him a place in a municipal hospital or sanatorium, and cannot, in practice, supply the necessary ailment for domiciliary treatment, or secure that the housing accommodation is adequate; then the man breaks down and enters the workhouse again, passing thus alternately from the Poor Law to the Public Health Department; the modern Public Health Service, just because of the existence of its older rival, being unable adequately to deal with the case; until eventually there ensues death in the workhouse and a widow and children—probably already made tuberculous—on the rates.

With all this overlapping of work and duplication of machinery, the amount of untreated sickness at any one time is plainly enormous. To take only that revealed by the Poor Law doctors themselves, we know now that nearly one-third of all the two million persons who sought Poor Law relief last year did so suffering from sickness,[1] and the greater part of them on account of disease or infirmity, *which, largely because it had not been treated when it should have been*, had gone so far that the patient was unable to work. The sickness of the applicant for Poor Law relief is, in fact, nearly always a neglected sickness. But this is not all. The medical inspection of school children is revealing an almost incalculable amount of minor ailments going entirely untreated, either by the private practitioner or by the public doctor, and

[1] Majority Report of Poor Law Commission, 1909, Part II. par. 124.

either by the Poor Law or the Public Health Service. Thirdly, to revert again to tuberculosis, we have the fact that this disease, which in itself alone produces one-seventh of all our pauperism, and the greatest of all the deductions from the adult working life of the people, is at the present time, among the whole wage-earning class, hardly ever properly treated until its ravages have advanced too far to be curable. It is unnecessary to instance the corresponding experience of cancer and of other diseases. "Almost every disease," Dr. M'Vail expressly told the Poor Law Commission, "can be dealt with from the standpoint of prevention; and whilst phthisis is specially important, yet the early stages of disorders of all organs of the body—heart, lungs, kidneys, digestive system, brain, and the rest—often furnish indications for preventive measures" which, if not applied in time, involve the community in the waste and expense of subsequent incapacity and treatment. This neglect of early treatment is, of course, all the more grave in that, in tuberculosis, and, as we are beginning to suspect, in many other cases, it means neglect of precautions against the spread of the disease to others.

In this administrative dilemma there are but two courses practically open to the statesman. In his able dissent from the Majority Report, Dr. Downes, the Local Government Board Medical Inspector for Poor Law purposes, sketches out one of them as his ideal. The whole of the public provision for the treatment of sick persons is to be relegated to the Poor Law. This means the transfer of the 700 Public Health hospitals to the Boards of Guardians (or the new Poor Law Authority); the reversal of all the arrangements now being made under the direction

of the medical officers of health for the medical treatment of school children; the rescinding of the recent orders of the Local Government Board as to phthisis, and the transfer of all provision for tuberculous patients to the Poor Law medical officer. Dr. Downes does not tell us frankly that this policy involves also the abandonment of the public health principles of "searching out cases, and of treatment in the interest of the public health irrespective of pecuniary means"—yet this necessarily follows, for no Poor Law Authority can possibly compel people to become paupers, or urge them to accept what cannot be other than parochial relief. Dr. Downes is, however, more candid on the obverse of the picture, for he makes it plain that he contemplates that the enlarged Poor Law, when it has swallowed up so much of the present work of the medical officers of health, is still to be "deterrent" (as, indeed, any Poor Law or any Destitution Authority must inevitably be), and is still to bear the stigma of pauperism. The reader will judge what havoc any such policy would make of all the success so far achieved by the Public Health Service in combating infectious disease, and what sort of a service we should have when the medical officer of health had been reduced to the status that this highly placed official of the Local Government Board evidently regards as his proper sphere—of somewhere between the borough surveyor and the sanitary inspector.

The other course, and, as it seems, the one to which Parliament every session more and more inclines, is to take the sick person altogether out of the Poor Law, and to make the Public Health Depart-

ment exactly as responsible for the treatment of all cases of tuberculosis, cancer, and rheumatism that would otherwise go untreated as it is to-day for small-pox and enteric. This involves the transference to the County or Borough Council, acting through its Public Health Committee, of the whole Poor Law Medical Service and its outdoor patients, the Poor Law infirmaries and dispensaries, and the hospital treatment of the present inmates of the workhouse sick wards. This, as we have seen, is the solution officially recommended by the responsible medical chiefs of all the departments concerned—the Chief Medical Officer of the Local Government Board for England and Wales, the Medical Member of the Local Government Board for Scotland, the Medical Member of the Local Government Board for Ireland, and the Chief Medical Officer of the Board of Education for England and Wales. This, too, was the solution urged by the distinguished medical man whom the Poor Law Commission specially appointed to investigate the very subject, Dr. M'Vail. Why, in face of this authoritative testimony against which no rebutting evidence was called, and of this remarkable concurrence of opinion among those practically concerned, the majority of the Poor Law Commissioners refused to adopt this solution it is difficult to understand. The minority of the Commissioners were more modest; they accepted the conclusions to which experience had led these authoritative witnesses, and those of the medical expert to whom the Commission had deputed the examination of the problem. The recommendation of the Minority Report, based on this weighty expert evidence, is for a unified medical service in each county and borough

of sufficient size, under the direction of the Public Health Committee of the elected Town or County Council; having in each case the necessary staff of whole-time salaried medical officers, including clinicians as well as sanitarians, institution superintendents as well as domiciliary practitioners; empowered, however, to give domiciliary treatment, and to make the necessary provision for home ailment and nursing wherever domiciliary treatment is judged expedient; adapting or increasing the existing buildings so as to provide (but only by way of supplement to whatever voluntary institutions there may be in each place) the necessary hospital and sanitorium accommodation for all diseases, including whatever public provision is made for maternity, the care of infants under school age, and senile or other permanent infirmity; the whole work being nationally under the supervision of a separate Public Health Department in London, administering (in order to prevent any increase in the local rates) a grant in aid of public health expenditure alone, and in substitution for the existing grants in aid to the Boards of Guardians, of not less than four millions sterling, apart altogether from the provision for lunacy.

At present it is scarcely too much to say that we have no systematic arrangements for the crippled and the infirm. No small proportion of children suffer from grave physical defects of frame or limb or member. These go largely unattended to prior to school age, because no authority is responsible. Between five and fourteen the child is within the sphere of the Local Education Authority, which in London and a few other places is providing most expensive schools in the hope of training these

physically defective children to earn their own living. They pass out into the world and are again without the protection of any public authority, with the unfortunate result that whilst they intensify competition in many of the sweated industries, their infirmities often prevent them from earning any adequate livelihood. At last they pass into the hands of the Poor Law, either to be given a dole of outdoor relief, practically without any medical examination and without supervision of their way of life, or to be merged with all sorts and conditions in the general mixed workhouse. Along with these unfortunates may be considered the later recruits to the same army of the invalidated—the prematurely broken-down man or woman, those rendered chronically infirm by rheumatism or heart disease, the sufferers from hernia or varicose veins, and the hundred and one others whose physical infirmities make them not worth a living wage. The great defect in our method of provision for all this great class, from infancy to old age, is, as it seems to us, the absence of any responsibility in the Local Health Authority. Seeing how helpless are these victims, and how grave is the financial burden that they place on the community, one would have thought it obvious that the Local Health Authority ought to know about every physically defective infant, in order to see that nothing was neglected in the early years which might prevent its becoming a cripple; one would have thought that the care of such children during school age was, again, primarily a matter of Public Health concern; one would have thought that when they became adult there ought to have been, again under the direction of the Health Authorities,

the ministrations of the health visitor,[1] and for those who are friendless something in the nature of rural settlements in which they could be put to such non-competitive work as they were capable of. Those prematurely invalided men and women who by reason of their physical infirmity had to resort to public maintenance ought surely to be the special charge of the Local Health Authority; to be treated from the medical standpoint in such a way as to stop malingering; to see that nothing was left undone by which the infirmity might be cured; to ensure that they did such work as they were capable of; and that, above all, they lived in such a way as not to aggravate their condition. The Minority Report recommends that the physically defective of all ages, who can be certified as unable by reason of their infirmity to earn a livelihood, should be the special charge of the Public Health Department of the County or County-Borough Council, which would find in the work a new and hopeful sphere.

We must here break off to consider an objection which has been raised, though less to the Minority Report scheme than to that of the Majority, that any such proposed change in the Poor Law Medical Service would be seriously detrimental to the interests of the private practitioner, if not of the medical profession as a whole. It is not that the doctors have put forward any claim that their private interest should be upheld at the cost of those of the whole community. But it is necessary for the welfare of

[1] Some of these physically defective persons can and do earn good wages. There are cases in which they have had to forego earning these wages in order to qualify for the medical treatment in the poorhouse infirmary, when they might just as well have gone on earning their wages while under treatment in the hospital and thus paid back some of the cost of it.

the community that there should be a strong, competent, and adequately remunerated medical profession; and it is quite fair to point out that any change which was likely to injure a profession of so much value to the public must be, to say the least of it, very critically scrutinised. In fact, the medical profession in the United Kingdom stands at this moment in a position of grave danger. A very large proportion of its members earn incomes which can only be described as scandalously inadequate, whilst many of those who now enter its ranks after a long and expensive education fail altogether to secure a footing. And for this evil, the unconsidered and piecemeal development of public policy, in connection with the Poor Law Medical Service, isolation hospitals, midwifery, some of the action with regard to infantile mortality and the treatment of school children, together with the wholesale extension of voluntary hospitals and dispensaries, may have been to blame.

Now, the Minority Commissioners had very seriously in mind this consideration when they were drawing up their recommendations; they took care to fortify themselves by competent medical advice; and they did not proceed without satisfying themselves by very careful inquiry among practically all sections of the medical profession that their proposals would certainly inflict no injury on any part of the profession, and that they would, on the contrary, go far to avert the present dangers and set it up on a firm and durable base.

What the private practitioner fears, to put it bluntly, is an extension of gratuitous doctoring, by which he will lose the poorer section of his present

paying patients. It is, however, a mistake to assume that the work of a Public Health Department need necessarily be gratuitous. The most typical work of the Public Health Authorities, the enforcement of house drainage and the improvement of domestic sanitary conditions, has nowhere been done without charge; and nearly always the procedure has taken the form of compelling owners and occupiers to execute the necessary work at their own expense. All this development has certainly not been disadvantageous to the independent plumber and builder. In the same way, a rise in the standard of health—for instance, the general enforcement of a higher level of attention to minor ailments in children attending school—really increases the practice of the private doctors of all grades. What, indeed, is true is that, *if we do not take thought about the matter, and if we do not go very deliberately into it as a matter of principle*, we are only too likely to find that Parliament and local authorities, driven year by year to take up some new service that the health of the community requires—whether this be midwifery or the medical treatment of school children—and unable, so long as they deal with the subject in this fragmentary way, to devise any convenient machinery for charge and recovery, may slip unawares into free doctoring, without protecting the interests of the present generation of medical men.

It is for this reason that the Minority Report elaborates a plan, and devises new machinery, for systematically charging an adequate fee to every person attended by the officers of the Local Health Authority, in every case in which that person is found to be able to pay, and for effectively recover-

ing that fee by legal process. It is proposed that, instead of taking it for granted, as we now do, that several hundreds of thousands of persons are entitled to gratuitous medical attendance, and instead of leaving the option of making a charge, case by case, to the impulsive decision of the chance majority of a committee, there should be settled by Parliament or by the Town or County Council a definite scale of incomes, according to number in family, which should constitute ability to pay. Such a scale is already in use by the Home Office in respect to children who are compulsorily removed to industrial and reformatory schools; such a scale is even now being framed by the London County Council with regard to medical treatment of school children. This proposed "income limit" for gratuitous medical treatment has, of course, nothing to do with the very different "income limit" for membership of clubs which has often been suggested. The limit for gratuitous treatment would be something like three shillings per week per adult, so as to admit only the class absolutely unable to pay the private practitioner's fee. It is proposed that the duty of making the necessary inquiry as to incomes, assessing the charges according to the prescribed scale, and recovering the sums due for all the branches of the work of the Town or County Council, should be made the work of a distinct department, under a new officer—the Registrar of Public Assistance—acting under the control of a separate committee of the Town or County Council, having nothing to do with the treatment of the cases. Under this system no one would be compelled to pay whose family income was found to be so low as to make it desirable in the

public interest that he should be treated gratuitously. On the other hand, every person whose family income was such that he could properly afford even the smallest fee would, if he had accepted the services of the Local Health Department, whether by using the public hospital, the school clinic, or the domiciliary medical attendance of the district medical officer, find himself charged a substantial fee, in proportion to his means, which he would be as strictly compelled to pay as he has now to pay his rates, his payment for an inmate of the county lunatic asylum, or his contribution for a child at the industrial school. The medical man would meanwhile receive from the public authority the proper professional remuneration[1] for his work, whether or not this was recovered by the local authority.

The primary object of this machinery for charge and recovery may be financial, for it is quite a mistake to suppose that recovery is practically impossible. It all depends on how you go about it. There need be no fear that the new Registrars of Public Assistance, undisturbed by irrelevant considerations, having their own expert staffs, and fortified by express authority from Parliament and from the Town or County Council as a whole, would not (whilst exempting at once all those falling below the scale minimum) quite successfully compel every person to pay who could afford to do so. An equally important object of this plan of charge and recovery is to confine the medical services of the Health Department to that section of the population

[1] This payment might take the form of a salary as in the county lunatic asylum, or of a fee as in the case of the police calling in a doctor to treat an accident.

which must, in the interests of the community as a whole, be provided with medical attendance at the public expense. It is in this systematic enforcement of payment that we see the great safeguard to the private practitioner. Every case would be automatically reported to the registrar and systematically investigated by his officers as to financial resources. The prosperous workman, or the stingy person of the lower middle class, who might be tempted to take advantage of the services of the Health Department because there was no stigma of pauperism, no relieving officer to face, and apparently nothing to pay, would promptly find himself served with a courteous but firm demand from the registrar for the payment of a substantial fee, exactly as he now receives the demand note for his municipal water rate or the municipal electric light. Finding that these services of the public doctor, though no longer guarded by a deterrent relieving officer, could not be obtained without this substantial payment, all those who could afford to pay the private doctor's fee would find no attraction in them. On the contrary, they would prefer, seeing that they had anyhow to pay, to choose their own doctors, to be attended to at their own homes, and to pay their own medical attendants. It is *this free choice of doctors* that affords the most potent inducement, to all who can afford the fee, to consult the private practitioner. If payment has to be made, anyhow by all who can spare the money, even the most parsimonious of those who at present go past the private practitioner's door will cease to find any reason why they should forgo this privilege of having their own doctor. Here, too, we see the real remedy for "hospital

abuse." If the endowed and voluntary hospitals and other medical charities sent automatically to the Registrar of Public Assistance the names and addresses of all their patients, and if the Registrar were empowered to make and enforce a prescribed charge upon all whose family resources were found on inquiry to exceed the statutory minimum, we should no longer find the resources of these medical charities drained and the sphere of the private practitioner curtailed by the resort to gratuitous medical treatment on the part of those who can afford to pay their own doctor's fee. And yet no sickness would go untreated. Hence the total income of the medical profession, in fees and salaries, would be largely increased.

This point should be carefully considered by those who are concerned for the private practitioner. The Majority Report of the Poor Law Commission proposes a great extension of "provident" dispensaries, to be subsidised out of the rates, membership of which, whether by paupers or subscribers, is to entitle men, women, and children to the right to choose their own doctors, and to free institutional treatment—a proposal which one medical man has summed up as "a public system, supported by public money, of free medical relief on a basis of contract practice."[1] Such a scheme might well prove ruinous to the ordinary medical man. What the private practitioner should insist on is the maintenance, intact, of his monopoly of the practice of those who prefer a "free choice of doctors." Any suggestion that the State Medical Service, or any collective organisa-

[1] *The Poor Law Commissioner and the Medical Profession*, by a Medical Practitioner. (London, A. C. Fifield, 1909.)

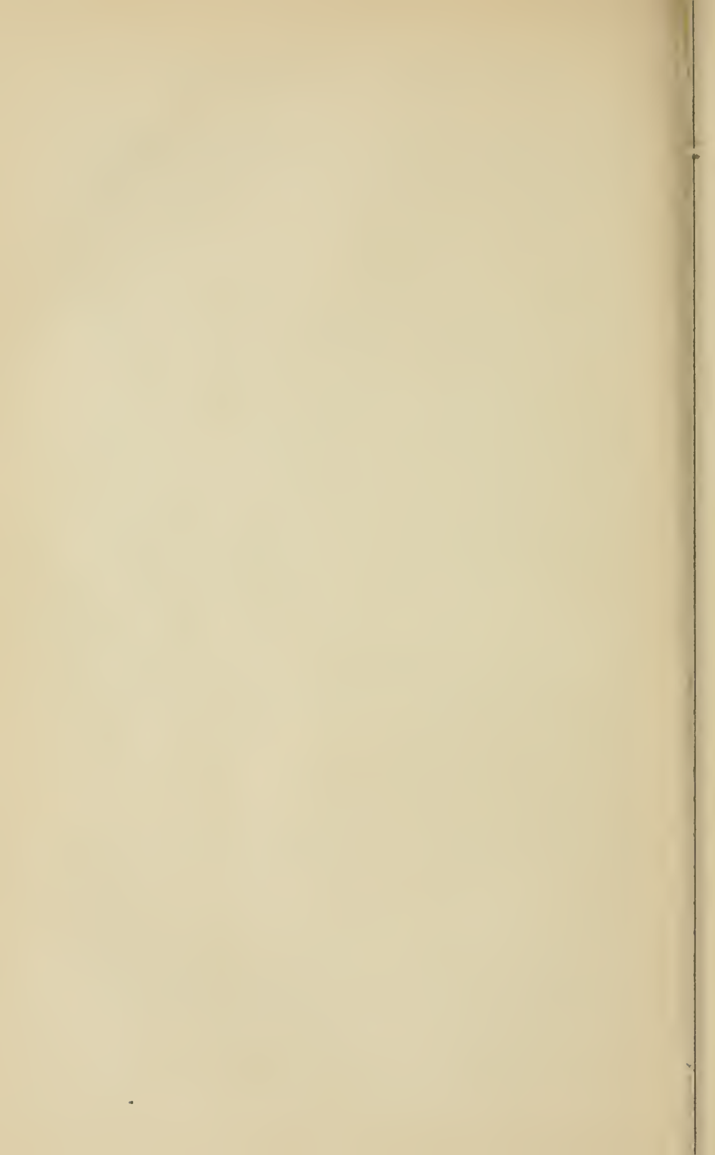
tion, should be allowed to offer this attraction should be instantly negatived. And, further, it should be insisted on that, whilst no one who needs the services of the public doctor should be turned away, there should be drawn a definite line of demarcation between those for whom the community will provide medical attendance without charge, and those from whom, if they take advantage of the State provision, the local authority will enforce repayment at such a rate as will encourage them to choose their own doctor. In the plan of charge and recovery by the Registrar of Public Assistance, the Minority Report furnishes for the first time an effective means of maintaining the safeguard of the private practitioner.

In conclusion let us emphasise the urgency of straightening out this tangle from the standpoint of the "larger expediency" of improving not merely the health but the character of our race. However we may desire to safeguard the interests of this or that profession or section of a profession, the final decision will be based, or ought to be based, on whether or not the proposed reform will strengthen and ennoble the men and women who are subject to it. The Minority Report adopts this proposal of a Unified and Preventive Medical Service not only because it appears to offer the only practicable escape from the administrative dilemma into which the co-existence of two rival rate-maintained medical services has brought us, and not merely because, by extending the Public Health principle of "searching out" disease and dealing always with the incipient case, without the stigma of pauperism, it holds out the prospect of securing an incalculable improvement in public health and a progressive

diminution in the present annual waste through sickness. This reform is demanded because its supporters believe that we shall thus curb physical self-indulgence, increase the care of the child by the mother, the concern of the husband for the wife, and positively heighten the desire and capacity of all persons to maintain themselves. To "take the sick out of the Poor Law" is, as we now see, the only way to put an end to what is inevitably a bad psychological reaction on personal character.

The Poor Law Authority—constitute it as you please, call it by what name you will—must always, just because it is a Destitution Authority, fail altogether in the important matter of supervision of the lives of its patients before and after the crisis of destitution. Unless a person chooses to apply for relief, no Poor Law Authority can touch him, or bring him under inspection or moral pressure, or even know anything about him. Immediately he chooses to take his discharge he disappears out of the ken of the Poor Law Medical Officer, he cannot be followed up, his home and method of life cannot be kept under observation, and no sort of influence can be brought to bear to prevent him getting into such a state as will inevitably bring him to the workhouse again. Take, for instance, the destitution brought about by drink. Under the Poor Law—*under any Poor Law*—the drunkard cannot be touched until he is in a state of destitution. A man may be neglecting his children, leaving his wife without medical attendance, or maltreating a feeble-minded child, and yet no Poor Law Authority can do anything to prevent the destitution which will probably ensue. It is only when the man is

suffering from delirium tremens that he is taken into the workhouse, put into a clean bed with two attendants to look after him, dosed with the costly and agreeable morphia, and then, when he has recovered from his debauch and can return to his work, let out to begin his evil courses again. In fact, under the scheme of the Minority Report, with the Education Authority, the Public Health Authority, and the Asylums Authority responsible for searching out the incipient destitution of the neglected child, the sick wife, and the maltreated feeble-minded child, the drinking head of the family would be called to book long before he found himself in the comfortable quarters of the workhouse. Indeed, it seems apparent that once the Local Health Authority was responsible for searching out diseases, one of the first diseases which would call for systematic prevention and cure would be those self-indulgences in "racial poisons" which threaten to impair the stock. With the treatment of sickness by the Local Health Authority there is, in short—through the machinery of the health visitors and sanitary inspectors, the municipal milk dispensaries and schools for mothers, the medical treatment of the children and the visits of the school nurse—no little opportunity for preventing, by inspection, by advice, by exhortation, by compulsory removal, and, where necessary, by prosecution, many of those practices which now result in much of the waste and expense of disease. We do not maintain or enforce personal responsibility by letting things alone.



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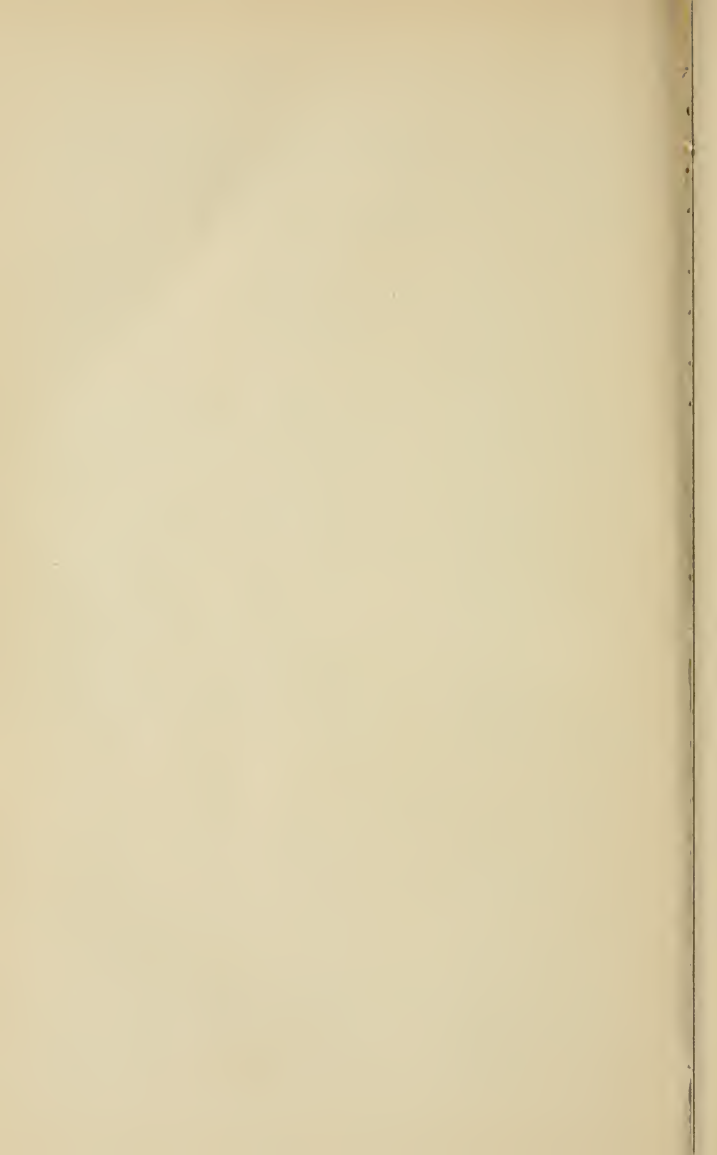

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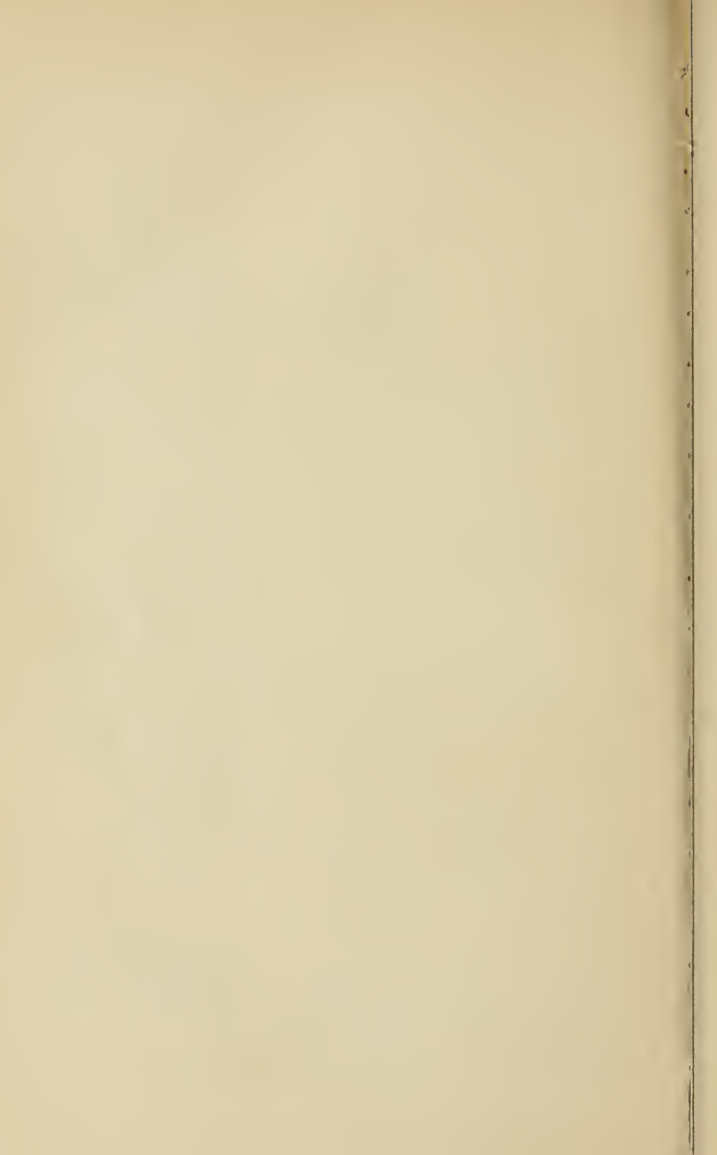

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