The mixed economy for medical services in Herefordshire c. 1770 - c. 1850

by

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TABLE OF CONTENTS

Appendices

List of figures and maps

List of tables

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Summary

This study considers the mixed economy for medical services in Herefordshire between 1770 and 1850. Medical services were an integral part of wider systems of welfare and were provided within a mixed economy that included private practice, state provision, philanthropic activities and mutual societies. Significant resources were spent within the sector and influence over their deployment was of direct interest to parishes, the municipal council, magistrates, philanthropists and individual members of the elite. Four types of medical services are reviewed. These are the provision of personal care by medical practitioners in the private, public and charitable sectors, the establishment of Hereford General Infirmary, changes in institutional services for the insane and developments in public health.

Two underlying themes are discussed throughout the thesis. The first of these is the complexity of the mixed economy for medical services. Important changes over the period are identified and the interrelationships between the various sectors investigated. The dominance of public, private or charitable provision shifted in the period as a result of both national and local factors.

The second theme explored is the interplay between politics and the systems and institutions providing medical services. The importance of political considerations in shaping local policy towards medical services is demonstrated through detailed case studies. These include examining the link between the launch of the subscription appeal for Hereford Infirmary and the parliamentary election campaign in 1774, approaches taken towards the management of the cholera epidemic of 1832 and the campaign to establish a public lunatic asylum in the late 1830s.

Abbreviations

HL	Hereford Library
HRO	Herefordshire Record Office
GRO	Gloucester Record Office
GwRO	Gwent Record Office
TWNFC	Transactions of the Woolhope Naturalists' Field Club

Introduction

Historiographical Review and Research Questions

This study explores the mixed economy for medical services in one rural county, Herefordshire, between 1770 and 1850. It explores the individuals and social groups that influenced the operation and development of local systems and institutions providing medical services and illustrates how on occasion struggles for influence among the elite were played out in conflicts over their control. Medical services were an integral part of wider systems of welfare and were provided within a mixed economy that included private practice, state provision, philanthropic activities and mutual societies.[1] The provision of medical services was closely associated with other relief provided to the poor including the provision of cash doles and institutional relief. Significant resources were spent within the sector and influence over their deployment was of direct interest to parishes, the municipal council, magistrates, philanthropists and individual members of the elite.

Competition for control of these resources was a political issue and recognised as such. There were a number of different roles an individual could fill within the welfare structures, for example, as a subscriber to a charity, a charitable trustee, a Poor Law official, a local ratepayer, a justice of the peace, a parish or council official, or, for some, as a medical practitioner.[2] Each of these offered opportunities for the exercise of influence over medical services and individuals made use of this to achieve a variety of personal objectives. Shifts in the power balance between

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[1] J. Innes, 'The 'mixed economy of welfare' in early modern England: assessments of the options from Hale to Malthus (c.1683-1803) ', in M. Daunton (ed.), *Charity, self-interest and welfare in the English past* (London, 1996), pp. 139-180, J. Barry and C. Jones (eds), *Medicine and charity before the welfare state* (London, 1991), A. Brundage, 'Private charity and the 1834 Poor Law', in D. T. Critchlow and C. H. Parker (eds), *With us always: a history of private charity and public welfare* (London, 1998), pp. 99-119 and N. McCord, 'The Poor Law and philanthropy' in D. Fraser (ed.), *The New Poor Law in the nineteenth century* (London, 1976), pp. 87-110.

social groups affected their ability to exercise agency and influence over medical services and competition for control over these services was, on occasion, an expression of more generic social tensions.

This thesis has two main themes. The first is to explore the complexity of the mixed economy for medical services in the period, charting major changes, exploring the interrelationships between the private, public, philanthropic and mutual sectors and making explicit the different roles that institutions and individuals played in relation to different types of care. The scope of the study includes care provided by medical practitioners in private practice or through public or philanthropic provision, services provided by institutions such as voluntary hospitals, dispensaries and lunatic asylums and the management of public health issues, including the cholera epidemic of 1832. By taking a broad overview, interrelationships between the different parts of the overall systems in place for medical care can be identified and explored. The dominance of public, private or charitable provision shifted in the period as did some of the forms and structures within each sector. The second underlying theme is the interplay between politics and the systems and institutions providing medical services. Consideration of the role of political institutions including Hereford corporation, local magistrates and Poor Law Unions as well as the roles played by individuals are used to explore this theme. The case study presented shows the importance of political considerations in shaping local policy and services.

Herefordshire was selected as a suitable subject for research after consideration of the existing historiography and an assessment of the primary sources available. The span of approximately eighty years covered by the study is most often associated with the effects of the industrial revolution and the rise of new industrial cities in the midlands and north. As a predominantly rural county

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[2] P. Langford, *Public life and the propertied Englishman, 1689-1798 (Oxford, 1989)*, pp. 217-232.

with very little in the way of canal or railway infrastructure until the 1850s, Herefordshire's experience in these decades was atypical of most of England. Agriculture remained the main economic activity and the county did not experience the impact of new industries or radical changes in demography or social structure that were so much a feature of this period in many other parts of the country.[3] Studies of agricultural areas are underrepresented in work by medical historians of the period who have tended to focus on developments in the newly emerging industrial regions or important provincial cities.[4] The analysis presented includes both the minor provincial city of Hereford together with the more rural hinterland comprising five small market towns and rural parishes. This allows for comparative analysis between rural and urban areas within one county and adds an additional layer of complexity through consideration of the interrelationships between county wide and local interests.

The approach adopted draws on extensive local primary sources and secondary historiography. The main sources examined are outlined here in order to demonstrate the methodology used but are discussed in more detail in each chapter. A full listing is included in the bibliography. The principal sources used to consider the private sector provision of medical services are medical registers, supplemented by census information for 1841 and 1851, and private diaries and casebooks. The main sources used for public provision are individual parish records for the period prior to 1834, minutes of the new Poor Law Unions, records of the local Boards of Health and printed medical registers. The private provision of services for lunatics are examined through surviving asylum records, lunacy returns and correspondence made to justices at quarter sessions and the printed

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[3] E. L. Jones, *Agriculture and the Industrial Revolution* (Oxford, 1974), pp. 41-59.
[4] See for example, J. V. Pickstone, *Medicine and industrial society: a history of hospital development in Manchester and its region, 1752-1946* (Manchester, 1985), H. Marland, *Medicine and society in Wakefield and Huddersfield, 1780-1870* (Cambridge, 1987) and M. E. Fissell, *Patients, power and the poor in eighteenth-century Bristol* (Cambridge, 1991).

report of a Parliamentary Select Committee enquiry into conditions at Hereford Asylum. Sources for public provision for the insane include quarter session records, minutes of committees and the records of the Joint Counties' Asylum at Pen-y-fal, near Abergavenny. Evidence for general philanthropic activity is drawn from the digest of endowed charities prepared for the Charity Commissioners between 1819 and 1837 by Edmund Clark and updated in the 1860s and 1870s.[5] Primary sources for medical philanthropy include the extensive records of Hereford General Infirmary, which comprise printed *Annual Reports* and Governors' minutes and relate not only to the voluntary hospital but also to the lunatic asylum charity.[6] Surviving records of other local charities have also been consulted, notably those of the Jarvis Charity. Sources used for mutual provision are Poor Law minutes and secondary literature. Information reported in the *Hereford Journal* (established 1740) and *Hereford Times* (established 1832) have also been used extensively. Hereford has received scant attention from academic historians but the extensive local history material, much of which is published in the *Transactions of the Woolhope Naturalists' Field Club,* has been drawn on to supplement the primary sources used. Throughout the study the aim is to chart local policy making against national trends and to explore the factors that shaped the Herefordshire experience. As John Pickstone has argued, local studies in medical history provide an opportunity to examine both the 'links between sectors of medicine, and between medicine and other sectors of social life'.[7]

The increasing influence of the social science disciplines on the history of medicine from the 1960s led to a shift in emphasis away from administrative, demographic or institutional approaches towards one that recognised the

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[5] E. Clark, *The Reports of the commissioners in England and Wales relating to the County of Hereford, 1819-1837 (London, 1837).*
[6] The majority of these are in HRO, S60.
[7] J. V. Pickstone, 'Medicine in industrial Britain: the uses of local studies', *Social History of Medicine,* 2 (1989), pp. 197-203.

importance of the social context in any historical analysis of medical topics.[8] The social history of medicine has now developed a rich historiography and sub-specialities of its own, many of which are drawn on for this study. The key areas considered are the medical marketplace, medical philanthropy, the rise of the medical profession, histories of hospitals, the care of the insane and public health.[9] In relation to voluntary infirmaries, recent accounts of individual hospitals have moved beyond the description of institutional forms and administrative regulation to an appreciation of the complexity of the changing relationship between institutions and society. Whereas earlier institutional histories tended to emphasise the similarity of the provincial voluntary infirmary model, more recent studies have emphasised how institutions are shaped by and serve their local community. Fundamental aspects of local society can also be revealed through an examination of a particular institution. [10] Assessed as a collective body of evidence, these local studies, together with comparative studies of particular aspects of voluntary hospitals, have confirmed the diversity of local patterns lying

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[8] L. Jordanova, 'The social construction of medical knowledge', *Social History of Medicine,* 8 (1995), pp. 361-381, pp. 361-363.

[9] Standard works include; on the medical marketplace, R. Porter (ed.), *Patients and practitioners: lay perceptions of medicine in pre-industrial society* (Cambridge, 1985), W. F. Bynum and R. Porter (eds), *Medical fringe and medical orthodoxy, 1750-1850* (London, 1987) and R. Cooter (ed.), *Studies in the history of alternative medicine* (Basingstoke, 1988); on medical philanthropy, D. Owen, *English philanthropy, 1660-1960* (London, 1965); on hospitals, J. Woodward, *To do the sick no harm: a study of the British voluntary hospital system to 1875* (London, 1974), L. Granshaw and R. Porter (eds), *The hospital in history* (London, 1989) and K. Waddington, *Charity and the London hospitals, 1850-1898* (London, 2000); on the medical profession I. S. L. Loudon, *Medical care and the general practitioner, 1750-1850* (Oxford, 1986) and A. Digby, *Making a medical living: doctors and patients in the English market for medicine, 1720-1911* (Cambridge, 1994); on Poor Law medical services, J. Lane, 'The provincial practitioner and his services to the poor, 1750-1800', *The Society for the Social History of Medicine,* 28 (1981), pp. 10-13, R. G. Hodgkinson, *The origins of the National Health Service: the medical services of the New Poor Law, 1834-1871* (London, 1967) and M. W. Flinn, 'Medical services under the New Poor Law', in D. Fraser (ed.), *New Poor Law*, pp. 45-66; and on asylums, A. T. Scull, *The most solitary of afflictions: madness and society in Britain, 1700-1900* (London, 1993).

[10] A. Borsay, *Medicine and charity in Georgian Bath: a social history of the General Infirmary, c. 1739-1830* (Aldershot, 1999).

behind the common institutional form of the charitable infirmary.[11] Research examining a broader range of medical services for a particular locality, has identified the importance of lay involvement in shaping medical services as well as the influence of medical practitioners and patients themselves.[12] It has also been recognised that conflict both between these groups and within them influenced the development of local services.[13]

The study also discusses themes from other specialisms within social and cultural history, in particular the histories of welfare, philanthropy and the Poor Law. [14] The growing influence of the voluntary and mutual sectors in the provision of welfare services from the 1990s stimulated researchers to challenge previous teleological accounts that described progress from private and charitable models towards state provision and to take a more critical look the nineteenth-century experience. [15] Welfare historians in particular have turned their attention to analysing the complexity of the inter-relationships between the different elements of the mixed economy and the changing balance between the various sectors.[16]

Research on provincial culture, urbanisation and the development of a consumer culture is also drawn upon.[17] Support of and involvement in voluntary societies has been identified as integral to the establishment of a middle-class identity and

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[11] A. Berry, 'Patronage, funding and the hospital patient, c. 1750-1815: three English regional case studies' (unpublished doctoral thesis, University of Oxford, 1995).
[12] Marland, *Medicine and society.*
[13] Pickstone, *Medicine and industrial society.*
[14] For a general introduction to these topics see, for example, on welfare and philanthropy, M. Gorsky, *Patterns of philanthropy: charity and society in nineteenth-century Bristol* (London, 1999), introduction, Owen, *Philanthropy* and F. K. Prochaska, 'Philanthropy,' in F. M. L. Thompson (ed.), *The Cambridge Social History of Britain, 1750-1950* (Cambridge, 1990), pp. 357-393. On the Poor Law see A. Brundage, *The English Poor Laws, 1700-1930* (London, 2002).
[15] M. Daunton, 'Introduction', in Daunton (ed.) *Charity, self-interest and welfare*, pp.1-22.
[16] Gorsky, *Patterns of philanthropy*.
[17] On urbanisation and the consumer society see P. J. Corfield, *The impact of English towns, 1700-1800* (Oxford, 1982); L. Davidoff and C. Hall, *Family fortunes: men and women of the English middle class, 1780-1850* (London, 1987) and P.

the assertion of cultural authority.[18] The primary focus of the study is on interrelationships within the 'public' rather than the 'private' spheres of provincial life. Although the primary actors were men, women's contribution to the numerous political and voluntary associations has now been recognised.[19] As Frank Prochaska has demonstrated, women were actively involved in many areas of nineteenth-century philanthropy.[20] Although aspects of women's roles and contributions are examined, the scope of this study does not extend to a detailed consideration of the gender issues implicit in the relationships discussed.

It has been argued that a significant change took place in the nature of philanthropic activity from the late seventeenth century; a move characterised by the shift from the personal endowment charity to the new organisations of 'associated philanthropy'.[21] Mirroring the developments in commercial enterprise that lead to the rise of the joint stock company, new charitable organisations were created that were based on collective rather than individual effort. The typical charity of the earlier period was based on a personal endowment, more often than not set up on the death of a benefactor. The initial gift was invested in land or securities and the income used for a variety of purposes to alleviate suffering or to provide education. In contrast, a typical charity of the later period was likely to be a local hospital, funded by small, regular gifts from a large number of supporters or alternatively one of the many national charities that were established from the eighteenth century onwards. The evidence suggests that in Herefordshire, the new style of charitable organisation did not take hold until the last quarter of the

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Borsay, *The English urban renaissance: culture and society in the provincial town, 1660-1760* (London, 1989).

[18] R. J. Morris, 'Voluntary societies and British urban elites, 1780-1850: an analysis', *Historical Journal,* 26:I (1983), pp. 95-118.

[19] See, for example, Davidoff and Hall, *Family fortunes,* pp.416-449.

[20] F.K.Prochaska, *Women and philanthropy in nineteenth-century England* (Oxford, 1980).

[21] Owen, *Philanthropy*, pp. 10-16.

eighteenth century and that even from that date, donors continued to use the older established mechanisms as it suited them.

Philanthropic activity was time-consuming and while establishing a charity on their death released the benefactor from further effort, charity was only dispensed through the good offices of those who acted as trustees and administrators. It was not until the Charitable Trust's Act of 1853 that steps were taken to establish a permanent body to administer the nation's endowments. The act established the Official Trustees of Charitable Funds, who invested funds on behalf of trustees and would remit the income to them for distribution.[22] Up until this time, responsibility for investing capital and distributing charitable funds rested with trustees who were normally members of the local elite or other family members. The aristocracy, gentry, MPs, municipal corporations and the clergy were the main groups to shoulder this responsibility and philanthropic activity was both a demonstration of power and one of its responsibilities and rewards. Philanthropic activity was an integral part of the wider role of the elite and the organisational structures used to administer charities were similar to those developed and used in other collaborative activities. The joint-stock principle adopted by many new charitable foundations was also used to fund the development of basic infrastructure, notably the funding of improvements in roads through turnpike trusts and attempts to develop canals within the county.

It was down to individuals to promote the development of their local area. For some activities, such as improvement commissions, this was done through pressing for an Act of Parliament to grant authority to raise funds for defined activities. For other projects, notably the establishment of hospitals, a charity was established which was under the control of the donors. By taking a broad overview of developments in the period, interrelationships between philanthropy and other activities begin to emerge. Attempts to reform some of the ancient

charitable endowments were undertaken by the same men who promoted the development of canals and roads, remodelled Hereford city or set up local schools or dispensaries. In small communities it was frequently one or two people who drove developments in many or all of these fields.

The shorthand term 'The Medical Marketplace' used by historians evokes a picture of a diverse supply of medical products and treatments and a vibrant and competitive marketplace in which patients were active consumers.[23] It emphasises that medicine was a business in which medical advice, medicines and other treatments were commodities sold to provide a livelihood to many different categories of traders.[24] What is less often emphasised is that this market was also diverse in the ways in which consumers accessed care. One option was to pay a medical practitioner directly but for many this was not affordable. For a minority, for example, domestic servants, employers could be expected to pay for medical treatment, while some independent workers subscribed to mutual societies that provided insurance cover for medical bills.[25] However the main access routes were either through a charitable organisation that provided free treatment for eligible cases or to approach the local Poor Law officials. In addition to medical practitioners therefore, philanthropists and local parish and union officials also played an important part in controlling access to care.

The inability of a large part of the population to afford the services of medical practitioners was recognised as a failure that could not be left unresolved. Mercantilist political economy emphasised the need for a growing population to provide productive labour for agriculture, industry and the armed

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[22] Owen, *Philanthropy*, pp. 202-208.
[23] Porter (ed.), *Patients and practitioners*, Bynum and Porter (eds), *Medical fringe* and R. Cooter (ed.), *Alternative medicine*.
[24] Marland, *Medicine and society*, pp. 205-251.
[25] Marland, *Medicine and society* pp. 176-204, M. Gorsky, 'The growth and distribution of English friendly societies in the early nineteenth century', *Economic History Review,* 51 (1998), pp. 489-511, P. H. J. H. Gosden, *The friendly societies*

forces. Enlightenment ideals endorsed the ability of a medical profession based on science and technology to deliver benefits through an expanded range of services delivered through hospitals, military and naval medicine and infant and maternal welfare.[26] The principle of liberty as expressed in the American and French revolutions began to associate the health of the population with the health of the political system and to assert the rights of democratic citizens to work and subsistence. Benthamite utilitarianism encouraged the application of organised effort towards the greatest good for the greatest number.[27] With the reduction in military expenditure following the end of the Napoleonic wars, increasing resources were dedicated to domestic issues, in particular the relief of poverty. A distinction was made between the labouring poor and the indigent, who did not work either through debility or unwillingness. While the impotent indigent and the labouring poor were considered as deserving of some form of help, by the early nineteenth century opinions were hardening towards those who were considered to be unemployed through choice. This group was viewed as idlers who should be forced to work rather than subsidised. As new policy approaches were worked out, the pervasive belief in laissez-faire meant that philanthropic and mutual initiatives continued to be encouraged in addition to increased public provision. [28]

Medical philanthropy flourished in England from the early eighteenth century through the development of voluntary infirmaries providing inpatients and outpatient services. By the end of the century new forms of medical charity had developed including the development of dispensaries, lunatic asylums and more specialist hospitals, particularly in London and the other major population

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in England, 1815-1875, (Manchester, 1961) and P. H. J. H. Gosden, *Self-help: voluntary associations in the nineteenth century* (London, 1973).

[26] G. B. Risse, 'Medicine in the age of Enlightenment', in A. Wear (ed.), *Medicine in society: historical essays* (Cambridge, 1992), pp. 149-195.

[27] D. Porter, *Health, civilisation and the state (*London, 1999), p. 57.

[28] *Ibid.* pp. 111-113.

centres.[29] In Herefordshire the period to 1850 saw the development of one voluntary infirmary and several charitable dispensaries within the county. The appeal for the Hereford General Infirmary was launched in 1774 and purpose-built premises opened in 1783. The charity was extended to provide services for lunatics and funds were raised to build a purpose built Asylum that opened as a charitable institution in 1793. Despite the success of the Infirmary, the philanthropic model proved not to be viable for the Asylum and it was soon leased to two doctors to be run as a private madhouse. The first dispensary in the county opened in Ledbury in 1824 and was followed the following year by one in Ross-on-Wye. A dispensary was opened in Hereford in 1835. These philanthropic services were targeted at the non-pauper poor who could not afford to purchase services on the open market, but were not eligible for parish relief. By providing help in a temporary period of illness it was hoped that long-term sickness would be avoided and families would continue to be able to sustain themselves. Some of these charitable ventures interacted with the Poor Law organisations, for example by providing services to paupers but charging the expense to the Poor Law authorities, and by supporting those who might otherwise claim relief via the Poor Law system.

The concept of reciprocity is an important theme in the historiography of voluntarism and the Georgian voluntary infirmary movement. [30] In broad terms this recognises that benefits flowed back to subscribers and medical practitioners as well as to patients treated by the philanthropic institutions. In return for a financial contribution, subscribers and donors gained the ability to recommend patients but also public recognition of their role as philanthropists and the

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[29] I. S. L. Loudon, 'The origins and growth of the dispensary movement in England', *Bulletin of the History of Medicine,* 55 (1981), pp. 323-342 and Scull, *Most solitary of afflictions.*

[30] R. Porter, 'The gift relation: philanthropy and provincial hospitals in eighteenth-century England', in Granshaw and Porter (eds), *Hospital in history* (1989), pp.

opportunity to contribute to the management of the organisation. The historiography also stresses the wider social function the organisations played in terms of a tangible and practical demonstration of the obligations and responsibilities of the elite to all sectors of society. This concept of reciprocity between those giving and receiving charity, between the burden of responsibility and the potential benefits that could accrue from fulfilling it, provides a useful framework for exploring the exercise of power and influence. Roy Porter notes that the voluntary infirmaries were designed to transcend party and religious differences and that this ability to attract wide based support was an important factor in their success.[31] While the examination of subscription lists and donor records has confirmed the broad base of support for the infirmary model, it has also been demonstrated that conflict among elite groups also occurred. John Pickstone highlighted the importance of political disputes in his study of the Manchester region, identifying that they occurred both between medical practitioners and philanthropists and between different groups of philanthropists.[32] Adrian Wilson has mapped contested elections against the dates of hospital establishment in order to explore whether they were established as a result of pre-existing social harmony or were a result of it. [33] The case study of the establishment of the Hereford General Infirmary confirms the importance an infirmary appeal could play as a campaign issue in a contested election.

Many people had little option other than to fall back on the Poor Law system. Until 1834 this was organised on an individual parish basis although a

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147-178. For a general review of the historiography of the Georgian voluntary hospital movement, see Borsay, *Medicine and charity*, pp. 4-5.

[31] Porter, 'Gift relation', pp. 152-154.

[32] Pickstone, *Medicine and industrial society* and J. V. Pickstone and S. V. F. Butler, 'The politics of medicine in Manchester, 1780-1792: hospital reform and public health services in the early industrial city', *Medical History,* 28 (1984), pp. 227-249.

[33] A. Wilson, 'Conflict, consensus and charity: politics and the provincial voluntary hospitals in the eighteenth century', *English Historical Review,* 111 (1996), pp. 599-619.

minority of parishes chose to work together in select vestries or municipal corporations. These individual parishes facilitated access to medical services by paying medical practitioners to provide services to needy paupers. [34] There was considerable flexibility in the system, allowing parishes to decide on the extent of medical services provided, the contractual arrangements agreed with practitioners and on occasion, to extend help to the non-pauper poor. After 1834 responsibility for pauper medical services lay with the new Poor Law Unions which agreed contracts with individual medical practitioners, authorised individual cases for treatment and managed issues such as professional standards and competence. [35] The main purpose of Poor Law Unions was the relief of the pauper poor and the bread and butter of their work was the assessment of need and entitlement and the authorisation and provision of relief. Medical services were both a form of support provided and an integral part of the process of assessment of entitlement for general relief. In their role as Union Medical Officers, practitioners had to strike a balance between responsibility to provide adequate care to their patients while complying with the regulations of the Poor Law system and the financial constraints placed on the cost of relief. Beneficiaries or their agents had the opportunity to raise issues of entitlement and Medical Officers could be investigated for issues relating to professional competence. The system also developed an appeals process that allowed the potential for the central authorities to overrule local decision-making. For rural areas in particular, the local evidence suggests that the medical services put in place under the New Poor Law had a significant influence on the numbers of qualified practitioners employed in the county.

The transformation of medical practitioners from a group of disparately educated tradesmen into a recognisable medical profession has variably been

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[34] Lane, 'Provincial practitioner' and Marland, *Medicine and society*, pp. 57-70.

placed between 1680 and 1815. Traditional historiography has characterised the rank and file practitioners of the eighteenth century as ill-educated men, more tradesmen in drugs than professional specialists, whose practice was based on idiosyncratic training based on the apprenticeship system. It is argued that it was not until the movement for medical reform had led to the Apothecaries' Act of 1815 that provincial practitioners evolved into the trained generalist, the general practitioner. This view has been challenged by Geoffrey Holmes who argued that the development of the medical profession occurred almost a century earlier, between 1680 and 1730. [36] Irvine Loudon argued that the transformation occurred sometime after 1740, influenced by the development of provincial hospitals and dispensaries and as medical education became more systematic based on lectures and demonstrations at the developing teaching hospitals, especially those in London. [37] The evidence for Herefordshire shows that many of the factors identified as important influences by Loudon developed later than in London and many other provincial areas. As already noted, while the provincial infirmary movement started in the 1740s, the infirmary at Hereford did not open until 1776, and while the first dispensaries opened in London in the 1790s, the first one in Herefordshire did not open until 1824.

Peter Bartlett's work on the provision of services for lunatics has drawn attention to the importance of the shift in relative power from justices of the peace to officials working for the new Poor Law Unions after 1834.[38] In Hereford, local tensions escalated throughout the late 1830s and culminated in a petition for a House of Commons Select Committee enquiry into the local private madhouse. At

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[35] Hodgkinson, *Origins of the National Health Service* and Flinn, 'Medical services', pp. 45-66.
[36] G. S. Holmes, *Augustan England: professions, state and society, 1680-1730* (London, 1982).
[37] I. S. L. Loudon, 'The nature of provincial medical practice in eighteenth-century England', *Medical History,* 29 (1985), pp. 1-32 and *Medical care and the general practitioner.*

the heart of this local dispute was a struggle for control between county magistrates on the one hand, and the reformed municipal council for Hereford and the newly established Poor Law Union for the city on the other.

Local responses to the threat of the cholera epidemic in 1832 provide another opportunity to examine the interrelationships between political tensions and health systems. The threat of an epidemic grew in the period leading up to the Reform Bill and a comparison of the response in Hereford and the market town of Ledbury examines the differing policies of the unreformed municipal corporation in Hereford and parish officials in Ledbury to the potential danger. The factors that influenced the policy makers are explored. Differences in ideology, the strength of public opinion and the need to manage the local election emerge as key factors that affected the policies adopted.

The tension between the principles of libertarianism and more interventionist policies is demonstrated by the changing role of the state in relation to medical services. Public medical services were transformed with the passage of the New Poor Law legislation in 1834 and the General Medical Order of 1842. The framework of a national system was established which included stipulations of the maximum ratio of practitioners to population served and minimum qualifications for those employed by Unions.[39] The care of lunatics also came under increasing central control with the introduction of requirements for registration and inspection by justices of the peace in provincial areas at the end of the eighteenth century.[40] Enabling legislation of 1808 and 1828 empowered local justices to raise funds to establish public asylums before legislation in 1845 finally required all counties to make public provision for the insane. Despite the

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[38] P. Bartlett, *The Poor Law of lunacy: the administration of pauper lunatics in mid-nineteenth century England* (London, 1998).
[39] Hodgkinson, *Origins of the National Health Service,* p.14.
[40] Scull, *Most solitary of afflictions*, W. L. Parry-Jones, *The trade in lunacy: a study of private madhouses in England in the eighteenth and nineteenth centuries*

growing interest in public health issues from the 1830s, legislation remained permissive until the Sanitary Act of 1866.[41] An exception was the measures put in place to deal with the threat of cholera in 1832.[42] Despite pressure for regulation of the medical profession from the start of the nineteenth century, national registration was not introduced until 1858. Philanthropic organisations also remained unregulated and under control of the local trustees or governors.

Figure 0.1: The Mixed Economy for Medical Services in Herefordshire c.1770-c. 1850.

	Personal Medical Services	Inpatient Care	Provision for Lunatics	Public Health
PRIVATE SECTOR	Private practitioners		Private madhouses from 1802	
PUBLIC SECTOR	Poor Law provision- Parishes pre 1834, Unions post 1834	Workhouses	Licensing and Inspection to 1851 Public asylum post 1851	Improvement Acts from 1774 Boards of Health
CHARITABLE SECTOR (Institutions and Individuals)	Dispensaries from 1824 Outpatient services at General Infirmary Jarvis charity	Inpatient services at General Infirmary	Voluntary asylum 1799-1802 Asylum charity	
MUTUAL SECTOR	Friendly Societies			

(London, 1972) and L. D. Smith, *Cure, comfort and safe custody; public lunatic asylums in early nineteenth-century England* (London, 1999).

[41] A. S. Wohl, *Endangered lives: public health in Victorian Britain* (London, 1983).

[42] For a general discussion of the impact of the cholera epidemic of 1832 see R. J. Morris, *Cholera 1832: the social response to an epidemic* (London, 1976), M. Pelling, *Cholera, fever and English Medicine, 1825-1865* (Oxford, 1978) and M. Durey, *The return of the plague, British Society and the cholera, 1831-2* (Dublin, 1979).

Figure 0.1 presents the mixed economy for medical services discussed in the body of this work. It demonstrates that private, public, philanthropic and mutual sectors worked together to provide an overall system of medical services. The table uses four classifications of care, personal services to an individual at home or as an outpatient, inpatient care, institutional care for lunatics and public health activities undertaken on the basis of local or central legislation.

The interrelationships between the sectors were made more complex by the fact that individuals could operate in more than one sector, for example an individual could be a member of the town council, a medical practitioner and also a governor of the General Infirmary. These complexities are explored in later chapters.

Before progressing to the main body of analysis, chapter one sets the context for the study, providing a brief summary of the major social, economic and political changes in Herefordshire between 1770 and 1850. Chapters Two to Six examine the research themes with reference to four main areas. These are the provision of personal care by medical practitioners in the private, public and charitable sectors, the establishment and administration of Hereford General Infirmary, changes in the provision of care for the insane and improvements to the public health infrastructure. A brief overview of each chapter is provided below. The conclusion summaries the main points arising from the study.

Chapter One establishes the context for the study by presenting an overview of Herefordshire society between 1770 and 1850, highlighting important features and making comparisons with national trends. A brief description of the main economic activities and the development of the transport infrastructure is provided followed by a discussion of demographic growth in rural and urban areas within the county. The structure of local society is examined in order to identify members of the political elite and the key institutions through which political power was mediated. The system of welfare administration and of philanthropic activity is

presented and an overview of the organisation of medical services provided. The chapter ends with an assessment of the medical marketplace in the county.

*Chapter Two e*xamines the changing nature of medical practice over the period in private practice and the provision of services to paupers. The nature of private medical practice is explored based on secondary literature and local sources including the ledger book of a medical practitioner, private diaries and correspondence, trade directories and census information. Changes in the number and type of practitioners are analysed in relation to social and demographic changes over the period to identify trends in provision and employment opportunities. This is followed by an analysis of how medical practitioners fitted into the social structure, their social status and the wider roles they played in social and political life. Provision of medical services under the New Poor Law arrangements is also discussed, demonstrating the variation in services provided across the county and changes in this provision up to 1850. Questions of who was eligible for medical help, how entitlement was controlled and who by, are investigated.

Chapter Three examines the charitable provision of medical services within the context of overall philanthropic activity within the county and within the historiography of philanthropy. One key theme in this has been the rise of the new forms of associated charity in the eighteenth century, which replaced the earlier fashion for private endowments. The General Infirmary, established in 1776, was the first of the associated charities in the county and was set up on the model used by most of the eighteenth-century voluntary infirmaries. Despite its undoubted prestige, which meant that it attracted a significant number of legacies and donations, it was not was not the largest charity in the county. This was an endowed charity established in 1793 on the death of George Jarvis who left a sum in excess of £76,000 for the benefit of the poor of three small rural parishes. The Jarvis Charity was traditional in organisation but its size and the operational

problems it faced challenged contemporary notions of what constituted legitimate charitable activity, who was entitled to receive it and how it should be accessed. The charity's success was limited both by the restrictive nature of the rules governing endowed charities and in the range of services it was considered acceptable to provide. The Jarvis charity also interfaced with Poor Law services and provides an excellent case study for consideration of contemporary views on the appropriate contributions of the various sectors in the mixed economy. Outside Hereford city, medical charities were shaped by the local communities and promoted by the leading citizens and as a consequence developed unevenly across the county.

Chapter Four examines the establishment and operation of Hereford General Infirmary. The hospital was not established until 1776, which was relatively late in terms of the voluntary hospital movement and several decades after similar institutions had been set up in neighbouring Worcester and Gloucester. Although a local clergyman had campaigned for an infirmary from the 1760s and had gained the public support of at least one major landowner and the Bishop of Hereford, no subscription appeal was started until the contested parliamentary election of 1774 acted as a catalyst for action. Thomas Harley, the third son of a local aristocratic family, was contesting the Herefordshire county seat with two other candidates and sought to use his public support of the charity to promote his campaign. The local elite, particularly those associated with the city council were crucial to the success of the initial appeal as was support from the clergy. The detailed case study illustrates the complexity of factors that lay behind philanthropic endeavour and affected its success.

Subscription lists are used to analyse the basis of support for the Infirmary and records of governors' meetings to examine how lay people chose to get involved in the management of the organisation. As highlighted in a number of other studies, many infirmaries faced periodic financial difficulties, although most

survived in some form to be incorporated into the NHS in 1948. The longevity of the institutions indicates the importance they played both in terms of practical help and as a symbol of civic pride and Christian charity. [43]

Chapter Five examines the provision of institutional care for lunatics over the period. The eighty years between 1774 and 1851 saw a marked shift in the local provision of care for the insane and in the legislative framework that sought to regulate this provision.[44] Prior to the Act for Regulating Private Madhouses of 1774, legislation for the management of lunatics was limited to the application of parts of the Vagrancy Act of 1714, which allowed justices of the peace to apprehend and confine any lunatic deemed to be 'furiously mad'. Seventy years later, legislation passed in 1845 required all counties to provide for pauper lunatics in public institutions and consolidated a framework of regulation for private madhouses. A specialist asylum was first established in Hereford at the end of the eighteenth century as an extension to the Infirmary charity. The local movement for lunacy reform in the 1830s was led by a few of the county justices of the peace, who made several attempts to take advantage of the enabling measures provided by the 1808 and 1828 legislation to press for a public asylum. In addition to their concerns over the standards of care in the private asylums in Herefordshire, they were also concerned that the majority of the insane were still cared for outside asylums. Local asylum keepers, ratepayers and Poor Law Unions opposed attempts at reform prior to 1845. Tensions reached a crisis point in 1836 in a dispute over jurisdiction for licensing Hereford Asylum that escalated to a Parliamentary Select Committee Enquiry. This was inconclusive in its findings and therefore supported the current arrangements. It was not until counties were required to make provision for pauper lunatics in 1845 that the reformers were able to put their plans for a public asylum into place.

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[43] Borsay, *Medicine and charity*, and Berry, 'Patronage'.
[44] Scull, *Most solitary of afflictions*.

Chapter Six discusses the development of public health measures in the county, focussing in particular on the response to the threat of cholera in 1832. Herefordshire was one of only four counties not to record any cholera deaths during the epidemic although all of the surrounding counties were affected. Differing responses to the threat and to central requirements for preventive measures are examined through a comparison of the activities of the Boards of Health in Hereford City and in Ledbury. The epidemic coincided with the months leading up to the election of 1832 and the response of officials and the public reflects the specific concerns and priorities of the period.

The conclusion draws together key findings from each of the preceding chapters to present the main findings of the study. The main features of the systems for the provision of medical services are summarised, highlighting who held powerful positions within the system and how this influence was gained and exercised. The social status of those holding influential positions and changes to their power bases over the period are presented to show how influence in the systems dealing with the provision of medical services were an integral part of political relations in provincial society. Individuals could influence healthcare services through participation in government institutions or poor relief and charity organisations in addition to personal philanthropic efforts. The study demonstrates the complexity of the mixed economy for medical services and makes explicit the contributions of the private, public and philanthropic sectors. Philanthropic and public provision expanded considerably over the seventy years of the study and elite groups competed for control of the new structures that developed to manage and allocate resources.

Chapter 1

Herefordshire c. 1770- c. 1850: a brief survey of 'the garden of England'

This chapter establishes the context for the later detailed discussion of aspects of medical services and health systems in Herefordshire. It provides a summary of the economic and political organisation of the county in the period together with a brief description of major changes in demography and the general infrastructure. A brief account of significant developments in the provincial city of Hereford and each of the provincial market towns is also included and the major aristocratic and gentry families are introduced. The chapter concludes with an assessment of the medical marketplace in the county.

Throughout the period under review, Herefordshire remained a largely rural county with a predominantly agricultural economy and a population that lived in scattered parishes. In the eighteenth century the aristocracy and a small number of old established families dominated the political life of the county and the interests and influence of this group remained important up to the middle of the nineteenth century. The economy remained firmly based on agriculture and associated services and activities, with no significant new industries established in the county in the period.[1] Due to a sparse population and a well-established trade route centred on the River Wye, there was limited interest in investment in the communication infrastructure, and as a consequence canals and railways developed later than in other places. Hereford was the county town and also the seat of the Bishop of Hereford and centre for diocesan administration. The city provided the main service facilities for the county acting as the commercial centre with a wide range of trades and crafts as well as an increasing range of leisure

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[1] Jones, *Agriculture and the Industrial Revolution*, pp. 41-59.

facilities. The five small market towns of Leominster, Bromyard, Ledbury, Ross-on-Wye and Kington encircle Hereford at a distance of between eleven and nineteen miles, all providing services to the surrounding rural areas. Although Hereford is situated in the geographic centre of the county, poor communications limited its influence and the market towns and their surrounding rural areas developed somewhat independently of each other, depending on economic and political factors specific to their localities.

The closest principal towns outside the county borders are Shrewsbury, Worcester and Gloucester on the English side, and the smaller towns of Monmouth, Brecon, Hay-on Wye and Presteigne in Wales. Herefordshire is bounded by the Black Mountains to the west and the Malvern Hills in the east, and these geographical factors contributed to the comparative isolation of the county prior to the improvements in roads, canals and railways. The Wye is the principal river in the county, flowing eastwards from Wales to Hereford where it turns south to Ross-on -Wye and then continues in a south-westerly direction to Monmouth and then south to Chepstow. Here it runs into the Severn estuary from where goods were transported to and from Gloucester and Bristol. (Figure 1.1)

Contemporaries celebrated the natural beauty of the county with its gently rolling hills, mild climate, fertile soil and prosperous rural economy. John Clark who was asked to survey the county in 1794 noted:

> The county of Hereford is equalled by few spots in the island of Great Britain for the production of every article that can contribute to the comfort, the happiness, and, in some degree, the luxury of society. Here a verdure almost perpetually reigns ... hence the ancients, with much propriety, complimented this favourable district with the appellation of the Garden of

England.[2] ...On whatever side the spectator turns his eyes, the prospect before him is equally inviting; whether to gratify the fanciful sallies of a wandering taste, by their external charms, or the daily demands, and more peremptory cravings of human wants, by their store of internal wealth. The gentlemen's seats, where Art occasionally steals, imperceptibly, to assist Nature in her endeavours to please, gives the spectator an idea of *taste*.

> The farm-house, surrounded by large fields of yellow corn, green meadows, blooming orchards, and wide lawns covered with herds of cattle, that of *wealth;* the towering spire and neat village, that of *devotion and decorum*: and, what is particularly gratifying to the humane mind, the cottage gives the idea of *comfort*.[3]

The fulsomeness of Clark's praise reflects Herefordshire's reputation for a variety of agricultural products and as a renowned beauty spot and tourist destination. The Wye river tour, travelling south from Ross-on-Wye to Chepstow attracted tourists from the 1760s and by the 1780s there were a number of published written accounts of the trip which celebrated the scenery of the lower stretches of the river where it winds between steep wooded cliffs.[4] Herefordshire's charms were also celebrated and publicised by two local landowners, both leading figures in the Picturesque Movement. Uvedale Price, a local landowner whose estate was at Foxley, some ten miles west of Hereford, celebrated the rich agricultural lands of the middle Wye, with its richly varied landscape of cornfields, pasture, hop fields, woodlands and parkland.[5] His friend,

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[2] J. Clark, *General view of the agriculture of the County of Herefordshire* (London, 1794), p. 8.
[3] *Ibid.* p. 10.
[4] For example, W. Gilpin, *Observations on the River Wye and several parts of South Wales* (London, 1782).
[5] U. Price, *Essays on the picturesque* (London, 1794).

Richard Payne Knight, had an estate on the banks of the River Teme on the northern border with Shropshire where he focussed his efforts on landscaping amongst somewhat wilder terrain.[6] William Cobbett who visited the south of the county around Ross-on-Wye in 1821 was equally enthusiastic about its beauty and its agricultural potential. 'The land very rich, the pastures the finest I ever saw, the trees of all kinds surpassing upon an average any that I have before seen in England.' [7] Timber was also plentiful, mainly planted in hedgerows, around fields or on the tops of small hills. The Forest of Dean, straddling the Herefordshire and Gloucestershire border was an area of extensive forests and inspection of this timber as a potential source for naval ships was a prime reason for Nelson's visit to the area in 1801.

1.1 The economy

Herefordshire's agricultural economy was noteworthy for its diversity, which included grain, hops, apple and pear orchards, cattle, sheep and pigs.[8] The county normally produced a surplus of agricultural goods the majority of which were exported down the River Wye via Chepstow to markets in Bristol. High transport costs were recognised as limiting the economic development of the county both by restricting the expansion of exports and also increasing the price of coal, lime and manufactured goods imported into the county. A few products whose value could bear the high transport costs such as the better quality cider were sold in London. Cattle were reared in the county and fattened closer to the final urban markets in the Midlands and south-east England.[9] By the end of the eighteenth century improved canal networks, mainly outside the county, meant

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[6] R. Payne Knight, *The landscape: a didactic poem* (London, 1794).
[7] W. Cobbett, *Rural rides,* (reprinted London, 1940), p. 21.
[8] Jones, *Agriculture and the Industrial Revolution*, p. 41.
[9] *Ibid.* p. 146.

that cider and apples were being sold to the growing markets in the industrial towns of the Midlands and northern England.[10]

The nature of its mixed agricultural economy and soil type meant that parliamentary enclosure and improvements in crop rotation had a limited effect in Herefordshire. By 1675 only 8 per cent of the county was open and the Norfolk system of rotation was unsuited to local conditions.[11] In 1794 Clark estimated that there were still some twenty thousand acres of wasteland, half of which were situated on the more mountainous borders of Wales and he recommended that these be used as woodland. In addition, some land in the county was still held in common and farmed according to traditional crop rotations that included periods of fallow. In general though, Clark praised the farming and husbandry methods, noting the application of new crop rotations that incorporated cabbages and turnips where these were appropriate.[12] Much of the land was more suited to clover and rotation grasses and these were promoted by the local landowners who also exploited water meadows to support stock rearing.[13] There is evidence of investment in new machinery, such as ploughs, drills, and winnowing machines by both the larger landowners and smaller farmers, notably on the Cornewall estate at Moccas.[14]

It has been estimated that the proportion of land held by tenant farmers increased to about 85 per cent by the end of the eighteenth century indicating that the majority of farmers in Herefordshire were tenants of larger landowners.[15] Clark does not comment on tenure arrangements except to note that the size of farms 'is generally pretty extensive', ranging from four to five hundred acres for

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[10] *Ibid.* pp. 44-45.
[11] *Ibid.* pp. 46-49.
[12] Clark, *General view,* pp. 16-20.
[13] Jones, *Agriculture and the Industrial Revolution*, pp. 50-51.
[14] *Ibid.* p. 55.
[15] G. E. Mingay, *Land and society in England, 1750-1980* (London, 1994), p. 34.

large farms to fifty to one hundred acres for small.[16] Mingay notes that in general a farmer and his family could manage farms of up to 100 acres but that above this acreage they would probably need to hire additional labour.[17] Clark comments that many of the land-owning elite were resident in the county to a greater extent than elsewhere in the country and that as a result of this they remained aware of and interested in the well being of their tenants.[18] In particular, he praised the then Lord Lieutenant, Lord Bateman of Shobdon Court, as an enlightened landowner practising modern methods of farming and able to offer employment to all in the parish who needed it.[19] For Uvedale Price, too, the organisation of the rural economy was an integral part of his philosophy of landscape management. Price spent most of his time on his estate and made a virtue of not leaving it.[20] T. A. Knight, brother of Richard had a national reputation for experimentation with horticulture but was considered by contemporaries as only one of many progressive landowners in the county.[21]

Price and Knight were among the founders of the Herefordshire Agricultural Improvement Society, which held its first show in the spring of 1798. The Earl of Oxford was the first president, serving from 1798 to 1801, and other founder members included the Duke of Norfolk and members of the leading county families including Cornewall, Cotterrell, Scudamore, and Biddulph. The first show, focussing on cattle, was held in Hereford. At a further show held later the same year, prizes included awards for a new apple variety, ploughing with oxen and rearing the largest family without parish relief. This set the pattern for

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[16] Clark, *General view*, p. 14.
[17] Mingay, *Land and society*, p. 143.
[18] Clark, *General view,* p. 10.
[19] *Ibid.* p.16
[20] S. Daniels and C. Watkins, 'A well-connected landscape: Uvedale Price at Foxley', in S. Daniels and C. Watkins (eds), *The picturesque landscape: visions of Georgian Herefordshire* (Nottingham, 1994), pp. 40-44.
[21] J. Duncumb, *General view of the agriculture of the County of Hereford* (London, 1805), p. 52.

the society to hold several shows a year in Hereford and one in Leominster.[22] By 1804, the society's shows offered prizes in a variety of classes that included manure, drainage, the most productive acre of cabbages and hoed turnips and planting and care of orchards. Over the years considerable attention was focussed on improving the local Ryeland sheep, which was renowned for the fineness of its fleece, by crossbreeding to produce a heavier carcass. The local cattle breed, Herefords, was also improved and became nationally renowned for beef production.[23]

This evidence shows that both leading landowners and tenant farmers were actively developing the agricultural economy throughout the period, despite the limitations of the transport infrastructure.[24] Clark optimistically noted in 1794 that 'in this wealthy county, where there is so much work to be done, and so few hands, comparatively, to perform it, there are few poor that do not deserve to be so'. [25] However, despite seasonal demand for labour from Wales and the West Midlands to supplement the local workforce, the livelihoods of many agricultural workers remained precarious. The imbalance between wages and food prices in the years at the turn of the century meant that additional relief had to be provided by parishes either in the form of cheap food or parish doles.[26] Although Herefordshire was not unduly troubled by agricultural disturbances over this period, the county was affected by the national depression in agricultural prices and the increased labour surplus following the end of the Napoleonic wars.[27] In 1832, Henry Williams was sentenced to fourteen years transportation for 'sending a threatening letter to Mr Monkhouse of Whitney, because he used a threshing

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[22] J. Lewis, *Three into one: the Three Counties Agricultural Show, 1797-1997* (London, 1997), pp. 15-32. The first society was wound up in 1828 after 30 years as it had run up significant debts. The society was relaunched as the 'New Herefordshire Society' the following year, free of the accumulated liabilities.
[23] Jones, *Agriculture and the Industrial Revolution*, p. 46.
[24] *Ibid.* p.52.
[25] Clark, *General view*, p. 27.
[26] Jones, *Agriculture and the Industrial Revolution*, p. 56.

machine'.[28] A meeting held to discuss the general agricultural situation and the Corn Laws in January 1850 had to be abandoned as protectionists feared for their safety from a large number of free traders who entered the meeting in the Shire Hall.[29]

In addition to agriculture there was some scattered small-scale industry in and around the county. The lower reaches of the Wye had been an important early industrial centre for coal-mining, charcoal making and small-scale iron workings.[30] The poor internal communications infrastructure in the county encouraged the development of the smaller towns as intermediate centres. These provided markets for stock and agricultural products in addition to a range of services supporting the rural economy and processing agricultural products. Kington, in the west of the county was at the meeting point of five ancient tracks used by drovers herding stock from Wales and an active financial and legal sector developed to support this market. The largest industry in the town was a nail-making forge established in 1786.[31] Leominster had developed as a wealthy medieval town with an economy based on wool from Ryeland sheep and other traditional industries. These included dyeing, leather making, boot and shoe making, gloves, ropes, candles, hat and wig making. By the 1830s the town was in decline as factory produced goods produced cheaper alternatives to the products of these traditional industries.[32] Ledbury and Bromyard also serviced their local areas, producing sacks, lines and rope to support wheat and hop farming. Several of the banking firms that served the small towns were linked to important county families, notably two local Ledbury families, the Biddulphs of

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[27] *Ibid.* p. 217.
[28] Lewis, *Three into one*, p. 20.
[29] *Ibid.* p. 21.
[30] R. Jenkins, 'Industries in Herefordshire in bygone times', *TWNFC, 22* (1938), pp.103-118.
[31] J. B. Sinclair and R. W. D. Fenn, *The Border janus: a new Kington history* (Kington, 1995), pp. 21-27.

Ledbury Park and the Cocks family of Castle Ditch who operated as Cocks Biddulph Bank at Charing Cross. This served as the London agent for many country banks in Herefordshire and Wales and local account holders included Hereford Infirmary.[33] One of the investor's in the Kington and Radnorshire Bank was Thomas Harley's agent, James Crumner, while a savings bank was established in Ross-on-Wye in 1816 under the patronage of Sir Hungerford Hoskyns.[34]

Ross-on-Wye also had a buoyant hotel and tourist sector catering both for travellers on their way to and from south Wales and for visitors taking the Wye tour. John Egerton, the Rector of Ross-on-Wye from 1745 to 1771 and later Bishop of Durham, entertained friends by taking them on the river and by 1760 boats were available for general hire. Several written accounts of visits to the area were published including Thomas Grey's description of a visit in the summer of 1770 and William Gilpin's *Observations on the River Wye and several parts of south Wales* published in 1782. William Wordsworth also visited the area.[35] By 1836 it was possible to take a day trip from Ross-on-Wye to Chepstow in a steamboat for 10s. James Barrett built the Royal Hotel in 1837 offering 'well-aired beds', 'superior post horses', ' Pleasure Boats', 'Homebrewed beers,' 'excellent stabling' and 'an omnibus to meet every train'. Noteworthy visitors included the Honorable John Byng in 1787, Samuel Taylor Coleridge in 1794 and Lord Nelson, who visited the town in 1802.

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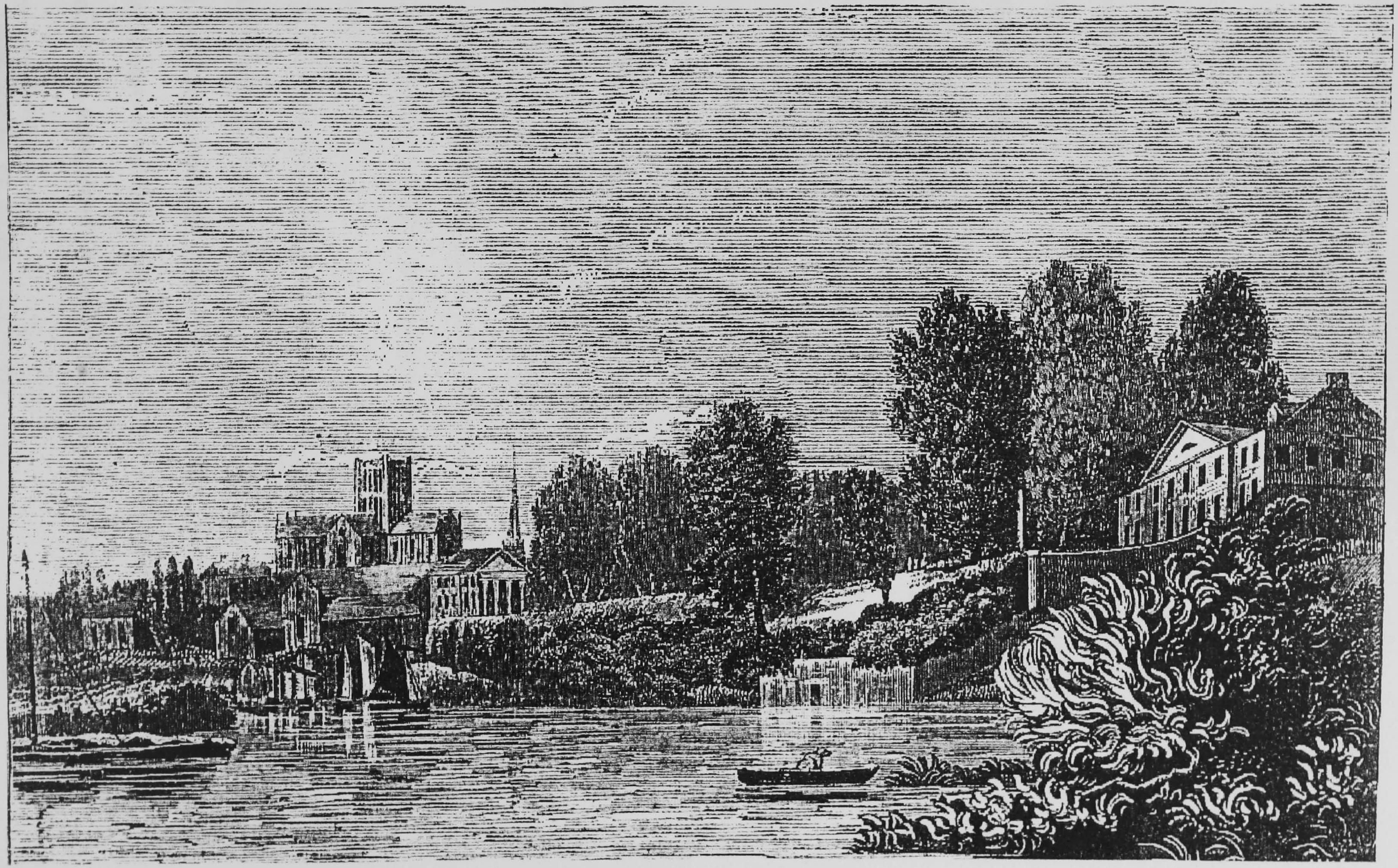
[32] N. C. Reeves, *The town in the Marches: a history of Leominster and its environs* (Leominster, 1973), pp.121-126.
[33] J. Hillaby, *The book of Ledbury: an essay in interpretation* (Birmingham, 1982), p.129. Branches included the Old Worcester Bank, the Monmouth Bank, the Chepstow Old Bank, the Newport Old Bank, the Pembroke Bank, the Camarthen Bank, Mutlow and Rankins Ledbury bank and Webb, Spencer and Co also in Ledbury.
[34] Sinclair and Fenn, *Border janus*, pp. 29-31 and P. Hughes and H. Hurley, *The story of Ross-on-Wye* (Logaston, 1999), p.141.
[35] Hughes and Hurley, *Ross-on-Wye*, pp. 111-118.

Figure 1.1: Map of Herefordshire 1840
Source : S. Lewis, *The topographical dictionary of England (London, 1840)*

Figure 1.2: View of Hereford from below the Infirmary
Source: W.J. Rees, *The Hereford guide* (Hereford,1827*).*



1.2 The development of the communication infrastructure

Improvements to the communication infrastructure within the county in the period to 1850 were limited to attempts to upgrade road and river transport. Although the national canal network reached adjacent counties in the eighteenth century their extension into Herefordshire was very limited until a direct route from Gloucester to Hereford was completed in 1845. In the intervening period some investment was channelled into tramway improvements within the county to improve access to the Monmouth-Brecon canal which had developed to service the Welsh coal-mines. Hereford was not connected to the national rail network until 1853. Appendix 1 summarises the main improvements to the communication infrastructure in the county between 1721 and 1860.

Herefordshire's roads were described as terrible by every commentator of the period, despite efforts to improve them using local turnpike trusts created by individual acts of parliament.[36] The Ledbury Turnpike Act of 1721 was the first in the county and established a town based trust covering all roads entering the town. Acts were approved for Hereford in 1730, Leominster in 1735, Ross 1749, Bromyard in 1751 and Kington in 1756. The turnpike acts were created by and required the financial support of the local elites. For example by 1794 the Kington turnpike had some fifty-four trustees which included members of the aristocracy, gentry, clergy, lawyers, doctors, a headmaster and a wealthy ironmonger and woolstapler.[37]

By the end of the eighteenth century the county was integrated into the national transport system established through the expansion of coaching services. In 1786, a coach left the Oxford Arms, Kington at 5pm on Friday and arrived in London at midday on the Sunday, but by 1835 use of the extended mail coach route from Aberystwyth to London meant that it was possible to reach

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[36] Clark, *General view*, pp. 51-54.

London in seventeen hours.[38] In 1774 the coach from Hereford took thirty-six hours to reach London but this had been reduced by a third by 1800. The extension of coaching services increased demand for hotel facilities and stabling which led to large new facilities such as the City Arms and the Green Dragon hotels in Hereford.[39] Ross-on-Wye was also on the mail route and became an established coaching centre on many networks. From there it was possible to travel to London and Milford on the Royal Mail, to Brecon on the Paul Pry, to Camarthen on the Nimrod, to Monmouth on the Rapid, to Ledbury on the Man of Ross, to Gloucester on the Rising Sun and to Hereford on the Champion. In 1821, after George IV was held up by traffic congestion in the town, there was a threat that the mail coach would be re-routed and as a consequence the new Gloucester Road and another bridge across the river were constructed. In the 1830s a new turnpike road was built between Ross and Ledbury and the Wilton Road north towards Hereford was further improved in 1833.[40]

Up to 1855, the main route for goods entering or leaving the county was river transport on the Wye via the Severn to Bristol.[41] In 1777, the average annual trade down river to Bristol from Hereford is estimated to have included 9,000 tons of corn and meal and 2,000 tons of cider. The Wye is tidal from its mouth on the Severn estuary at Chepstow to just below Tintern and sailing vessels were limited to this stretch. At Tintern goods were unloaded and transferred to smaller flat-bottomed barges which were hauled upriver by men to Monmouth and then on to Ross-on-Wye and Hereford. This route was in use from the sixteenth century although navigation was always difficult due to natural shallows, winter flooding and summer droughts. Early industrial and fishing technologies further increased

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[37] Sinclair and Fenn, *Border janus*, p.105.
[38] *Ibid.* p.112.
[39] G. Roberts, *The shaping of modern Hereford,* (Logaston, 2001), p.43.
[40] Hughes and Hurley, *Ross-on-Wye*, pp. 116-118.

these navigation hazards, in particular the construction of weirs that were built to improve the traditional fishing grounds for salmon and to provide an energy source for water mills processing corn and paper. Throughout the seventeenth century efforts were made to establish a reliable route from Chepstow up past Hereford to Whitney, near Hay, and to establish a linked river route from Hereford to Leominster via the River Lugg. Commissioners were appointed under local Acts of Parliament of 1695 and 1726 with powers to force the building or destruction of weirs and to pay compensation. Improvements were limited to establishing a regular system of river transport bringing raw materials into the Forest of Dean area and exporting coal down river from Lydbrook. A further navigation act in 1809 established a horse towpath linking Lydbrook to Hereford that enabled coal to be transported more easily upriver. Attempts to improve navigation on the Lugg were never a success due to considerable technical problems and lack of sufficient local support from Leominster and the north of the county who began to consider the possibility of linking with the Midlands canal networks.

The river route down the Wye was very circuitous for goods travelling between Gloucester and Hereford as all goods had to be carried down the Wye to Chepstow before travelling back up the Severn to Gloucester. In 1790 proposals were put forward for a canal to link the two cities. The route was to go via Ledbury with a branch line to Newent where there were plans to develop coal-mining. In April 1791 an Act of Parliament approved the construction of the canal by the Herefordshire and Gloucestershire Navigation company. Despite ongoing financial difficulties a line from Gloucester via Newent to Ledbury was officially opened in March 1798. The beneficial economic effects of the canal were limited as there was no way of transporting goods on from Ledbury to the rest of the

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[41] V. R. Stockinger (ed.), *The rivers Wye and Lugg navigation: a documentary history, 1555-1951* (Logaston, 1996) and I. Cohen, 'The non-tidal Wye and its

county. In addition, the Newent coal-fields could not match the lower prices of coal brought into the area by canal and declined rather than expanding as had been hoped. The grand concept of an inland navigation from Gloucester to Hereford was thus diminished to a sixteen mile ribbon of water serving a few villages and a couple of small market towns practically devoid of any industry in any form.[42]

In the north of the county, the first proposals to link Hereford and Leominster with the Staffordshire and Worcestershire canal at Stourport and the River Severn near to Bridgenorth were put forward in 1777. This would have established a much shorter route from Herefordshire to the developing markets in the midlands and the north and explains the lack of enthusiasm for the Wye River route from those in the north of the county. Nothing came of these plans until 1789 when the proposal was revived with the support of the Earl of Oxford, Thomas Harley and Viscount Bateman and an Act of Parliament was passed in 1791 that authorised the raising of £150,000 capital. A length of canal between Leominster and the Mamble colliery in Staffordshire opened in 1794 but the line was never extended further due to technical difficulties.[43]

Although there were two stretches of canal in Herefordshire by 1800 their impact was therefore limited as neither reached Hereford. While the new routes did enable cheaper coal to enter the county from Gloucester and Staffordshire, this only benefited areas close to the canal terminuses at Leominster and Ledbury due to the difficulties and cost of onward transportation. No fundamental changes had been made to the traditional trade routes leading out of the county while only limited improvements had been achieved within the county borders.

The Wye continued to be the main route for imports and exports and the state of

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navigation', *TWNFC,* 36 (1955), pp. 83-101.
[42] D. Blick, *The Hereford and Gloucester canal* (Witney, 1994), p. 24.
[43] C. Hadfield, *The canals of south Wales and the border* (Cardiff, 1960), pp. 191-195.

the roads meant that the market towns remained difficult to reach. Where changes had occurred, or been proposed, they had been to link peripheral towns to routes or centres outside the county, which served to weaken their links with Hereford and the rest of the county. Thus, Ledbury's ties with Gloucester and Worcester were improved, Leominster was exploring a link north to Stourport and Kington interests were seeking to exploit both the northern routes out of the county and those west to Wales. Rather than improving the cohesiveness of the county therefore, factors were encouraging the differential development of the market towns.

Although further improvements were made to the transport infrastructure in the next fifty years they remained limited until a comprehensive rail network was established in the 1850s. In the interim, the west of the county derived some benefits from connections to the South Wales canal network, which by 1800 extended via Monmouth and Abergavenny to Brecon. [44] By 1825, a tramway had been constructed which ran from Hereford via Grosmont to Abergavenny where it met the canal. Further north a rail extension from the Brecon canal terminus to Hay had been opened in 1816 from where a tramway was built to Eardisley and then on to Kington in 1820.[45] Interest in extending the Gloucester to Hereford canal from Ledbury to Hereford increased from 1812 led by John Biddulph of Ledbury Park although no further construction took place until the 1840s. The Act to complete the canal was passed in 1839, the canal was extended to Withington in 1844 and the canal basin at Hereford was finally filled on 22 May 1845.[46] By 1847, traffic was sufficient to cover mortgage and loan interest charges and perversely, the first railways in the county also helped to increase traffic on the canal. The first rail link to Hereford opened in 1853 when the Shrewsbury-Leominster- Hereford line opened, followed in the same year with services to

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[44] *Ibid.* pp. 164-171.
[45] *Ibid.* pp. 182-183.

Abergavenny and Newport. In 1855 the route from Hereford to Gloucester via Ross-on-Wye was opened and in 1857 the route from Hereford to Brecon was completed via Leominster and Kington. The closure of the Hereford to Gloucester canal was ensured by the development of the Hereford to Worcester railway and in 1862 it was sold to the West Midlands Railway Company who converted the canal to a railway line. It was, therefore, only in the mid 1850s that a comprehensive transport system was finally established which provided effective links within the county to Hereford and from there to the rest of the national networks.[47] River trade rapidly declined once this effective alternative to the old route down the Wye had been established.

1.3 Population and the development of towns

Between 1801 and 1851 the population of Herefordshire increased by 31 per cent compared to an increase of 102 per cent for England and Wales in the same period.[48] In common with other agricultural counties, labour migration out of the county to the developing industrial areas was a major contributory factor to this slower than average increase.[49] Table 1.1 provides details of population estimates for 1801 and 1851. In 1801, the population was estimated at some 88,436 of which 76 per cent (67,503) lived in 208 rural parishes.[50] A further 8 per cent (7,108) lived in the six parishes within Hereford City, and 16 per cent (13,825), within the parishes of the five market towns. Over this fifty year period the rural population grew by 25 per cent, that of Hereford by 62 per cent and the

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[46] Blick, *Hereford and Gloucester canal*, pp. 33-45.
[47] Roberts, *Modern Hereford,* pp. 48-51.
[48] B. R. Mitchell and P. Deane, *Abstract of British historical statistics* (Cambridge, 1962). The population of the county peaked in 1871 and then declined for the rest of the century.
[49] J. E. Grundy, 'Population movements in nineteenth century Herefordshire', *TWNFC,* 48 (1986), pp. 488-500.

population of the market towns by 50 per cent. This shift in population within the county from rural areas towards Hereford and the smaller urban centres resulted in a reduction in the overall proportion living in rural parishes. In 1851, 73 per cent of the population lived in rural areas, 10 per cent in Hereford and 17 percent in the market towns. While Herefordshire's demographic experience in this period is therefore atypical it still indicates a considerable rate of growth over the period with a relative shift in population away from the rural parishes.

Table 1.1: Population increase in Herefordshire from 1801-1851.

	Population 1801	Population 1801- %	Population 1851	Population 1851-%	% increase 1801-1851
Hereford City	7,108	8%	11,536	10%	62%
Bromyard	2,392		3,093		29%
Kington	2,062		2,871		39%
Ledbury	3,058		4,624		51%
Leominster	3,966		5,214		31%
Ross-on-Wye	2,347		4,017		71%
Total Market Towns	**13,825**	**16%**	**19,819**	**17%**	**43%**
Rural Areas	67,503	76%	84,134	73%	25%
Total Herefordshire	**88,436**		**115,489**		**31%**

Source: *Census of England and Wales, Population Tables for the years 1801- 1851.*

In the fifty years between 1801 and 1851 the population of Hereford increased by 62 per cent of which 24 per cent occurred between 1811 and 1821 and 13 per cent in the following decade.[51] Census records show that between 1821 and 1831 the number of people within the city liberties mainly employed in agriculture fell from 299 to 70. In the same period there was a 54 per cent increase in the number of people engaged in occupations outside the agricultural sector,

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[50] *Census of England and Wales, Population Tables for the years 1801-1851.* The figures quoted are for the geographic county rather than the registration county.

principally in retail and manufacturing.[52] Although the demographic changes in Hereford over this period were therefore more modest than in many other places, the first half of the nineteenth century was nevertheless a period of considerable change and growth in the city.

1.4 Improvement in Hereford and the market towns

In the seventy years between 1770 and 1850, extensive rebuilding and expansion transformed the medieval city of Hereford. Over the same period, the social and cultural life of the town was shaped by many of the commercial and cultural developments associated with the growth of other provincial centres in this period.[53] In 1774, Improvement Commissioners were appointed under the terms of the Hereford Paving, Lighting and Licensing Act and over the next few years oil lamps were introduced, some streets were pitched and flagged and Widemarsh Common was enclosed. Between 1782 and 1799, six of the old city gates and part of the city wall were taken down as were the old prison and the gaol.[54] The problems and cost of maintaining old buildings was vividly illustrated in 1786 when the west front and half the nave of the cathedral collapsed. The first phase of reconstruction ended in 1793 when the cathedral reopened for services but restoration continued until 1850 with the cathedral again closed for services between 1841 and 1850. Burials were stopped within the cathedral precinct from 1793 and the surrounding area was later paved and fitted with oil lights.[55] The erection of new premises for the St Giles' almshouses in 1770, the General Infirmary building in 1783, the new County Gaol in 1796 and

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[51] *Ibid.*
[52] W. Collins, *A short history of Hereford* (Hereford, 1912), pp. 43.
[53] See for example Corfield, *Impact of English towns* and Borsay, *English urban renaissance*.
[54] Roberts, *Modern Hereford*, pp.132-133.
[55] D. Whitehead, 'The architectural history of the Cathedral since the Reformation', in G. Aylmer and J. Tiller (eds), *Hereford Cathedral: a history* (London, 2000), pp. 255-275.

the Lunatic Asylum in 1799 were all part of this extensive remodelling of the city. These prestigious public buildings were funded from a variety of sources. Public subscriptions were used to raise money for St Giles' almshouse, the Infirmary and the Lunatic Asylum while the new Gaol was paid for from the county rate. The period also saw some fine new private homes built in the city, notably the Duke of Norfolk's town house built in 1790 and the houses in St. Owen's street, which developed as a fashionable area for successful professionals. From 1816 efforts were made to dismantle the medieval Butchers' Row and stop the practice of keeping pigs in garden areas in town and in 1817 a new Shire Hall was built. In 1826 the Wye Bridge was widened and oil lighting replaced by gas lighting. The water supply continued to be taken from the River Wye and lack of improvement in sewerage and drinking water supplies was one of the factors that led to calls for reform under the Municipal Reform Act of 1835. No real progress was made on this issue until the Hereford Improvement Act of 1854.[56]

New leisure facilities also developed, including a theatre, coffee-houses and a public park, Castle Green, that was laid out on the site of the demolished medieval castle. Race meetings were held several times a year to coincide with the assizes. Members of the Herefordshire Society met several times a year in London, providing an opportunity for the county elite to socialise together. The Society had been established in 1710 as a philanthropic institution but appears to have functioned principally as a dining club by the late eighteenth century.[57] The prestigious Three Choirs Festival was held in the City on a triennial basis bringing together the cream of county society and the cathedral clergy. From 1755, responsibility for the management of the festival was vested in joint stewards, the bishop or dean of the host city and one lay individual, who were responsible for all organisation and publicity and also underwrote the festival for any financial

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[56] Roberts, *Modern Hereford*, pp.110-111.
[57] Jones, *Agriculture and the Industrial Revolution*, p. 52.

loss. These onerous duties meant that the office was not always popular, as demonstrated in 1791 when the Duke of Norfolk expressed reluctance to take up the post when approached by Bishop Butler of Hereford.[58] The festival attracted many notables from outside the county and in 1788, when held at Worcester, was attended by King George III and other members of the Royal Family.

The market towns developed along different patterns with few improvements achieved before the nineteenth century. Much depended on the interest of local landowners, some of whom took a particular interest in improvement, notably John Biddulph (1768-1845), in Ledbury. Although born a second son, Biddulph succeeded to Ledbury Park when his elder brother adopted his wife's name and estates, and soon became the prime mover for reform in the town, supporting the Hereford and Gloucester canal and other ventures. His brother, Robert sat as a Whig member for the county from 1796 to 1802 and his son, Robert, won Hereford City for the Whigs in 1832 on the reform ticket. The Ledbury enclosure act of 1813 allowed for the sale of rights of Bradlow Common with the profits to be applied to the improvement of the town and the market and main-street was altered to improve access for coaches before being paved in 1821 with oil lamps introduced in 1823. In 1808 the drains had been covered in order to improve the water supply and this scheme was extended following a typhoid outbreak in 1826. In 1828, new reservoirs were completed and a piped water supply provided to every house. In 1835 the Ledbury Improvement Act appointed Commissioners, with John Biddulph at their head to levy a rate and enforce further improvements.[59]

Without an active local sponsor, improvements were generally much more sporadic. A pumped water supply at Ross-on-Wye had been established in 1709 by John Kyrle who had also built almshouses, refurbished the church spire and

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[58] W. Shaw, *The Three Choirs Festival* (London, 1954), p. 24. Langford, *Public life and the propertied Englishman,* p. 566.

built a pleasure walk.[60] The eighteenth-century water system was refurbished in the early nineteenth century and remained the basis of the town's supply to the 1950s. Despite the tourist boom, little more was done to improve the town until the 1830s when a further Improvement Act authorised the sale of lands to raise funds. Work was undertaken to pave streets, remove obstructions, set up a gas works to light the streets, provide a lock-up for prisoner, sink wells and form a police force. [61] The Kington Improvement Society was founded in 1829 and began work to macadamise the main streets, provide gas street lighting and introduce a proper system of sewerage. [62] Gas lighting was introduced to Leominster in 1836 and in 1852 the old town hall was taken down in order to relieve congestion in the market place.[63]

1.5 Parliamentary representation and local government

In the eighteenth century, landowners dominated political power in the county both as members of the House of Lords and Commons and through their influence on local government as justices of the peace. Most of the principal families were well-established local landowners although at least one notable estate was sold to a buyer who had made their fortune from cotton spinning.[64] Some families, notably the Foleys, benefited from the grant of a peerage that brought with it a seat in the House of Lords.[65] The failure of male heirs in some families, including those of Cornewall, Scudamore and Bateman was also an

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[59] Hillaby, *Book of Ledbury,* pp. 129-132.
[60] John Kyrle was celebrated as a philanthropist and improver by, among others, Alexander Pope and Samuel Coleridge.
[61] Hughes and Hurley, *Ross-on-Wye*, pp. 119-120.
[62] Sinclair and Fenn, *Border janus*, p.39.
[63] Reeves, *Town in the Marches*, p.127 and p.166.
[64] Jones, *Agriculture and the Industrial Revolution*, pp.161-181. In 1809 the Earl of Essex sold his estate at Hampton Court to Richard Arkwright for £230,000.
[65] Langford, *Public life and the propertied Englishman,* p. 513. Lord Foley was one of thirteen men granted a peerage by Lord North in 1776.

important factor effecting the relative influence of particular factions at particular times.

Prior to 1832, eight MPs represented Herefordshire in the House of Commons, two members for the county and a further two each for the three boroughs of Leominster, Hereford City and Weobly.[66] In 1816 it was estimated there were only sixteen voters in Weobley all of which was controlled by the Marquis of Bath who had bought up all the ancient vote houses and controlled nominations. With the exception of Weobley, there were, on occasion, contested elections in all the other three constituencies prior to 1832. Under the terms of the Reform Act the seats for the county were reduced to five with Leominster losing one and the 'rotten' borough of Weobley losing both representatives.

In Leominster, the right to vote was vested in all inhabitants who paid 'Scot and Lot', that is who paid the rates and dues levied by the town council. Up to 1832, MPs were mainly drawn from the local gentry with Lord Bateman of Shobdon Court and Richard Payne Knight serving for periods in the late eighteenth century. However Herefordshire interests did not dominate the town, some of those elected had interests in Shropshire and some were outside candidates from further afield. The contested elections lead to considerable disruption and drunkenness in the town and, on occasion, to disputed returns. In 1789, for example, 785 votes were cast and the losing candidate out of three successfully petitioned for the removal of one of the declared winners. In 1826 one of the successful candidates, Thomas Bish was reported to have spent some £10,000 on the election and was later removed for banking irregularities. Following the Reform Act, there were 340 voters in the constituency.[67]

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[66] L. B. Namier and J. Brooke, *The history of Parliament: the House of Commons, 1754-1790* (London, 1964) and W. R. Williams, *Herefordshire members, 1213-1896* (Brecon, 1896) provide much of the background to this section.
[67] Reeves, *Town in the Marches*, pp.143-147.

Representatives of the local aristocracy dominated the two seats for County Herefordshire throughout the period and there was considerable competition at times. Some of the longest serving members of the period were Thomas Harley (1776-1802), Velters Cornewall (1722-1768), Sir John Cotterrell (1806-1830) and Robert Price (1818-1841). The electorate was widely dispersed throughout the county and in the 1774 contested election 6,052 votes were cast, each voter having two votes. There were contested elections in 1774, 1776, and 1796, indicating that there was considerable competition for political power, despite the costs of an election in such a relatively large constituency. [68]

In Hereford City, the pre-1832 electorate comprised 1,110 freemen, a status that could be attained by birth, marriage, apprenticeship, gift or purchase but was subject to ratification by Hereford corporation. In 1832, 645 non-resident freemen were excluded from the franchise and 459 £10 householders added to give a reduced electorate of 920. Throughout the period members of parliament were drawn from among the influential county families including the Scudamores, father and son, who together served from 1768 to 1805, and the Symonds of Pengethley, also father and son, who served from 1761 to 1780 and 1796 to 1818 respectively. MPs later in the period included Viscount Eastnor, who served from 1818 to 1836, and Edward Bolton Clive who served from 1826 to 1841. Up to 1826 the members returned were all Tories but from 1832, Edward Bolton Clive and Robert Biddulph ushered in a period of Whig domination that was to last until 1865.

This brief summary shows that Herefordshire's political life was dominated by a small number of families with longstanding links to the county. Appendix 2 sets out the families who exercised important political influence in the period, listing peerages, periods of parliamentary representation and key county offices

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[68] F. O'Gorman, *Voters, patrons and parties: the unreformed electoral system of Hanoverian England* (London, 1989)

held. In 1770, the Harleys, Earls of Oxford and Mortimer, were the dominant aristocratic family in the county. Their power declined after Robert, 1st Earl of Oxford's fall from office on the death of Queen Anne in 1714 to the extent that they were denied entry to the county magistracy some time before 1745, but from the mid-century their political fortunes recovered.[69] The Harley seat was at Brampton Bryan in the north of the county and they exercised significant influence both in the north of the county and in the adjoining county of Radnorshire in Wales. Edward, 4th Earl of Oxford, took his seat in the Lords on the death of his father in 1755 and served as Chief Steward of Herefordshire from 1755 to his death in 1790. His younger brother, Thomas, who had served as Lord Mayor of London and been an MP for the City, won one of the two County Hereford seats in 1776 and represented the county until his death in 1802. A third brother, John served as Archdeacon at the Cathedral before being appointed Bishop of Hereford in November 1787, although he died a few weeks later. [70]John's two sons became the 5th and 6th Earls of Oxford as the 4th Earl had no children. Thomas Harley had two daughters, the elder of whom, Anne, married the son of Admiral Rodney and inherited the Berrington estate from her father. Her husband died at an early age but Anne continued to play a part in local affairs as did her sons.

Another influential family was the Foleys, whose seat was at Stoke Edith in the east of the county, and whose influence spread into Worcestershire where they were important industrialists. The family represented Herefordshire in the 1760s and 1770s and for most of the first half of the nineteenth century. Thomas who served for County Hereford between 1768 and 1776 was created 1st Lord Foley in 1776 and took up a seat in the Lords. Charles Fitzroy Scudamore, of Holme Lacey, served as member for Hereford from 1754 to1768 and his only

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[69] N. Landau, *Justices of the peace, 1679-1760* (London, 1984), p. 114.

daughter and heir Frances became the second wife of Charles, Earl of Surrey in 1771. After his father-in-law's death in 1782, Charles was MP for Hereford City from 1784 to 1786 until he succeeded his father as 11th Duke of Norfolk. Norfolk's principal estates were in Sussex and the West Riding although he also had interests in Gloucester. Although the couple had a legal separation due to Frances' insanity, he continued to be active in the political and social life of the county, acting as Chief Steward from 1790 until his death in 1815. On Frances' death in 1820, the Holme Lacy estate passed to Daniel Burr who represented Hereford City from 1837-1841. Another branch of the Scudamore family, based at Kentchurch, dominated one of the Hereford City seats for much of the period.

Viscount Bateman, of Shobdon Court, who held an Irish peerage, represented Leominster from 1768 to 1784 and was Lord Lieutenant from 1747 until his death in 1802. His replacement was George Capel, 6th Earl of Essex who had inherited the Hampton Court estate from his maternal grandmother, Frances Conningsby in 1781 and who served as Lord Lieutenant from 1802 until 1839. The Somers-Cocks, a banking family of Eastnor Castle, in the east of the county, were raised to the peerage in 1821. Viscount Somers held one of the seats for Hereford City for fourteen years prior to the Reform Act and acted as Chief Steward from 1816. He succeeded as Second Lord Somers in 1841 and was Lord Lieutenant from 1845 until his death in 1852. Another member of the family represented Hereford City from 1847 to 1852. Other families with influence were established members of the Herefordshire gentry including the Cornewalls of Moccas, the Prices of Foxley and the Cotterrells of Garnons, all of whom became Baronets in the period, and the Biddulphs of Ledbury, a banking family associated with the Somers-Cocks.

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[70] Namier and Brooke, *The history of Parliament* and Williams, *Herefordshire members.*

Throughout the period responsibility for local administration was vested in the justices of the peace, 'men of ample fortune' who administered the communities in which they resided. The Lord Lieutenant of the County was responsible for drawing up a list of those entitled to serve as justices with those named on the commission having the option of taking up office. [71] The early eighteenth century saw an increasing reluctance on the part of those named on commissions to take up office and this eventually led to a reduction in the property qualification in order to expand the number of those entitled to serve on the bench. One result of this was that the number of clerics on commissions increased, rising from 51 in 1702 to 932 in 1761 and this group came to be very influential particularly in rural counties.[72] Norma Landau notes that this remodelling of the bench typified the social mobility of the age and also acted to replace the prestige of the individual justice with that of the justices as a group, as increasing emphasis was given to their administrative and judicial functions.[73] Magistrates' duties increasingly focussed on imposing the central government's idea of order rather than administering justice in the interests of the local elite. Norma Landau has described this as a move from a patriarchal model, where the ruler is intimately connected to the concerns of his inferiors, towards a more patrician model, where rule is based on a more distanced impersonal application of the law.[74]

Table 1.2 below sets out the composition of the Commission for Herefordshire in 1792 and in 1817.[75]

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[71] Landau, *Justices of the peace,* pp.1-4.
[72] Moir, *The justice of the peace*, (London, 1969), pp. 77-102.
[73] Landau, *Justices of the peace,* pp.143-144.
[74] *Ibid.* p. 4.
[75] In compiling these numbers, the honorary nominees listed at the head of the commission have been excluded. The number extracted for 1792 is comparable to the 187 reported by Landau, which excludes peers and honorables. Landau, *Justices of the peace,* p. 366 and HRO, Q/JC.

Table 1. 2: Composition of the Herefordshire commission of the peace in 1792 and 1817.

Social category	1792	1792 %	1817	1817 %
Peers/ Honorables	13	6%	11	4%
Knights/ Baronets	11	5%	11	4%
Esquires	127	63%	138	49%
Clerics	43	21%	99	35%
Drs in Divinity	4	2%	11	4%
Drs in Law	1	0%	3	1%
Drs in Physic	4	2%	8	3%
Total	**203**	**100%**	**281**	**100%**

Source: Commissions of the Peace for 1792 and 1817, HRO, Q/JC.

The largest social group listed in both commissions is esquires followed by clerics, with the number of clerics increasing considerably over the period, accounting for fifty-four of the total increase of seventy-eight. Moir reports that by the 1830s the clergy made up more than half of the justices actively participating in Quarter Sessions across the country.[76]

Different powers were vested in justices acting individually, as the double justice (two justices) acting in petty sessions, or in the whole bench operating at the quarter sessions. The duties accruing to petty sessions included the surveillance of parish government, appointment of overseers of the poor, the appointment of surveyors of highways, the approval of parish accounts and the licensing of alehouses. The out of sessions side of the justices' role also increased in the eighteenth century as they dealt with turnpikes, land tax, enclosure and Poor Law disputes. The quarter session meetings were formal sessions held in public at which justices considered issues relating to the county facilities such as gaols and houses of correction. They also made up the grand jury at the assizes and elected a chairman who had an important role in running the proceedings although the sovereign appointed the assizes judge. [77]

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[76] Moir, *Justice of the peace*, pp. 106-107.
[77] Landau, *Justices of the peace,* pp. 20-35.

The jurisdiction of the Herefordshire county bench did not cover the municipal borough of Hereford. Prior to the Municipal Reform Act of 1835, the governing body of Hereford was the corporation made up of thirty-one chief citizens with the posts of mayor, aldermen and councillors decided by rotation. The corporation exercised exclusive jurisdiction in the city through the quarter sessions, petty sessions and mayor's court. Members of the corporation, with one or two exceptions, were of the same political party and voted together in elections, thus enabling effective domination of the city institutions.[78] From 1832, there were increasing allegations of corruption and calls for reform led by the recently established *Hereford Times* and in 1833 James Booth and Charles Austin undertook an assessment of the past performance of the corporation as part of evidence being collected for the proposed Municipal Corporations Act.[79] Their report confirmed several examples of misuse of power, including evidence that the grant of freedom of the city had been used to manipulate the composition of the council, corruption in the administration of charities and shortcomings in the police force and gaol. Between 1831 and 1835 the Council drew up three petitions to parliament protesting against the curtailment of their rights but the period of domination of the old guard was at an end. In the elections of December 1835, only four of the old members were re-elected, a significant victory for the reformers. Although the city petty and quarter sessions were retained, changes were made to the operation of the police force and a new gaol had to be provided. [80]

Leominster also had a town council but elsewhere in the county administration was in the hands of the vestries of the remaining 214 parishes.

Under the Elizabethan settlement, the parish was the basic unit of local

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[78] D. J. Mitchell, 'Hereford in the Age of Reform, 1832-56', *TWNFC*, 44 (1982), pp. 91-114.
[79] *Hereford Corporation- Inquiry into the existing state of Municipal Corporations in England and Wales* (Hereford, 1833).

government responsible for the upkeep of roads and the administration of the poor law. Under the Old Poor Law arrangements, many parishes had some workhouse provision and there were certainly workhouses established in Hereford, the market towns and several rural parishes before 1834, although many of these were not much larger than moderate-sized farmhouses.[81] In Ledbury the first workhouse was established in 1733 and part of it was converted to a house of industry in 1786. Employment included rope making, pin heading and work on the Ledbury to Hereford canal. Following the introduction of the New Poor Law in 1834, the majority of parishes within the county boundaries were allocated between eight Poor Law Unions. Hereford city comprised the six city parishes and the surrounding rural area. Ross, Leominster, Bromyard, Leominster and Kington Unions comprised a market town and surrounding rural parishes. The remaining two Unions, Weobley and Dore, were made up of mainly rural parishes with several small and medium-sized villages. A considerable number of parishes on the border with Wales were allocated to Hay Union, centred around Hay-on-Wye and others in the north were allocated to Ludlow Union. Bromyard, Ledbury, Ross and Dore Unions all included several parishes from the bordering counties.[82]

1.6 The medical marketplace in Herefordshire

It has been argued that general cultural shifts influenced the pattern of health care in a number of significant ways during the eighteenth century as elite culture adopted a more scientific and practical approach towards a number of areas, including health and medicine. [83] The reasons for this are complex but included a relative decline in religious belief, a wish to distance themselves from the

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[80] Mitchell, 'Hereford in the Age of Reform', pp. 94-97.
[81] S. A. Morrill, 'Poor Law in Hereford, 1836-1851', *TWNFC*, 41 (1974), pp. 239-252 and N. Elliott, *Dore workhouse in Victorian times* (Hereford, 1984).
[82] Morrill, 'Poor Law in Hereford.

association of religion with radical politics and popular culture and the growth of enlightenment ideas among the elite and middle classes. Despite these trends, the evidence shows that a wide variety of belief systems continued to shape attitudes to health and to medical care and many aspects of earlier popular medical culture survived. Attitudes were also influenced by fundamental shifts in the structure of the economy as the industrial revolution generated major population movements from the countryside to towns and an expanding urban-based working and middle class facilitated the growth of consumer culture. These trends tended to disrupt the acquisition of traditional skills and the networks in which they operated and medical skills and services became part of the burgeoning consumer society, advertised in newspapers and other publications, sold by post, in general stores or at fairs. [84]

Before 1700, medical care was primarily undertaken within the family supported by informal networks comprising relatives, friends and neighbours. In addition, there were many individuals within local communities who, while not full-time medical practitioners, possessed particular skills and expertise such as preparing herbal medicines or setting fractures. For the majority of the population, recourse to a professional medical practitioner was not taken for granted, but considered when other treatments had failed or for very specific complaints. [85] Self-care, or domestic medicine, was based on the application of medical knowledge held by family members and other lay persons within their circle. Many of these skills were learnt through practical experience, watching and copying and by the oral transmission of skills from one individual to another.

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[83] K. Thomas, *Religion and the decline of magic* (London, 1987), ch. 22.
[84] R. Porter, *Health for sale: quackery in England, 1650-1850* (Manchester, 1989).
[85] P. Wilson, 'Acquiring surgical know-how: occupational and lay instruction in early eighteenth-century London', in R. Porter (ed.), *The popularisation of medicine, 1650-1850* (London, 1992) pp. 42-71.

Medical and health issues were widely discussed and formed an integral part of generalist publications such as the *Gentleman's Magazine*.[86]

Medical knowledge was also disseminated via specialist texts, or medical advice books, a large number of which were printed in English from the seventeenth century.[87] Their number increased during the eighteenth and nineteenth centuries to cover a vast array of subjects including preventative and curative advice. Many promoted a particular regimen to be followed to maintain good health, dealing with diet, exercise and personal hygiene. These books were an important source for domestic medical recipes, many based on traditional herbal remedies, recommended to treat complaints such as fever, gout, rickets, jaundice, worms, burns and piles. They also included practical directions for minor surgical procedures including lancing boils, cleaning and dressing wounds and the removal of corns, moles and freckles.

Despite the comprehensive nature of these remedies and treatments promoted for use in the domestic sphere, most manuals suggested there were limits to self- treatment and recognised that there were some complaints for which more specialist knowledge was needed.[88] From the third quarter of the eighteenth century accredited medical practitioners became more dominant amongst the authors of these texts, but even among these authors there was considerable variety of opinion about the appropriate balance between self-care and the need to call on the professional. One popular author who continued to emphasise the scope for domestic medicine was Richard Reece, a native of Herefordshire who was apprenticed to a country surgeon and served as an assistant at Hereford Infirmary before going to London in 1800. He practised as

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[86] R. Porter, 'Laymen, doctors and medical knowledge in the eighteenth century: The evidence of the *Gentleman's Magazine'*, in R. Porter (ed.), *Patients and practitioners,* pp. 283-314.
[87] G. Smith, 'Prescribing the rules of health: self-help and advice in the late eighteenth century', in Porter (ed.), *Patients and practitioners*, pp. 249-282.

an apothecary, obtained a MD from Edinburgh and published numerous medical works between 1800 and his death in 1831, including *The Domestic Medical Guide* in 1803.[89]

Literate lay society was characterised by a high level of medical awareness and a good understanding of treatment options that enabled people to undertake regular health maintenance at home and to develop sophisticated opinions and strategies relating to their own health.[90] They were active consumers of health care who were able to exercise individual choice among the plethora of treatments available to them. The illiterate sections of society were not excluded from all access to popular medical knowledge as the oral tradition of passing on information continued and even the content of medical advice books would have been available to them through a literate intermediary.[91]

The eighteenth century is well known for the range of medical practitioners providing a variety of services and skills. Some of these were individuals practising a particular skill or providing services in a settled locality, for example village-based herbalists or bonesetters or a tradesman selling commercially produced medicines to the public. Others were itinerants such as tooth-pullers travelling from fair to fair or an individual selling patent medicines.[92] Although surviving evidence for the existence and activities of these practitioners is sporadic, there is nevertheless plenty of evidence that a wide range of practitioners were active in Herefordshire.

The *Hereford Journal*, which circulated throughout Herefordshire and neighbouring vicinities, included advertisements for medical preparations in every

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[88] Wilson, 'Acquiring surgical know-how', in Porter (ed.), *Popularisation of medicine* (1992), pp. 42-71.
[89] J. Hutchinson, *Herefordshire biographies* (Hereford, 1840), pp. 91-93.
[90] Porter, 'Laymen, doctors and medical knowledge', in Porter (ed.), *Patients and practitioners*, pp. 283-314.
[91] M. E. Fissell, 'Readers, texts and contexts: vernacular medical works in early modern England', in Porter (ed.), *Popularisation of medicine*, pp. 72-96.
[92] Bynum and Porter (eds), *Medical fringe and medical orthodoxy.*

issue, several of which were sold and distributed by the paper's owner, C. Pugh. In an edition in December 1770, five column inches were used to promote seven of Dr. Hill's medicines that were available from the newspaper's office. The products listed were pectoral balsalm of honey for coughs and consumption, elixir of bardana for gout and consumption and five different tinctures each with their own special use explained in some detail. Water-dock was recommended for the treatment of scurvy, valerian for nervous complaints, centaury for the digestion, spleen-wort for hypochondriacal disorders and sage to guard against deafness, tremblings and other signs of approaching old age.[93] The same edition also advertised Dr. Rysseeg's balsamic tincture that purported to cure scurvy and itches where other medicines had failed and which was available from an address in London. The following week eight column inches were taken up promoting Rowley's British Herb snuff, endorsed by the Dowager Duchess of Somerset, for use against headaches and to restore the sight, and Rowley's Herb Tobacco reputed to be effective against disorders of the head, eyes, nerves, stomach, breast and lungs. Pugh distributed both of these and also stocked Daffy's Elixir. This latter popular brand was widely available across Herefordshire, stocked by T. Scarlett in Eardisley, G. James in Kington, P. Davis in Leominster and W. Grimes in Bromyard.[94] Medical books were also advertised in the paper, for example the issue of the third edition of John Hill's *The Useful Family Herbal,* which was stocked by Pugh.[95] Individual remedies were frequently published, an example being a recipe for Thieves Vinegar recommended by the contributor A.B. for use by clerics and gentlemen of the medical profession against infection.[96]

Itinerant healers also used the paper to advertise their services, including Dr Uytrecht, an oculist from Mechelin in Belgium, who visited Hereford in October

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[93] *Hereford Journal,* 20 Dec. 1770.
[94] *Hereford Journal,* 27 Dec. 1770.
[95] *Hereford Journal*, 13 Sept. 1770.
[96] *Hereford Journal*, 23 Aug. 1770.

1776 after spending some time in Shropshire. His advertisement included mention of several cases he had successfully treated in the county; Edward Whittle cured of a harelip in five days, Richard Crass deafness cured, William Careless cured from blindness by an operation in seven or eight minutes and Joan Davis cured of a bad mouth cancer. Further declarations of cures effected were included from three of the six Hereford city parishes and Esther Morris of Saint Nicholas, Lewis Parry of St John Baptist and Hannah Lane of St. Owens were all mentioned in person. [97] Some practitioners established regular routes, travelling to see their patients and advertising the dates of their visits in advance. J. Sylvester, a dentist from Worcester, advertised the fact that he was to visit Kington in 1848 and by 1852 Joseph Levison, who was based in Hereford, travelled to the market towns on a regular basis several times a year.[98]

Despite its relative isolation therefore, the market for medical goods and services in Herefordshire was sufficiently well developed for consumers to be able to access a range of medical treatments. Local suppliers were connected to national distribution channels that enabled patients to purchase many goods and services locally or by post and there was sufficient consumer demand to attract itinerant practitioners to the county. The next two chapters explore the activities of medical practitioners in the county, the services available and how they were accessed. It was only a minority of the population that were able to purchase services directly from individual practitioners and a variety of mechanisms developed to enable other sectors of the population to access medical care, including poor law medical service and philanthropic organisations.

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[97] *Hereford Journal*, 23 Nov. 1776.
[98] Sinclair and Fenn, *Border janus*, p. 55.

Summary

Up to the middle of the nineteenth century, Herefordshire remained a predominantly rural county with economic development hampered by a relative lack of progress in developing improved roads, canals and railways. Despite the poor infrastructure, both farmers and landowners took steps to improve and develop agricultural production and were able to take advantage of developing markets in the new industrial cities. Hereford remained the only town of any size in the county but the market towns did expand during the period, each developing different characteristics and orientations dependent on the communication infrastructure and trade patterns in their area. The population living in rural areas also continued to grow in the period to 1850, albeit at a slower rate than in the more urban areas. National distribution networks were sufficient to ensure the county was integrated into the developing markets for a growing range of consumer items that included medical goods and services.

The economic and political life of the county was dominated by a small number of wealthy and influential families who exercised power through their roles as landowners, employers, and political representatives. The jurisdiction of the county magistracy did not extend to Hereford and Leominster where political power was in the hands of a tiny oligarchy, comprised of professional men and members of the gentry. The lack of industrial development in the county meant that there was no new large middle class of manufacturers and factory owners to challenge existing elites. As a result, it was Hereford corporation that took the major role in promoting the development of the medieval city while in rural areas it was the landowning class who took the lead in promoting improvements to the infrastructure. The established church was also influential in the county, both through the cathedral clergy and through the high proportion of rural clerics serving as magistrates.

Chapter 2

Medical services: private and public provision

This chapter considers medical services provided in private practice and in the public sector through the Poor Law arrangements. The main sources used are medical registers, trade directories, the census information for 1841 and 1851, Infirmary and Poor Law records, private diaries, and civic and charity records. It has been estimated that approximately one-third of the population could afford access to medical care on a private fee paying basis in the early eighteenth century, rising to about one-half by the middle of the nineteenth century.[1] Section 2.1 reflects on the nature of private medical practice and the relationship between patients and their doctors. Section 2.2 presents evidence on the number of practitioners in the county, the types of employment open to them and their competitors in the market place. Section 2.3 considers the medical services provided under the New Poor Law arrangements, focussing on the contractual arrangements between unions and practitioners. Section 2.4 explores the development and operation of mechanisms to control access to Poor Law services to those deemed entitled to receive them. Section 2.5 discusses changes in medical training and education over the period. Section 2.6 considers the development of the local profession, the social status of medical practitioners and the wider roles they played in local society, particularly as members of town councils. The summary at the end of the chapter draws out comparisons between private and public sector practice and assesses the influence of the local medical profession and others on the services provided.

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[1] Digby, *Making a medical living*, pp. 44-45.

2.1 Provincial private medical practice

Medical practice in the period up to the eighteenth century, has been traditionally categorised as consisting of four branches; physic, surgery, midwifery and pharmacy and medical practitioners as divided between three specialities; physicians, surgeons and apothecaries.[2] Physicians were considered to be the elite of the profession, practising the art of medicine, making diagnoses, recommending treatment and prescribing drugs based on an assessment of the patient's condition. Despite the fact that these university-educated men did not practice physical examination, undertake manual procedures or dispense medicines, their medical education was considered to provide sufficient expertise in the fields of surgery and pharmacy to enable them to oversee the services offered by surgeons and apothecaries. Both these groups trained through apprenticeship with surgeons expected to limit their activities to manual treatments and apothecaries to dispensing the medicines prescribed by physicians. In particular, apothecaries did not have the authority to prescribe independently, a limitation supported by the legal precedent of the Rose Case of 1704 that was not overturned until 1830.[3] In practice however this tripartite division of the profession did not reflect the realities of medical practice outside London. In the provinces, surgeon-apothecaries provided the majority of care and most of their income came from fees from dispensing medicines.[4] The numbers of practitioners in the county are considered in detail in section 2.2.

Record books of individual practitioners are an important source for the study of medical practice in the eighteenth and nineteenth centuries. One source for Herefordshire is the ledger book of Delabere Walker, a surgeon-apothecary

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[2] I. S. L. Loudon, *Medical care and the general practitioner*, pp.18-22.
[3] *Ibid.* pp. 22-23.
[4] I. S. L. Loudon, 'Medical practitioners 1750-1850 and the period of medical reform in Britain', in Wear (ed.), *Medicine in society,* pp. 219-247.

practising in the small market town of Bromyard.[5] The ledger book covers the period 1821 to 1823 by which time he was established in practice as a surgeon-apothecary, having completing a five-year apprenticeship with Joseph Severn in the town in the 1770s.[6] The ledger includes details of the types of services he provided, who his patients were and the geographic range of the practice, but does not record the diseases or diagnoses made. The evidence indicates that Walker ran a standard provincial practice dealing with relatively minor complaints including setting broken bones, dental extractions and treating cuts, ulcers, scalds and burns. He also used leeches, phlebotomy and catheterisation, attended maternity cases and inoculated children against smallpox. Walker's patients came from a wide variety of backgrounds and included the parish poor, local clergymen, farmers, solicitors and tradesmen. His patients lived within a radius of about eight miles of Bromyard, which was the approximate maximum distance that could be covered on horseback in a day. [7]

As was the custom, Walker attended many of his patients in their homes and the charges levied reflected in large part the distance he had to travel. [8] The lowest charges recorded were for visits within Bromyard which were frequently charged at 2s 6d whatever the complaint, for example the visits to Wilcox of Pump Street for phlebotomy and to Howells for examining and dressing a wound. On occasion, this fee was reduced, as for Mr Bray the butcher who was charged only 2s for 'repet pilule' and 1s 6d for linament, while Mrs Colley, also of Bromyard had her charge of 2s 6d discounted to 2s 4d in return for doing some washing. Outside the town, visits were charged at 7s 6d or 10s 6d depending on

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[5] P. H. Crosskey, 'Ledger book, 1821-1823, of Mr Delabere Walker, surgeon and physician of Bromyard', *TWNFC*, 40 (1971), pp. 277-279. I am grateful to Mrs Walker for access to the original ledger.
[6] P. J. Wallis and R. V. Wallis, *Eighteenth-century medics (subscriptions, licences, apprenticeships* (Newcastle-upon-Tyne, 1988). Delabere Walker is recorded as serving a five-year apprenticeship with Joseph Severn from 1777 for a premium of £6.
[7] Loudon, 'Nature of provincial medical practice', pp. 8-12.

the distance or the time taken for the visit. Walker attended Mr Stinton of Bringsty several times in March and April of 1821 and normally charged 7s 6d for a visit, but when he attended for a night and 'was detained some hours' the charge rose to 10s 6d. Similarly Mr Morris of Newbury was usually charged 7s 6d for a visit but was charged 10s 6d for several visits in July 1821 when Walker attended to dress an 'extensive scald' that one of the servants had incurred.[9]

The local gentry paid for medical attention to a number of patients, principally the various members of their household. The Pytt family of Kyre Park settled an account with Walker for £43 4s 10d in January 1822 and paid a further £10 3s 6d in December 1822. These fees covered charges for visits made to Mr Baker (four), Mrs Baker, Mrs Smith (two), Mrs Pytts, Miss Irvine, Mr Taylor, Hayes, the Coachman, the Coachman's child, the Footman, the cook, the gardener, the woman and Lottie Norman of Kyre Common. Reverend Apperley of Stoke Edith was also charged for attendance on several individuals who were recorded as Miss A, Miss G, Miss L, servant, nurse, butler, Evans' child, footman and maid. Although the details of treatment provided are scarce there are several records of Walker vaccinating children against smallpox. Captain Avyling paid 7s for his servant boy to be vaccinated, Mr Drew was charged 7s 6d for his son and Mr Lawrence of Hedgehouse £1 6s 6d for vaccinating two children.[10]

Evidence from the ledger book indicates that cash flow into the practice was sporadic with patients running up considerable debts before they were billed and payment was often delayed for several months. The largest recorded outstanding balance was £79 19s due from Reverend Apperley in April 1822. This was settled partly in cash and partly with a bank draft but by July 1823 a further £43 7s 6d had accumulated, against which only a part payment of £5 is recorded as being received. Mr Lawrence of Hedgehouse owed £23 1s 6d in

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[8] Walker's ledgerbook and Crosskey, 'Ledger book of Delabere Walker'.
[9] *Ibid.*

June 1823 of which he paid £10 leaving an outstanding balance of £13. For some patients charges were not recorded for individual treatments, but as a total. In August 1822, the ledger book records a balance of £2 19s due from R. Dansie Esq. and records a variety of services individually before entering a charge of £5 5s for 'attendance from time to time'. The final bill was rounded up to £10 and marked as settled. The Reverend Winnington 's debt was recorded as £14 2s 6d but was settled at £14. From these details, it is clear that Walker used a variety of billing and payment arrangements depending on the client. In addition to providing various credit arrangements, he also accepted payment in kind on occasion. Peel settled his bill of £5 for the period July to December 1822 with building materials while others paid part or all of a bill by providing services such as washing or hauling coals.[11]

Walker was employed by the overseers of Avenbury parish to provide services to the poor and the ledger book records the name of various patients seen over the period. Between 15 August 1822 and Easter 1823, Walker attended patients on thirty-six occasions and charged the parish an overall bill of £16 9s 8d. The charge for the next half-year was only £4 and this variability in levels of expenditure perhaps explains why Walker was not employed on the basis of a fixed-price contract by the parish. Under this arrangement, which became increasingly common in the eighteenth century, a practitioner would treat all paupers referred to him for an agreed annual fee.[12] In contrast to this trend, Walker was employed on an individual fee basis. Pencombe parish was also charged for individual patients with bills rendered of £9 0s 6d for 1821, 14s 6d for April 1822 and £4 8s 6d for September to November 1822. These were parishes with whom Walker had a long-term relationship, but there were others that used his services more sporadically. Leominster parish is only recorded once in the

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[10] *Ibid.*
[11] *Ibid.*

ledger book when charged £1 15s 6d for the treatment of Annie Biggerton and Ullingswick parish was charged £10 4s for fifty recorded visits to James Servant between January 9 and April 16 1823.[13] Elsewhere in the county, some parishes did use the contract system, for example in Kington the parish accepted a tender of Dr Sabine to provide all medicines and attendance in 1820 and in Ross-on-Wye Edward Wilmott was appointed on a salary of £20 for the year in 1822. [14]

Although the legislation framing the Old Poor Law did not require parishes to provide medical services to paupers on parish relief, in practice many did so. The arrangements made with individual practitioners varied with some parishes paying for individual treatments while others paid a fixed price for services or an agreed period. As noted, the contract arrangement became increasingly popular and a study based on Warwickshire found that some thirty-four percent of parishes were farming their poor by 1800. [15] The Old Poor Law arrangements were based on individual parishes and services differed from parish to parish. The Select Committee report of 1844 noted that the cost of medical relief in the north of the country was one-sixth of that in southern and midland counties, but services varied considerably within these regions too.[16] Hilary Marland notes that in Wakefield, for example, parishes sometimes authorised part-payment of medical bills for those considered able to contribute something towards the cost of treatment. She also notes that parishes authorised payment to a range of practitioners including midwives, bonesetters and other local healers and on occasion paid for spa treatment. [17] There is evidence to suggest that the level of

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[12] Lane, 'The provincial practitioner and his services to the poor', pp.10-11.
[13] Walker's ledgerbook and Crosskey, 'Ledger book of Delabere Walker'.
[14] Sinclair and Fenn, *Border janus,* p. 50. and Hughes and Hurley, *Story of Ross,* p. 91.
[15] Lane, 'The provincial practitioner and his services to the poor', pp.10-11.
[16] Marland, *Medicine in society,* p. 56.
[17] *Ibid.* pp. 57-61.

medical care available to the poor under this system was not necessarily significantly worse than for those that could pay for treatment themselves.[18]

Walker's ledger book indicates that he provided a comprehensive range of services but other practitioners may have developed special expertise depending on the other practitioners in the vicinity. An article drawing on information from the casebook of Gwyn James, who practised in Kington prior to his death in 1801, suggests that he collaborated in this way with the other two practitioners in the town.[19] Although James, Passey and Thomas are all recorded as surgeon-apothecaries in 1783, James' casebook makes no reference to him undertaking any surgical procedures or dealing with childbirth.[20] His preferred treatments were either bleeding or the prescription of medicines, several of which were his own recipes, although he also used preparations from the London pharmacopoeia and proprietary medicines including Scot's pills, Bracken pills, Dover's powders and Daffy's Elixir. Mr Thomas is said to have referred to James for advice on prescribing and preparing medicines.[21] Other sources refer to Passey acting as a surgeon, which suggests that perhaps the three Kington practitioners specialised in different areas of medical practice rather than competing directly by offering exactly the same range of services.[22] In common with Delabere Walker, James had a varied clientele which included tradesmen, paupers and gentry, including Lord Bateman of Shobdon Court and Thomas Lewis Esq. of Harpton, for whom he appears to have acted as general factotum.[23]

For members of the wealthy elite, who regularly spent part of their time in Herefordshire and part in London, there was the opportunity to seek the advice of a much greater range of practitioners. The diaries of John Biddulph of Ledbury

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[18] Lane, 'The provincial practitioner and his services to the poor', p. 13.
[19] R. Williams, 'Reflections on a doctor's day book', *Transactions of the Radnorshire Society*, 35 (1976), pp. 5-9.
[20] S. Foart Simmons, *The Medical register for the year 1783* (London, 1783).
[21] Williams, 'Reflections on a doctor's day book', p. 7.
[22] R. Parry, *History of Kington* (Kington, 1845), p. 43.

are one surviving source from the Herefordshire gentry. His journal for the period 1796 to 1798 records his efforts to deal with persistent headaches and rheumatic pains for which the doctors could provide no easy relief.[24] Biddulph took active control of his own health problems, calling on several medical men for advice in an attempt to gain a common diagnosis from them and seek out effective treatment. In May 1796 he was in London where he was taking regular hot and warm sea-water baths as recommended by doctors Hayes and Bush. In June he was in Herefordshire and as his head was still troubling him, he dropped in to see Dr Blount, a physician in Hereford. On 1 July Dr Seward came to see him at home in Ledbury and recommended that he cut his hair off and bathe his head as well as his body in a sea-water bath. On his return to London on 5 July he followed Seward's advice and cut his hair before attending Drs Hayes and Bush again. They approved the action taken but suggested he go to the seaside as soon as possible 'as the sea air and exercise would do me as much good as bathing'. Accordingly Biddulph went first to Ramsgate and then to Brighton where on 4 August he met Dr Hayes who recommended he return to London and see Dr Bush. Bush was out of town but promised to meet him with 'any other practitioner' the following Monday. Biddulph took Dr Pitcairn along with him and remained under their joint treatment until the end of the month. They disagreed with 'what Dr Hayes has ordered' and recommended he take 'bark with pills of opium and epices at night'. Although Biddulph was not satisfied with the results of the treatment he continued to seek their advice. On 29 August he 'called on Bush who still persisted in his old opinion, not being convinced I sent for Dr Brand the apothecary who seemed very much of Bush's opinion- I then called upon Dr Pitcairn who was out- but appointed to call the next morning'. Pitcairn duly came to see him but did not provide the reassurance the patient needed; 'saw Pitcairn

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[23] Williams, 'Reflections on a doctor's daybook, p. 8.
[24] HRO, G2/IV/72, Biddulph diaries, 1796-1798.

who still remained doubtful respecting my disorder but I thought he seemed rather inclined towards Bush's opinion.' On the 4 September, Biddulph was back in Ledbury and noted 'Dr Seward and Miss Sarah Roberts took tea' although he did not mention whether or not Dr Seward was also treating him.[25]

It would appear from this that Biddulph gave precedence to the opinion of London based practitioners but also referred to the local Herefordshire doctors when he was in the county. His diary mentions two visits from Dr Seward and that both Dr Blount and his wife and Dr Hill from Ross visited the house for social occasions. Although the dairies refer to all these medical practitioners as Dr, only Thomas Blount can be confirmed to be a physician. John Seward was apprenticed as an apothecary to Joseph Severn of Bromyard in 1783 and is likely to have been well established in practice by 1796, while Thomas Hill was a surgeon-apothecary based in Ledbury.[26] Biddulph clearly took an active role in managing his own illness, compared the treatments recommended to him by various doctors and took a second and third opinion when he felt it necessary.

The water therapies adopted by Biddulph were popular with many patients. From 1722 the use of cold water as a universal preventive was promoted with both drinking and bathing being prescribed as treatments. The origins of water treatments lie both in holy wells with a pagan or Christian association and in the classical therapeutic tradition of the cool regimen. By the eighteenth century their use was increasingly justified on the basis of the scientifically assessed properties of the waters.[27] In June 1828, the Kington vestry paid for William Jones to visit the waters of Llananno Wells to help his affliction with the King's Evil and the waters in Holywell Wood on Bradnor Hill and at Crooked Well were also regarded as having useful restorative properties. [28]

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[25] *Ibid.* May to Sept. 1796.
[26] Wallis and Wallis, *Eighteenth-century medics.*
[27] R. Porter (ed.), *The medical history of waters and spas* (London, 1990).
[28] Sinclair and Fenn, *Border janus*, p. 52.

Although there were no spas of national significance in Herefordshire, there were a considerable number within easy travelling distance, the principal ones being Llandrindod Wells, Cheltenham and Malvern Wells. [29] John Pateshall, a surgeon-apothecary who suffered from chronic rheumatic problems, was advised to travel to the renowned spas in Buxton and Bath to seek relief. [30] Sea bathing also became increasingly popular as the eighteenth century progressed and promoted the development of seaside resorts such as Brighton, Weymouth and Aberystwyth. Members of the wealthy Banks and Crumner families from Kington were avid visitors to Welsh spas and sea-side resorts at Aberystwyth and Llandrindod Wells as well as travelling further afield to Aix-la-Chapelle.[31] In December 1803 Brother Jenkins of the Leominster Moravian Community took his family to bathe at Aberystwyth as a preventive measure after one member of the family was bitten by a mad-dog.[32]

Some practitioners, mainly physicians, came from the gentry class. A local example of one of these 'gentleman physicians' is Martin Dunne, whose family were landowners at Aymestry in the north of the county very close to the border with Shropshire. Martin and his younger brother, Thomas, were both born at Gatley Park in the 1740s but the family moved to the nearby market town of Ludlow in south Shropshire in 1755. In 1760 Martin went to Brasenose College, Oxford, where he achieved a law degree in 1768 followed by a medical degree in 1770. His father died the same year and Martin returned to Herefordshire and established a practice in Ludlow where he continued to live until his death in 1814. After his brother's death, he took charge of the education of his two nephews, the elder of whom, Thomas, trained as a doctor in London and

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[29] C. Hamlin 'Chemistry, medicine, and the legitimization of English spas, 1740-1840', Porter (ed.), *Medical history of waters and spas,* pp. 67-81.
[30] HRO, A 95/AP, Letter from John to his mother, Aug. 1800.
[31] Sinclair and Fenn, *Border janus*, pp. 52-53.
[32] Leominster Moravian records, Dec. 1803. I am grateful to Vera and Basil MacLeavy of Leominster Moravian Church for access to these records.

Edinburgh. Martin wished Thomas to join him in practice in Ludlow but he resisted this suggestion for several years although he did finally inherit Gatley Park from his uncle. Ludlow was a prosperous commercial centre and Dunne was able to build up a considerable practice and was the first honorary physician to Ludlow dispensary, which opened in 1781. In addition to the normal treatments used by physicians such as bleeding, blistering, purgatives, medicines and the recommendation of a more holistic regimen, Dunne also used electrotherapy to treat muscular and rheumatic conditions from the late 1770s.[33]

Galvani is credited with introducing electrotherapy into Italy in the late 1760s but it did not become well established in England until the early nineteenth century so that Dunne appears to have been one of earliest practitioners to use this treatment technique.[34] Notes of twelve case studies of him using electrotherapy have survived, two of which appear to have been written by the patients themselves, both of them women. Miss Heighway's account covers the twenty years from 1775 to 1794 during which time she describes recurrent symptoms including muscular pain and spasms.[35] During one attack her jaws became clenched shut so that she had to be fed liquids through a gap in her teeth, more remarkable perhaps in that at the same time as these convulsions she also suffered from fits of 'excessive talkativeness'. During one of these she notes that:

> I gave my opinion on every individual of my acquaintance with many pertinent remarks. Every sentiment of my soul was exposed to view whether in favour or disfavour of myself. I had also described the entire history of England from the conquest to the

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[33] J. D. Blainey, 'Dr Martin Dunne of Ludlow, 1740-1814', TWNFC, 36 (1971), pp. 271-283.

[34] Experimental electrophysiology was pioneered by Luigi Galvani. He published *De viribus electricitatis in motu musculari* (On electrical powers in the movement of muscles) in 1792.

[35] HRO, F 76/IV/72, Records of Martin Dunne.

present day with many relevant anecdotes of each reign... Dr. Dunne informed me that he had rarely heard such good sense.

In 1779, after several years of more conventional treatment including bleeding, blistering, purgatives and the recommendation of a general regimen which incorporated regular cantering on her pony, Dunne suggested he use electricity based on the Leyden jar. Miss Heighway notes that:

> I was put to sit on an insulated stool and a piece of flannel applied to each side of my face and sparks drawn through by means of a brass rod. In about five or six minutes the muscles of my face somewhat relaxed.

Research into the relationship between patients and practitioners has shown that the axis of power between patient and practitioner was complex and dependent in part on their relative social status.[36] Despite no clear improvement in Miss Heighway's condition the relationship between patient and physician continued for almost twenty years until her recorded complete recovery in 1794. Despite her chronic symptoms, she was able to lead a full social life for much of the time and there is no feeling from the case study that her illness caused her social embarrassment. Her patient's narrative is written in a lively and interesting style, recording symptoms and treatments in an objective manner in a narrative that may have been written for scientific interest, as an example of the new treatment available, perhaps as testimonial to its efficacy.[37] The relationship portrayed is one where the views of both doctor and patient are accorded validity, due in part at least to the relative equality in their social status. Dunne had been born into a land-owning family and was named on the commission of the justices

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[36] See for example R. Porter and D. Porter, *Patients' progress: doctors and doctoring in eighteenth-century England* (Oxford, 1989) and Porter, *Patients and practitioners.*

[37] For a discussion of the variety of medical information to be found in patients' journals and letters see J. Lane, "The doctor scolds me': the diaries and

of the peace for Herefordshire. He was a member of a small group of practitioners who had a university degree that qualified him as a physician and as such would have been accepted as one of the leaders of the local medical profession.

2.2 Medical practitioners in Herefordshire

In 1783, Samuel Foart Simmons published a revision of his *Medical Register*, first issued in 1779. [38] The register listed 3,166 practitioners in England outside London classified into one of four categories, physicians, surgeon-apothecaries, surgeons and apothecaries. Barber-surgeons and fringe practitioners were excluded as were midwives and other 'irregular' medical practitioners. The 1783 *Register* showed that physicians were very scarce and that practitioners categorised as surgeon-apothecary by Simmons fulfilled the demands for medical services for the majority of the population. Simmons does not use the term 'surgeon, apothecary, man-midwife' although this was common in trade directories of the day.[39] Of the 3,166 practitioners recorded, 82.3 per cent were classified as surgeon-apothecaries, 89 or 2.8 per cent as surgeons and 107 or 3.3 per cent as apothecaries. There were 363 physicians, 11.4 per cent of the total. Simmons' designation of the majority of medical practitioners as surgeon-apothecary indicates a difference between the realities of provincial medical practice at the end of the eighteenth century and the traditional tripartite division of the profession.[40] Irvine Loudon has commented that the majority of practitioners earned their living from treating medical ailments and undertaking

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correspondence of patients in eighteenth-century England' in Porter, *Patients and practitioners,* pp. 205-248.

[38] Foart Simmons, *Medical register.*

[39] J. Lane, 'The medical practitioners of provincial England in 1783', *Medical History,* 28 (1984), pp. 353-371, p. 356.

[40] *Ibid.* pp. 353-371.

simple surgical procedures and that there was little difference in the range of diseases treated by the various branches of medicine. [41]

Simmons' *Register* provides listings by county which have been summarised by Joan Lane to show the relative numbers of practitioners across England.[42] As reliable and consistent population estimates are not available for 1783, comparative information on the ratio of practitioners to population across the country is more difficult to calculate. Using data from the register and population estimates from first national census of 1801, Anne Digby has estimated that on average there was one practitioner to 2,224 people in the provinces compared to a ratio of below 1:950 in London. There was considerable variation between counties with four with ratios lower than 1: 3,000 and eight with ratios of 1:1,000-1: 1,500. Digby estimates that the ratio for Herefordshire was towards the top end of this range with a practitioner to population ratio of between 1: 2,000 to 1: 2,500. [43]

Joan Lane has commented favourably on the accuracy of the register based on a comparison of the entries for Warwickshire to other source data.[44] This is also true for Herefordshire for which only six of the forty-two entries have not been traced to independent supporting information. These findings suggest that the register was reasonably accurate for English counties although the entries for Wales may be less comprehensive. Nevertheless it is important to note that errors in these small numbers would effect the ratios calculated quite considerably and they can therefore be considered as indicative only. Table 2.1 shows a considerable variation in population to practitioners in Herefordshire and the three adjacent English counties with Shropshire having the lowest ratio and

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[41] I. S. L. Loudon, 'A doctor's cashbook, 1828-1831', *Medical History,* 27 (1983), p. 262.
[42] Lane, 'Medical practitioners, 1783', p. 354.
[43] Digby, *Making a medical living*, pp. 15-20.

Gloucestershire the highest. The ratio for Gloucestershire was one of the four highest calculated by Digby who also notes two counties adjoining London in the top eight; Surrey, Bedfordshire and Buckinghamshire. [45] It is likely that the ratio noted for Gloucestershire was influenced by the proximity of Bath and Bristol, with more practitioners choosing to base themselves in those centres rather than in more rural areas.

Table 2.1: Medical Practitioners in Herefordshire and surrounding counties in 1783.

	Total	Physician	Surgeon & Surgeon-Apothecary	Population to regular practitioner
Herefordshire	42	5	37	2,000-2,499 : 1
Worcestershire	72	5	67	1,500-1,999 : 1
Gloucestershire	38	6	62	> 3,000 : 1
Shropshire	89	5	85	1,000-1,500 :1
Brecknockshire	11	0	11	Not given
Monmouthshire	23	3	20	Not given

Source: S. Foart Simmons, *Medical register for 1783* (London, 1783) and A. Digby, *Making a medical living*, pp. 22-23.

The register noted only eight physicians and 121 surgeon-apothecaries for the whole of Wales, which suggests either some under-recording by Simmons or a sharply different distribution for Wales than for English counties.[46] Although the range in ratios cannot be fully explained, it is reasonable to suggest that there was a link between the relative wealth of local communities and their ability to attract medical practitioners. The density of the population and the number of

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[44] Lane, 'Medical practitioners', p. 354. For Warwickshire 45 of the 50 surgeon-apothecaries and 4 of the 5 physicians listed were traced to other source material.
[45] Digby, *Making a medical living,* p. 21.
[46] Foart Simmons, *Medical register, 1783.*

towns are also likely to be explanatory factors. Herefordshire, with its scattered rural population and lack of industrial development, supported lower numbers of practitioners than Worcestershire or Shropshire, but significantly more than the neighbouring Welsh counties.

Simmons records five physicians as practising in Herefordshire, some 12 per cent of the total numbers listed for the county, slightly above the overall provincial average of 11.3 per cent. The percentage for the surrounding counties varies with Gloucestershire (16 per cent) and Monmouthshire (13 per cent) with a higher proportion of physicians than the average and Shropshire (6 per cent) and Worcestershire (7 per cent) a lower proportion. The register records no physicians at all in Brecknockshire. Fifteen of the twenty-three physicians in the region are recorded as resident in the county towns, three in Hereford, four in Shrewsbury, four in Worcester, two in Gloucester, and two in Monmouth with almost all others in established towns including Cheltenham, Chepstow, Cirencester, Ludlow and Stroud. [47] The register also notes a small number of practitioners classified as surgeons rather than surgeon-apothecaries. All of these are associated with provincial hospitals, institutions in which the classification between physician and surgeon was clearly defined. These positions were honorary and it has been argued that the incumbents of these surgical posts did confine themselves to surgery in this capacity, whatever the range of their professional work in their private practice. [48]

Table 2.2, below, is based on the residence information in Simmons and shows the distribution of the listed practitioners within Herefordshire. Fifteen of the forty-two practitioners, just over one third of the total, were listed as resident in Hereford. Twenty-one were recorded in one of the five market towns and only

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[47] Foart Simmons, *Medical register* . Details have been extracted from the relevant individual county listings.
[48] J. Lane, 'Medical practitioners', p. 356.

six in more rural areas.[49] Of these six, the apothecary may well have no longer been in practice leaving one physician and four surgeon-apothecaries in practice outside the urban areas.[50] Clearly access to a physician was much more limited than that to surgeon-apothecaries; three of the five based in the county were in Hereford, one in Kington and one in Madley. It was therefore surgeon-apothecaries who both prescribed and dispensed medicines to most of the population in addition to providing surgical and midwifery services.

Table 2.2: Categories of medical practitioner in Herefordshire 1783.

	Physicians	Surgeon/ Apothecaries	Surgeons	Apothecaries
Hereford	3	9	3	
Bromyard	0	3		
Kington	1	4		
Ledbury	0	2		
Leominster	0	4		
Ross-on-Wye	0	7		
Rural areas	1	4		1
Total	**5**	**33**	**3**	**1**

Source: Samuel Foart Simmons *Medical register for 1783* (London, 1783).

Table 2.3 summarises data showing the distribution of practitioners relative to population in the county in 1783 and 1851. Information on the number of practitioners is drawn from the detailed register of medical practitioners presented in Appendix 3, which lists all the regular practitioners identified as

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[49] Thomas Stead, listed by Simmons as resident in Broadward, is included in this analysis as practising in Bromyard as shown in *The Universal British Directory, 1793 (*London, 1792).

[50] Lane, 'Medical practitioners', p. 356. The apothecary was Timothy Markham, a yeomanry member of the Society of Apothecaries who Simmons listed as eleventh in seniority in the Society of Apothecaries in 1783. Simmons did not include him in the county index although Lane does in her numerical summary. Lane suggests that he restricted his profession to those in his own personal circle. He had married a wealthy heiress in Herefordshire and was responsible for rebuilding The Weare, a country house a few miles west of the City of Hereford.

working within Herefordshire between 1783 and 1851. The population information is drawn from summaries of the census of 1801 and 1851.

Table 2.3: Ratio of medical practitioners to population in Herefordshire in 1783 and 1851.

	Practitioners In 1783	Population at 1801	**Ratio of practitioners to population**
Hereford	15	7,108	1:474
Bromyard	3	2,392	1:797
Kington	5	2,062	1:412
Ledbury	2	3,058	1:1,529
Leominster	4	3,966	1:991
Ross-on-Wye	7	2,347	1:335
Rural	6	67,503	1:11,250
Total	**42**	**88,436**	**1:2105**
	Practitioners c.1851	**Population in 1851**	**Ratio of practitioners to population**
Hereford	19	11,536	1:607
Bromyard	5	3,093	1:619
Kington	5	2,871	1:574
Ledbury	5	4,624	1:925
Leominster	8	5,214	1:652
Ross-on-Wye	10	4,017	1:402
Rural	24	84,134	1:3,505
Total	**76**	**115,489**	**1:1,519**

Source: Census of Great Britain: population (England and Wales) 1801 and 1851 and Appendix 3.

In 1783, Hereford had a population of 7,108, or 474 persons to each of the fifteen medical practitioners working in the city. Equivalent ratios for the market towns varied between 335:1 in Ross-on-Wye to 1,529:1 in Ledbury. In comparison, the ratio for the rural areas was 11,250:1. At first sight, this range in quite startling, but in fact most of the population lived within an eight to ten mile radius of one of surgeon-apothecaries based in the market towns. As shown by the earlier discussion of Walker's practice, practitioners regularly travelled these kinds of distances to visit patients. Medical practitioners, as members of the service sector, chose to situate their practices at the small commercial centres

throughout the county and served the community of rural parishes within a radius of their chosen base.[51] By 1851, the number of practitioners had risen from 42 to 76, an increase of 81 per cent, and the average ratio of population to practitioners had reduced by 28 per cent from 2,105:1 to 1,519:1. However this average change masks different patterns in the various parts of the county as shown in Table 2.4.

Table 2.4: Change in practitioner numbers and practitioner: population ratio in Herefordshire between 1783 and 1851.

	Increase in practitioners 1783-1850	% increase in practitioners from 1783	Change in population to practitioner ratio 1783 to 1850	% change in ratio from 1783
Hereford	4	27%	+133	+28%
Bromyard	2	267%	-178	-22%
Kington	0	0%	+162	+39%
Ledbury	3	150%	-604	-39%
Leominster	4	100%	-339	-34%
Ross-on-Wye	3	43%	+67	+20%
Other Rural	18	300%	-7745	-69%
Total	**34**	**81%**	**-586**	**-28%**

Source: Table 2.3

In the fifty years between 1801 and 1851 the population of the rural parishes rose by 25 percent while the number of medical practitioners almost quadrupled. As noted in Appendix 3, ten of these practitioners held posts as Medical Officer to a Poor Law Union. Of the others, Peter Giles was employed as Medical Officer by the Jarvis Charity, Samuel Millard ran a private asylum in Whitchurch, and Evan Williams is recorded as being the medical referee for Clerical and Medical and other assurance societies. Thus thirteen of the twenty-three had some source of income to supplement any private fees they could earn, the majority coming from fees paid by Poor Law Unions. Despite this

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[51] Lane, 'Provincial practitioner and his services to the poor', p.10. Lane notes a radius of ten miles as being common in Warwickshire.

increase in the number of practitioners in the rural areas, the ratio of population to practitioner was still far higher than in Hereford and the market towns at 3,505:1 compared to a range between 402:1 to 905:1 for the urban areas. The preference of practitioners for a practice in one of the smaller towns is in line with the national pattern. Research into the West Riding has shown that practitioners chose to practise in smaller towns over the developing industrial centres due in part to the higher proportion of middle-class inhabitants who could afford their services and which therefore offered a realistic opportunity for a good standard of living. The social environment of the towns were also important, offering greater opportunities for practitioners to take up honorary appointments at infirmaries and dispensaries and integration with developing middle class cultural pursuits.[52] The pattern of distribution in Herefordshire shows that the urban areas were deemed preferable to the more rural villages and scattered populations.

The second half of the eighteenth century was recognised as something of a golden age for medical practitioners. The medical profession expanded and incomes were good, based on a virtual monopoly in the sale of prescribed medicines made up by the surgeon-apothecary and benefiting from the general increase in consumer demand in the period. [53] Demand for surgeons from the armed forces also increased employment opportunities up until the end of the Napoleonic wars. After 1815 many of these men were forced to return to civilian life causing an influx of additional practitioners into an increasingly overcrowded profession. Using census data from 1841, Irvine Loudon calculated a national average of 910 people to one physician or surgeon-apothecary in the country. [54]

The data for Herefordshire suggests that one result of increasing competition

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[52] H. Marland and P. Swan, 'Medical practice in the West Riding of Yorkshire from nineteenth-century census data' in *Essays in regional and local history in honour of Eric M. Sigsworth* (Hull, 1992), pp. 73-98, pp. 83-86.
[53] Loudon, 'Provincial medical practice', pp. 24-26.
[54] Loudon, *Medical care and the general practitioner*, app. v, p. 307.

among practitioners was an increase in the number choosing to provide services to the more scattered rural communities. In 1783 the proportion of practitioners in rural areas was very low, indicating that patients either travelled to see a practitioner or made only limited use of their services. In Hereford, Kington and Ross-on-Wye, the three towns with the lowest population to practitioner ratio in 1783, the ratio actually increased over the period whereas in the other three market towns it decreased. In 1783 there were 36 practitioners to a total population of 20,993 in the urban centres; by 1851 the equivalent figures are 52 practitioners to a population of 31,355. The comparative ratios are 583:1 for the earlier period and 602:1 in 1851. This average is remarkably stable and suggests that the urban sector offered few opportunities for expansion other than through the population increase over the period, and that practitioners chose instead to practise in more rural areas.

One possible reason for this is that the overcrowded nature of the profession led to downward pressure on incomes, forcing practitioners into the less lucrative rural areas where they were able to offer local services to those who had previously had to travel into one of the towns. Another reason for the increase seems to have been the increased employment opportunities offered by the arrangements for medical services under the New Poor Law. From 1836 each of the new Unions in the county appointed Medical Officers to provide services to paupers. Although the remuneration offered was undoubtedly low it nevertheless provided practitioners with some secure income from the provision of services to a section of the population who could not afford to access services on a privately.[55] In addition to some secure income, these appointments also offered status and an introduction into the community which were vital if a prosperous

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[55] Marland and Swan, 'Medical practice in the West Riding of Yorkshire', p. 87.

practice was to be established. Poor Law appointments are discussed further in section 2.3 below.

The categories of 'regular' and 'irregular' practitioners are convenient shorthand for historians considering the multifaceted and heterogeneous medical marketplace of the eighteenth and nineteenth centuries, although it is recognised that a clear distinction between the two cannot always be made. [56] The Medical Act of 1858 was the first attempt to legally define those entitled to practice medicine and to establish a process authorising prosecution of anyone not qualified under the act who continued to do so. Prior to this, the category of qualified medical practitioner was not so clear cut despite the fact that conventional routes for apprenticeship and training were well established. It did however exclude two specific groups, midwives and chemists who were active in providing specific services that brought them into competition with regular practitioners.

The rise of the specialism of man-midwifery during the eighteenth century has been well documented. [57] Although the Royal College of Surgeons did not introduce a separate midwifery diploma until 1845, lectures on midwifery were available to medical students at London hospitals and from private practitioners from the eighteenth century onwards.[58] In contrast to the apprenticeship system established for training surgeons and apothecaries, traditional midwifery skills were transferred informally from woman to woman and local reputations were based on practical results achieved by practitioners. Although the first provincial midwifery schools were set up in Manchester and Liverpool in 1790, these had

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[56] Loudon, *Medical care and the general practitioner*, pp. 13-18.
[57] For a discussion of midwifery in this period see J. Donnison, *Midwives and medical men: a history or inter-professional rivalries and women's rights* (London, 1977), A. Wilson, *The making of man-midwifery: childbirth in England, 1660-1770* (Cambridge, 1995), and H. Marland, (ed.), *The art of midwifery: early modern midwives in Europe* (London, 1993).

very limited effect on the training of midwives in the majority of the country where it continued to be a skill developed through practical experience. Despite the increasing influence of the man-midwife, female midwives continued to oversee the majority of normal births.

Comprehensive records of practising midwives are difficult to compile as many women practised on a part-time basis and were frequently not recorded as midwives in formal records such as marriage bonds or parish records. One surviving source are the records of ecclesiastical licenses granted in each diocese, although it is recognised that these records do not provide a comprehensive list of all those practising.[59] The ecclesiastical licensing system focussed on an assessment of good character as much as practical skills and was based on testimonials from reliable persons that midwives were Christian women of good repute. Applicants would obtain testimonials from clergymen, medical practitioners, midwives and other women and would present these with the licence fee, which could be quite substantial.[60] The system shows the wider importance of the traditional midwife's role in the community. In addition to organising and overseeing the birth, midwives were also authorised to baptise a child if it was likely to die and could be asked to bear witness that a mother had not committed infanticide or to identify the father of illegitimate children. There was an expectation that fathers would contribute financially to the upkeep of their offspring and this created a financial as well as a moral driver to identify paternal responsibility.[61]

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[58] Two of the most famous practitioners in the eighteenth century were William Hunter and William Smellie. See W. F. Bynum and R. Porter (eds), *William Hunter and the eighteenth-century medical world* (Cambridge, 1985).
[59] D. Harley, 'Provincial midwives in England: Lancashire and Cheshire, 1660-1760', in Marland, (ed.), *The art of midwifery*, pp. 27-48.
[60] *Ibid.* pp. 27-30. Harley records a licence fee of 18s 8d in the Chester diocese.
[61] T. R. Forbes, 'The regulation of English midwives in the sixteenth and seventeenth centuries', *Medical History,* 8 (1964), pp. 235-244.

Ecclesiastical licensing declined throughout the eighteenth century although surviving records show that it was still in operation in the Hereford diocese to at least 1801 for both midwives and surgeons. Forty-eight women received a license from the Bishop of Hereford between 1755 and 1799.[62] Nine of these were recorded as living in market towns, three in Kington, one in Ledbury, four in Ludlow and one in Presteigne. The remaining 39 were listed in smaller villages while none were licensed to practise in Hereford itself. This distribution is in marked contrast to that of the regular medical practitioners discussed earlier as a majority of the midwives were listed as living in small villages. The data, incomplete though it is, suggests that midwives continued to provide a major part of obstetric care for women in this period, with man-midwives called upon to deal with difficult cases where surgical intervention was deemed necessary.[63]

When Nicholas Geary's wife was expecting a baby, a midwife was arranged to help her at the birth but when complications arose Mr Cam was asked to attend. Cam was based in Hereford, eleven miles away and refused to attend for reasons that are not clear, and Geary then turned to Mr Griffiths, also based in Hereford. [64] Although Mrs Geary survived the delivery, the child was delivered dead. Despite the fact that Geary was a practising surgeon-apothecary with an established practice with several apprentices, he did not intervene himself or call on a colleague from the local town. Instead he looked for expertise from a practitioner from some distance away. This episode supports the view that while midwives managed normal deliveries, complications and difficulties with an

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[62] HRO, HD5, Diocesan call books. The diocese included parts of Wales and Shropshire. The records also record 35 licenses for surgery issued between 1748 and 1801, of which 12 were recorded in market town and 23 in villages. None were licensed for Hereford city.

[63] The reasons for the growth in popularity of the male man-midwife are complex. One factor was the use of forceps and other instruments by male practitioners in obstructed births from the 1720s that increased the possibility of delivering a live child. See Wilson, *The making of man-midwifery,* especially ch.12.

obstructed birth were more likely to be handled by a surgeon-apothecary specialising in this field. Records of the New Poor Law Unions in Hereford show that Union surgeons were not expected to oversee all childbirth cases although it was recognised that they would be called on in difficult cases. In recognition of this, Unions paid Medical Officers 10s 6d for a delivery while a midwife's fee was normally 2s 6d. [65]

The appearance of dispensing chemists from the end of the eighteenth century has been identified as posing a specific threat to the prosperity of the medical profession, a large proportion of whose income was derived from the profit on the sale of medicines. [66] The nineteenth century saw a rapid increase in the number of chemists and druggists who acted both as wholesalers to medical professionals and as retail suppliers direct to the public. In addition to selling patent remedies and making up individual preparations for customers, they also provided over the counter prescribing. [67] Many sold a wide range of retail goods in order to make a living, including toiletries and cosmetics, foodstuffs and other household items. [68] Data extracted from the 1841 census calculated that there was one chemist or druggist to every two medical practitioners in the country and that the numbers of chemists and druggists continued to increase. By 1870 the number of druggists and chemists exceeded medical practitioners in the West Riding, Lancashire and rural Lincolnshire.[69] A comparison of the numbers of chemists and druggists with those of regular practitioners in Herefordshire in 1851 is shown in Table 2. 5. The numbers of medical practitioners is taken from Table 2.3 above and those of chemists and druggists from *Lascelles directory*

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[64] HRO, A95/AP/11. Letter from John to his mother dated Sept. 1798.
[65] Harley, 'Provincial Midwives', p. 33.
[66] Loudon, 'Provincial medical practice', p. 24.
[67] H. Marland, 'The medical activities of mid-nineteenth century chemists', *Medical History,* 31 (1987), pp. 415-439.
[68] Marland, 'Medical activities', p. 423.
[69] *Ibid.* p. 421.

and gazateer of Herefordshire, 1851.[70] A total of thirty-four chemists and druggists are recorded across the county, compared to seventy-six regular practitioners, a ratio of 1: 2.05. The comparative ratio for Hereford is 1:1.7 and for the average of the market towns, 1:1.9. The ratios for the more urban areas of the county are in line with ratios calculated for other towns. Hilary Marland reports a ratio of 1.14 for Wakefield in 1851 and Irvine Loudon records ratios in 1853 of 1:1.2 for Dorchester and 1:1.7 for Blandford.[71]

Table 2.5: Comparison of medical practitioners and dispensing chemists in Herefordshire in 1851.

	Regular practitioners	Chemists & druggists
Hereford	19	11
Bromyard	5	3
Kington	5	3
Ledbury	5	3
Leominster	8	5
Ross-on-Wye	10	3
Rural areas	24	6
Total	76	34

Source: Table 2.3 and *Lascelles 1851 gazateer and directory of Hereford* (Birmingham, 1851).

The pattern for the more rural areas of Herefordshire shows a markedly different pattern. Only six chemists and druggists are listed outside Hereford and the market towns, compared to twenty-four medical practitioners, a ratio of 1:6. This tends to support the argument put forward earlier, that the number of medical practitioners in rural areas was influenced by the availability of paid employment, principally from the Poor Law Unions. It seems that dispensing chemists, a higher proportion of whose income was derived from retail sales, were unable to establish viable businesses in rural areas. At least two of those

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[70] This is the earliest comprehensive directory for the county.

listed also derived income from other retail activities. T. S. Hinde and A. Gough are listed in the village of Fownhope as 'grocers, tea dealers, druggists, ironmongers and flour dealers'. Similarly, James Powell in Eardisley is listed as 'grocer, draper, druggist and ironmonger'. [72]

2.3 Medical Services under the New Poor Law

Following the passing of the New Poor Law in 1834, the majority of Herefordshire parishes were allocated between eight Unions, which held their inaugural meetings from the summer of 1836 through into 1837.[73] The geographic area of each union was divided into districts for management purposes each served by a Relieving Officer whose responsibilities were to investigate claimants and authorise relief. Medical districts were often the same as the relieving districts although in some unions in Herefordshire they were fewer in number reflecting the fact that medical relief was expected to be a subset of the general relief given. The remunerated officers of the new Unions were the Relieving and Medical Officers and their work was closely interrelated.

The design of the New Poor Law was aimed at addressing the rising costs of poor relief and combating the moral vice of the poor, considered as one of the principle reasons for pauperism. The principles of deterrence and centralisation were influential in the development of policies that restricted out relief and used the threat of the workhouse to deter the poor from claiming relief. [74] Although medical services had been an important component of relief under the Old Poor

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[71] Marland, 'Medical activities', p. 419 and I. S. L. Loudon, 'The vile race of quacks with which this country is infected,' in Bynum and Porter (eds), *Medical fringe and medical orthodoxy,* pp.106-128, p, 109.

[72] *Lascelles 1851 gazateer of Herefordshire* (Birmingham, 1851)

[73] The majority of Herefordshire parishes were allocated to eight unions, Hereford City, Leominster, Bromyard, Ledbury, Ross, Dore, Weobley and Kington. However, as the boundaries of the Poor Law Unions were not entirely coterminous with the county boundaries some Herefordshire parishes were included in unions based mainly in the surrounding counties, notably, Ludlow, Hay and Monmouth.

Law, the provision of medical services was not a central consideration in the initial regulations of the new act. One clause granted justices of the peace the power to order medical relief in cases of sudden illness but in practice Unions found that they needed to provide more comprehensive services.[75] Although general outdoor relief was to be denied to the able-bodied poor this did not apply to those assessed as sick or infirm sick. In addition it was recognised that the timely provision of medical relief in the event of an accident or a temporary period of sickness might enable a family to maintain its economic independence in the longer term.[76] The provision of medical out relief therefore developed as an important part of the operation of the new Unions although the question of eligibility remained a crucial one for consideration at a local level. Unions were authorised to appoint Medical Officers and guidance was issued on general principles including the stipulations that only qualified practitioners should be appointed, attendance on sick paupers must be provided promptly and provision made for dismissal on proof of incompetence.[77] However, nothing was expressly stated about the provision of medical relief to non-paupers. As details of the contractual terms with Medical Officers were left to individual Unions to decide, the result was that the medical services provided varied considerably across the country. Variation in the level of provision had also been a hallmark of the Old Poor Law, with comparative figures showing that medical services in the north of the country were generally lower than in the south and midlands.[78] Evidence given to the Select Committee of 1838 reported that in some areas where relief

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[74] Hodgkinson, *Origins of the National Health Service,* pp. 1- 4.
[75] Flinn, 'Medical services', p. 48.
[76] Hodgkinson, *Origins of the National Health Service,* pp. 4-7.
[77] Hodgkinson, 'Poor Law medical officers of England, 1834-1871', *Journal of the History of Medicine,* 11 (1956), pp. 299-338. p. 300.
[78] Hodgkinson, *Origins of the National Health Service,* p. 8.

under the Old Poor Law had been more generous, the level of services provided fell as medical relief was witheld from non-paupers by the new Unions.[79]

Following the influenza epidemic of 1837-38, the Poor Law Commissioners began to take a more proactive stance towards a number of medical issues, including vaccination against smallpox. This was an area where it was recognised that a comprehensive service was needed if the measures were to be effective. Legislation in 1840 and 1841 provided for free vaccination for all.[80] The content of the General Medical Order of 1842 which set down a variety of measures that aimed to provide a more standardised national framework of medical relief was influenced by the publication of Edwin Chadwick's Sanitary Report which had considered the links between poverty and illness. Boards were required to appoint permanent salaried medical officers who were to hold the double qualification of Member of the Royal Society of Surgeons (MRCS) and membership of the London Society of Apothecaries (LSA). Medical Districts were not to exceed a population of 15,000 or a maximum area of 15,000 acres and Unions were required to undertake more public health measures including the investigation and removal of hazards such as foul drains and nuisances.[81]

All of the Herefordshire Unions considered the arrangements for medical relief at their first meetings, allocating parishes into medical districts and deciding on the type of contract that they wished to put in place. The main options were either to ask practitioners to submit a fixed price tender for providing services to a particular district for one year or to set out the payments to be made for individual visits and request expressions of interest in providing services on that basis.[82] For their first year of operation all the Herefordshire Unions decided to use the tender

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[79] *Ibid.* p. 10.
[80] *Ibid.* p. 28.
[81] Flinn, 'Medical services', p. 54.
[82] Hodgkinson, 'Poor Law medical officers', pp. 301-302.

system, whereby practitioners were invited to submit a fixed price bid for providing services under the contract terms proposed by the Guardians.[83] By 1851, the eight New Poor Law Unions in Herefordshire employed twenty-eight practitioners as Poor Law Medical Officers.[84]

Salaries were left to the discretion of the individual Boards of Guardians as was the detail of the remuneration method. Medical Officers were normally obliged to cover the cost of medicines and surgical appliances from their salary so that the cost of the items prescribed directly affected their net remuneration, creating a financial incentive to limit the medicines prescribed. If, on the other hand, practitioners were paid a fee for attendance with the Union paying the costs of medicines, there was no incentive to limit prescription costs, which increased the Union's financial risk. When the Select Committee considered the question of salaries in 1844, evidence was presented which showed that in some cases the fees paid by Unions were so low that Medical Officers were effectively subsidising the treatment of pauper patients.[85] The average cost of medicines prescribed was close to the fee received per patient leaving little to cover travel costs and the time taken to treat a patient. The remuneration level and method could therefore have a considerable effect on the quality of care and treatment provided to those patients eligible for medical relief. From the practitioner's point of view, the decision to take up a public appointment was not based simply on economic factors. It was recognised that the benefits accruing from a public appointment were not purely financial but also derived from the potential for an increase in private practice flowing from enhanced standing in the community or a need to keep potential competitors out of an area.[86]

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[83] HRO, K 42, New Poor Law Union minutes for 1836.
[84] *Provincial Medical Directory* (London, 1851).
[85] Hodgkinson, 'Poor Law medical officers', p. 303.
[86] *Ibid.* p. 303.

At the inaugural meeting of the Hereford Union in May 1836 the Guardians divided the six city parishes into three medical districts and agreed to invite tenders for the provision of medical relief to include surgical attendance, medical operations and attendance at the workhouse. All costs of medicines, surgical appliances and leeches were to be paid for by the Medical Officers out of the contracted salary with additional payments for midwifery services and some other extras.[87] The basic contractual arrangements were similar in the other Unions and although they reflected some sharing of financial risk between Union and Medical Officer the balance was clearly in favour of the Unions. Posts in all the Herefordshire Unions were advertised in the Hereford newspapers but response to the advertisements was variable across the county and in some cases the Guardians were forced to adjust the original terms proposed before they were able to make suitable appointments. Some medical districts attracted two or three bids while there were others for which no bid was received at all. Competition for the posts varied across the county, reflecting the nature of the local market. While in Hereford City and the market towns there was a cohort of suitable qualified practitioners eligible to apply for these posts, in the rural areas there may only have been a single practitioner living within the medical district. In general, competition for posts was fiercest in the market towns and minimal in the rural districts.

Despite the number of practitioners in Hereford city, the Hereford Union advertisement in 1836 only produced a single tender for each medical district and all at the same proposed price of £95 for the year, suggesting a high level of collusion among the three practitioners submitting bids. The Guardians disputed the level of the tenders and contracts were eventually settled for £80 although the following year there were substantial increases to £120 for Monmouth district and

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[87] HRO, K42/215, 9 May 1836, Hereford Union minutes.

£110 for the other two. It was normal for the contracts to be set on an annual basis, and the following year when they were re-advertised, another practitioner, Henry Barnard, submitted tenders for all three districts. He was not successful in that year although he was later appointed to one of the districts.[88]

Dore and Weobley Unions comprised only rural parishes and did not include a market town. Dore Union's first advertisement for Medical Officers for its three districts solicited no response and it was forced to re-advertise. Only one tender was received for the two more remote districts and John Lane's bid of £125 for the two districts was finally agreed to. Two bids were received for the Madley district, which adjoined the Hereford Union area, both for £60, one from George Terry who lived in Hereford and one from a candidate from London. George Terry had already been appointed as Medical Officer for one of the Hereford Union districts, which may have been a factor in the Board's selecting the external candidate Henry Jones Jenkins.[89] Lane and Jenkins continued to be the Dore Union Medical Officers beyond 1850, although Lane did not possess the double qualification required by the General Order of 1842. A third Medical Officer was appointed to cover the parishes closest to Wales in the later 1840s.[90]

The Medical Officers appointed by Weobley Union in 1836 also served into the 1850s. Charles Lomax and James Palmer were appointed on salaries of £60 in 1836, which had been raised to £65 per annum by 1843.[91] Medical districts in rural parishes were frequently very large due to the sparse and scattered population and in recognition of this practitioners were allowed to charge an additional 2s per patient as recompense for time taken up in travelling. The majority of the Weobley Union parishes were on the north bank of the Wye but a very few were on the south side of the river. This posed additional transport

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[88] *Ibid.* 9 May 1836, Hereford Union minutes.
[89] HRO, K42/85, 5 May 1837, Dore Union minutes.
[90] *Provincial Medical Directory 1851.*
[91] HRO, K42/475, 19 Apr. 1836, Weobley Union minutes.

difficulties and meant that the Guardians had difficulty in getting a Medical Officer to agree to travel south of the river. In 1836, Charles Lomax refused to cover these parishes and the Union came to an arrangement with Jenkins, the Medical Officer in neighbouring Dore Union, to cover them until the end of the year when they invited applications to provide services just for these Wyeside parishes. Two fixed price tenders were received, one for £25 from Jenkins and one for £15 from Kidley, the surgeon employed by the Jarvis Charity that operated in the vicinity. The Union was not keen to agree to a fixed price contract and eventually agreed a rate of 9s per case with Kidley. This arrangement continued with the Jarvis charity surgeon providing services to these parishes.[92]

In the market towns there was more competition between practitioners and also a more overtly robust negotiation between the bidders and the appointing boards. In 1836 Bromyard Union advertised for tenders for its three Medical Districts and received replies from four practitioners. There were three tenders for District 3, one for £90 and two for £95 and two for District 1 both at £80. No tenders were received for District 2, which was much smaller than the other two and consisted of a few rural parishes close to the Malvern Hills on the border with Worcestershire. The Board considered that all the tenders were too high and asked for revised bids, which were still considered to be excessive. The posts were re-advertised and this time bids were received from six practitioners, two of whom made a combined bid. There were two bids for District 1 both at £70 and a vote was used to decide the appointment. The successful candidate was W. Shelton Browne, an established local practitioner. District 2 was allocated to W. Addison although his tender of £26 was the highest of three bids for the district. Two bids were received for District 3, one for £60 and one for £70, but no appointment was made as the board still felt the tenders were too high. Revised

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[92] HRO, K42/475, 2 Apr. 1838, Weobley Union minutes. The Jarvis charity is discussed further in Chapter 3.

bids were requested and both were reduced to £50. The final decision to appoint went to a vote that approved the appointment of two practitioners, Howey and Seward, who were to serve in partnership. [93] The negotiation indicates that although local practitioners were at first unwilling to take on the obligations of a Poor Law appointment at a very low cost, they did eventually agree to this. Even at the reduced level of tenders forced by the Union there was still competition for the posts closest to the market towns, perhaps influenced by the need to avoid an external candidate being appointed. Appointment to a scattered rural parish was much less attractive.

Bromyard continued with a fixed price tender system for another year but in 1838 shifted to payment by individual case. [94]Expressions of interest were requested based on advertised payment rates of 5s for an individual, 10s for a family order with an extra 2s payable if the patient lived more than two miles from the Medical Officer's house. Mr West applied for District 2 and a Mr Ellerson from London for either District 1 or 2. No local practitioner was willing to take up appointment on the terms offered although Seward put in an alternative proposal of 7s 6d for an individual order with a distance allowance of 3s and Thomas Pitt submitted a fixed price tender of £45 for the workhouse. The board's decision to appoint the outside candidate, Ellerson, ran into difficulties when no testimonials were forthcoming and they eventually reached agreement with Pitt and Seward. With the exception of services for the workhouse, which continued to be remunerated on the basis of a fixed price tender, Bromyard Union persevered with a system of payment by case throughout the 1840s despite ongoing problems in agreeing terms.

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[93] HRO, K42/1, 4 July 1836, Bromyard Union minutes.
[94] *Ibid.* 23 July 1838, Bromyard Union minutes.

In 1850 the Union finally advertised in the *Medical Times* and the *Birmingham Herald* for a single Medical Officer for the whole district based on a proposal devised by the Calne Union in Wiltshire. The incumbent would receive a salary of £200 but was banned from doing any private work. He was required to provide surgical instruments from his salary but other costs of medicines, trusses etc. were to be covered by the Union. Twenty-five applications were received thirteen of which supplied adequate testimonials. [95] Four candidates, all from outside Herefordshire, were interviewed and John Owen from Mold was appointed. The Union also tendered for the supply of medicines and drugs for the union. Three druggists from Bromyard applied one of which was selected and a separate contract was placed with a Worcester druggist for drugs for the parishes close to Worcestershire.

2.4 Influence over Poor Law medical services

Medical examination and medical reports on a person's state of health were an integral part of the assessment process used to determine whether or not an individual was eligible to receive relief from the Union. Typical examples are the certifications issued by Mr Pitt, a Medical Officer for Bromyard Union in 1839. Pitt confirmed that Thomas Pullen of Much Cowarne was 'blind in the right eye and nearly so with the other'; [96] and that 'William James, (an able-bodied man), is dropsical and had diseased lungs and bladder.' [97] These certificates were needed to justify general relief from the Union for the individuals concerned. Access to the medical services provided by the Medical Officers was restricted by a system of 'tickets' issued by the Relieving Officers. The guardians normally met weekly and considered medical relief as part of the regular business of the Union. Medical Officers were often required to attend these meetings at which a weekly

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[95] HRO K42/6, various dates in Feb. 1850, Bromyard Union minutes.
[96] HRO, K42/2, 8 July 1839, Bromyard Union minutes.

medical report was presented and both ongoing cases and new applications for medical relief were considered. Medical Officers were required to keep a record of relief granted and visits made and the adequacy and accuracy of these records was frequently an area of tension between guardians and Medical Officers. In November 1843 the Bromyard guardians wrote to their Medical Officers setting out the detail required. They should

> for the future in every weekly return bring into one list all such pauper patients as may be under their care, together with the nature of their complaint, until such patients are cured or die, and the order for attending them expressed by lapse of time, so that the Board may see at one view what paupers are ill, the cause of their sickness and other requisite particulars for their guidance in ordering relief for such paupers. [98]

Strict record keeping was essential if the guardians were to ensure that access to medical relief was channelled through the Union's assessment mechanism. In the early years this was necessary to enforce the change from parish to Union responsibility. In July 1837, the Ledbury Union considered an instance in which Francis Moore, the overseer of Yarkhill Parish had requested medical relief for Thomas Bethall directly from the Medical Officer without going through the Relieving Officer. He was 'admonished not to do the like again'.[99] A further case was considered the following month in which Mr Ripple, the overseer of Colwall, had issued a medical order for John Lucy without going through the Relieving Officer. Once again, the Medical officer was censured. [100]

As noted above, the Medical Officers paid for any medicines prescribed but they also had the authority to order relief in the form of additional foodstuffs

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[97] *Ibid.* 9 Dec. 1839, Bromyard Union minutes.
[98] HRO, K42/3, 4 Nov. 1843, Bromyard Union minutes.
[99] HRO, K42/342, 27 July 1837 and 8 Aug. 1837, Ledbury Union minutes.
[100] *Ibid.* 22 Aug. 1837, Ledbury Union minutes.

and their discretion in this area was the subject of many disputes. Bromyard Union required Medical Officers to provide the patient with a copy of any order made for extra food such as mutton or wine, presumably to minimise disputes between those distributing the relief and the patients and to prevent patients from falsely claiming that additional supplies had been granted.[101] In August 1838, Mr Pitt was asked to attend the board to explain why he had approved orders for mutton, wine, tea and sugar to John Hotham. [102] Pitt justified the measures as medicinally necessary saying he considered the mutton as a tonic, but the Union responded by passing a motion that required medical officers to attend patients three times a week while extra food was being provided.[103] In the following months both Pitt and his colleague Seward were called before the Board to explain why they had continued to make general orders for the provision of mutton but were not visiting the patients three times a week. Ledbury Union expressed similar concerns, writing to Charles Lomax in May 1838 on the subject of the workhouse inmates.

> The Board cannot but express their surprise at the number of persons in the House who are ordered cider medicinally and are of the opinion that drugs and exercise and not liquor might be used for the care of the disorder for which cider is recommended.'

Lomax attended the next board to defend his treatment methods.

> It was his decided opinion that cider was on account of the debility of the Men and their swollen legs absolutely necessary for them- but he promised the Board that the moment cider could be dispensed with he would cease ordering it. [104]

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[101] HRO, K42/1, 5 Apr. 1837, Bromyard Union minutes.
[102] HRO K42/2, 20 Aug. 1838, Bromyard Union minutes.
[103] *Ibid.* 20 Aug. 1838, Bromyard Union minutes.
[104] HRO, K42/ 475, 28 May 1838, Ledbury Union minutes.

These examples demonstrate that the Guardians sought to ensure that access to medical relief was limited to that authorised by them and they also challenged the boundaries of what constituted appropriate treatment, particularly in the field of food relief. The medical relief system gave Medical Officers some independence in granting general relief and shows that in some instances they approved food relief that would not have been granted by the Relieving Officer. One group that the Unions tried to avoid supporting with medical relief was employees, as it was expected that their employer should pay for any medical treatment required. Weobley Union resolved that,

> where an order to attend a person who has been discharged or otherwise left his or her service on account of illness, has been given through the relieving officer, this board will consider it incumbent on them to cause proceedings to be instated against the employers of such persons on the grounds of their general liability to support their servants in sickness during the existence of their contract. [105]

Guardians were responsible for ensuring that medical services were provided to a minimum standard and Union minute books record many references to disputes about medical treatment. The system allowed for complaints to be made to the board of guardians who would then investigate the matter with the Medical Officer and decide on any action to be taken. If necessary, recourse could be made to the Poor Law Commissioners. A typical example of these complaints was an alleged case of delayed treatment provided to William Potter by Edward Seward that was considered by the Bromyard Union in August 1844. Mr Seward's response was that 'he was away from home when the order was delivered and that he came home late that night and went out

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[105] HRO K42/476, 21 Mar. 1842, Weobley Union minutes.

again early Saturday morning. His servant did not deliver him the order until he returned on the Sunday evening when he immediately visited the patient'. The Union dismissed the complaint. [106]

Complaints could originate from a variety of people, many coming from patients themselves or their relatives. Ann Freeman complained in mid-November 1847 that Surgeon Shelton Browne had not visited her since early October and James Watts complained of a delay in visiting his son.[107] In other examples, claims were brought via an overseer, or one of the Guardians. In cases where the patient was still alive, the result of a complaint could be to ensure that treatment was improved but in several instances complaints were investigated after a patient's death and in these cases there was nothing to be gained for the individuals concerned. The main purpose of the complaints' procedure seems therefore to have been to assess whether the Medical Officer was meeting the terms of his contract. In most cases, the result of the investigations was that the Medical Officer's explanation was accepted but there was also the opportunity to censure the Officer and in extreme cases to dismiss him.

On 13 April 1840, the Dean of St Asaph, a member of the Bromyard Union, presented a complaint from Sarah Lynk of Cradley to the Union meeting. She claimed neglect by Surgeon West who had only been to see her once in fifteen weeks although she had been confined to bed throughout the period due to a fracture.[108] The details of West's written response to the Board's investigation are not known but were clearly unsatisfactory as the Chairman wrote to him again on the subject. In early May the board reviewed the correspondence and concluded that West should be suspended and the case reported to the Poor Law Commission. The Commission responded that 'the

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[106] HRO, K42/4, 5 Aug. 1844, Bromyard Union minutes.
[107] HRO, K 42/5, 22 Nov. 1847, Bromyard Union minutes

Board of Guardians will see that it must be left in their hands, to decide whether they will accept Mr West's resignation should he offer it. If the Guardians decline to do so the Commissioners are prepared to issue an order for Mr West's dismissal on the grounds explained in their letter to that gentleman.' It appears that the easiest way to effect a dismissal was a letter of resignation from the surgeon but this did not appear to be forthcoming. The Union finally took action that was endorsed by the Poor Law Commissioners who confirmed that 'they think Mr West's letter amounts to a resignation and they desire the Guardians to proceed to a fresh appointment'. [109]

Clearly the decision to refer a case to the Poor Law Commissioners was taken seriously and this approach was only to be used judiciously. In June 1841, Pitt was questioned about not attending a workhouse boy who had been hurt in an accident in the Corn Mill. He responded that the message had been sent to him on Sunday morning between 9am and 10am at which time he was out. He returned home at between 1pm and 2pm and saw a boy from the workhouse who had been sent down to collect some medicine. The boy had reported that no one was hurt so that Pitt had not investigated further. The boy corroborated Pitt's story although the workhouse master said that he had sent a first message on Saturday evening. Although the board concluded that Pitt had been 'very neglectful', they decided not report the case to the Commissioners.[110] In December 1842, Pitt was again under investigation for a further three cases of alleged neglect. The Union dismissed two of these but the third was referred on to the Poor Law Commissioners. The complaint concerned the treatment of one of Maria Lloyd's children who had since died. Pitt's defence was based on a claim that Maria Lloyd had informed him that the children were recovering and also that in any case he was ill himself and therefore unable to attend. The

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[108] HRO, K42/2, 13 Apr. 1840, Bromyard Union minutes.
[109] *Ibid.* 29 Apr. 1840, Bromyard Union minutes.

Commissioners' decision was that Pitt should be reprimanded and told that in future he should ensure that an alternative practitioner would provide services if he was unable to attend in person.[111]

The Medical Officers could also call upon the Poor Law Commissioners for adjudication in matters of dispute. In January 1846, Shelton-Brown applied for the normal payment for midwifery for attending the wife of Charles Hill who he had been asked to attend by Mrs Chamberlain. The guardians disallowed the payment on the grounds that both the Hills were young and able-bodied and the Relieving Officer had not requested his attendance. The case was referred to the Poor Law Commissioners who upheld the Guardian's decision against the Medical Officer.[112]

An alternative approach for Unions attempting to ensure treatment was appropriate was to commission an independent report on a patient's case. In 1842 the Weobley union asked Zachariah Powell to provide a second opinion on the case of Sarah Griffiths, a patient under the care of Mr Lomax. [113]

> Last week I attended Sarah Griffiths with Mr Lomax at her request and feel no hesitation in saying that few such remarkable cases are seldom seen. All her symptoms considered there can be no doubt but the disease has been produced by a long and continual scrofulous attack which has subdued the vital energy of her constitution as to leave no hope of her recovery, nor does it appear that any other treatment would be proper than what has been already adopted.

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[110] HRO, K42/3, 12 July 1841, Bromyard Union minutes.
[111] *Ibid.* 30 Jan. 1843, Bromyard Union minutes.
[112] HRO, K42/5, 19 Jan. 1846 and 28 Sept. 1846, Bromyard Union minutes.
[113] K 42/476, 25 July 1842, Weobley Union minutes

In December 1847, the Bromyard guardians asked Dr Henry Bull, of Hereford to review the case of Martha Kyle from Collington who had been under the care of Mr Shelton-Brown. The summary of Bull's report stated that he

> had found her very ill and recommended her to be sent to an infirmary, but he forbare to give any opinion as to the manner in which the case had been treated not having held any communication with any of the medical gentlemen under whose care she had been placed. [114]

It is notable that both these reports were supportive of their professional colleagues and abstained from entering into a public disagreement over the treatment plan undertaken. No further details of either case are recorded, indicating that the boards took them as an endorsement of the Medical Officer's actions. Relationships between members of the medical profession were not always so harmonious, as shown in January 1847 when a dispute between two practitioners over the case of Benjamin Bowley was brought to the attention of the Bromyard Union.[115] Shelton-Brown wrote to the Guardians concerning a difference of professional opinion with Howey, a local surgeon who was not a Union Medical Officer. Howey then wrote complaining of Shelton-Brown's conduct but later asked for his letter to be returned. The Guardians chose not to interfere, and clearly felt the dispute was outside their sphere of interest.

These cases provide an insight into the ways that regulation of the medical profession were dealt with at the time. Guardians had a responsibility to address the issue of professional competence in relation to services to pauper patients but this did not extend to the other activities of medical practitioners. It is clear that the Guardians themselves recognised the limits of their competence

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[114] HRO, K42/5, 20 Dec. 1847 and 28 Sept. 1846, Bromyard Union minutes.
[115] *Ibid.* 18 Jan. 1847, Bromyard Union minutes.

and authority to make a judgement about professional conduct. Some ten years earlier, in 1837, the Bromyard Guardians had decided they had no jurisdiction into a case of non-attendance by Shelton-Brown on Richard Caswell of Tedstone Delamere as he was not a pauper patient.[116]

Poor Law Unions acted to address the fact that a large section of the community were unable to access medical services through a free market as they did not have sufficient cash income. Under the Old Poor Law, access to medical services was provided for those claiming parish relief and decisions about the entitlement to receive services and the services that would be funded rested with the local vestry. Under the New Poor Law national guidelines relating both to administration and services provided began to be introduced. The responsibilities of the local Unions became more clearly defined and a system was established that included opportunities for appeal to the central authorities in a number of areas, including the quality of care provided. By defining the qualifications of medical practitioners and specifying certain services, such as vaccination, that must be provided, Unions became increasingly responsible for defining and monitoring the care provided as well as funding it.

2.5 Education and Training

The late eighteenth century and early nineteenth century were a period of transition in medical education. [117] At the start of the period, there were two established routes to obtaining a recognised qualification as a medical practitioner; by acquiring a university degree in medicine or by completing a period of apprenticeship leading to qualification as a surgeon or apothecary. Physicians undertook an essentially theoretical, academic training and were qualified through holding a university degree that could either be earned through

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[116] HRO, K42/1, 16 Jan. 1837, Bromyard Union minutes.

a course of study, or purchased. The Royal College of Physicians had authority over its members within a boundary of seven miles from London but did not regulate the activities of its members on a national basis. The system of apprenticeship for surgeons and apothecaries was still based on laws and customs that had been in place since the Middle-Ages which required that a written agreement be drawn up between each individual master and apprentice setting out the important terms of the agreement. [118] These included the length of the apprenticeship, the amount of any premium payable, specifying that the apprentice would live in his master's house, keep his master's trade secrets and protect his master's goods. Once the agreement was signed, the master could not dismiss the apprentice provided that none of the terms of the indenture were broken.

By 1858 the system for medical training had altered to one of national certification with most medical practitioners obtaining membership of both the Royal College of Surgeons (MRCS) and the London Society of Apothecaries (LSA) with candidates taking a final examination in London. Although students undertook training programmes which each constructed individually, there was greater clarity about the curriculum to be covered and experience to be gained. University courses became more practically based and experience of hospital medicine became a core part of the training of both doctors and surgeons. The Apothecaries' Act of 1815 introduced compulsory licensing by examination for those seeking the qualification of LSA, and is a notable step in the move from an unregulated profession to one of national licensing. It was also important in the transformation of medical education from a haphazard system to one in which the regulatory body was concerned with the content of both theoretical lectures and practical experience in addition to running the examination process. The old

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[117] Loudon, *Medical care and the general practitioner*, pp. 29-53.

system of apprenticeship was still retained, with candidates having to complete a five-year term in addition to a further period of six months at a recognised hospital or dispensary.[119] One of the effects of these changes was that London hospitals and dispensaries became increasingly important in the provision of both teaching and relevant experience for prospective candidates. Even those who aimed for a provincial career as a surgeon-apothecary, or as the newly termed general practitioner could no longer train solely in provincial practice.[120] If they were to make their way in an increasingly competitive profession they needed to supplement the qualification from the Society of Apothecaries (LSA) with that of the Royal College of Surgeons (MRCS). From 1842, this double qualification was required for all those seeking appointment from one of the Poor Law Unions. [121]

Appendix 5 includes details of apprenticeship data available for Herefordshire practitioners. This is extensive for the eighteenth century but sporadic for the nineteenth. [122] The term of apprenticeship is almost always recorded as either five or seven years, which are the two most common terms noted by Joan Lane in her review covering the period 1710-1760.[123] As elsewhere, the premiums paid ranged from single figures to over £200. Lane notes that 57 per cent of premiums were between £50 and £63 with 21 per cent above £100, only 4 per cent above £150 and 12 per cent below £13. [124] The highest premiums recorded in Herefordshire in the eighteenth century are both for Thomas Paytherus, working in Ross-on-Wye, who received £170 for a seven-

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[118] J. Lane, 'The role of apprenticeship in eighteenth-century medical education in England', in Bynum and Porter (eds), *William Hunter,* pp. 57-104.
[119] S. C. Lawrence, 'Private enterprise and public interests: medical education and the Apothecaries' Act, 1780-1825' in French and Wear (eds), *British medicine in an Age of Reform*, pp. 45-73.
[120] I. S. L. Loudon, 'The origin of the general practitioner', in *Journal of the Royal College of General Practitioners',* 1983, January, pp.13-19. Loudon reports that the term general practitioner came into use between 1810 and 1840.
[121] Hodgkinson, *'Origins of the National Health Service,* p. 11.
[122] Wallis and Wallis, *Eighteenth-century medics*. The collated data provide a comprehensive listing of practitioners for the eighteenth century.
[123] Lane, 'Role of apprenticeship', p. 73.

year term for Richard Evans in 1783 and £205 for a five-year term for John Evans, presumably his brother, in 1790. [125] County directories for 1830 and 1835 include listings for both a Richard and Thomas Evans as physicians in the town and Richard Evans was one of the appointed guardians to Ross Union in 1836.[126] Paytherus himself had not trained within the county, being apprenticed to Richard Cheston in Gloucester in 1769. Joseph Severn of Bromyard took three apprentices at a premium of £105 each between 1782 and 1788 after having four earlier apprentices who paid premiums of between £6 and £50. He was able to charge a higher premium as he became an established practitioner as was John Maxwell who practised in Bromyard at the same time. Maxwell took his first apprentice in 1782 for £10 for a five-year term while ten years later he was able to command £105 for a seven-year term.[127] The fact that these men were working in the small market towns indicates that they were able to build prosperous practices in these communities. The majority of premiums recorded are between £40 and £80 but some were merely nominal. For example, Edward Laycock, an apothecary in Hereford, took on William Bevan for seven years for £1 in 1794 and John Reece was apprenticed to John Meredith, barber surgeon for 3 guineas for a term of seven years in 1801. [128]

Apprenticeship normally began at the age of fourteen and was essentially a practical training which involved learning by watching, listening and doing. Although a system of medical lectures had been established in some provincial areas by the end of the eighteenth century this was not the case in Herefordshire. For those that could afford it, the preferred option was to spend some time in London at one of the new medical schools attending lectures and demonstrations

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[124] *Ibid.* pp. 70-71.
[125] Wallis and Wallis, *Eighteenth-century medics.*
[126] *Pigott's Directory, for 1830 and 1835* (London, 1830 and 1835) and HRO, K42/406, Ross Union minutes, 1836.
[127] Wallis and Wallis, *Eighteenth-century medics.*
[128] *Ibid.*

and perhaps working in a hospital following completion of the apprenticeship term. One apprentice from the county that followed this option was John Scudamore Lechmere-Pateshall who came from an established Herefordshire gentry family. As John's father had died when his children were still minors, it was his mother Anne who had to arrange the training of her four sons.[129] John was apprenticed to Nicholas Geary of Leominster in 1796 for 150 guineas for a five-year term. In the indenture deed Geary promised that he:

> Will teach and instruct the said John Pateshall or cause him to be instructed in the Business or profession of a Surgeon and Apothecary which he now useth and also in the elements of anatomy according to the best of his skill, knowledge and judgement therein. [130]

Geary's was an established practice and he had taken at least two apprentices before John. [131] In correspondence written during 1800, John records that Geary's business was as good as he could remember with twenty-three to thirty patients, with the 'reap hook making me some work'. [132] During his apprenticeship John asked his mother for funds to purchase a number of second-hand medical books at a local auction and towards the end of the five-year term he suggested going to London to complete his medical education. Despite Geary's support for this idea, his mother did not agree at first, but in 1801 John did go to St Bartholomew's with the possible plan of later becoming a ship's surgeon. His mother required a full account of his expenditure while training in London and John provided the details set out in Table 2.6. [133]

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[129] HRO, A95/AP, papers of Ann Pateshall.
[130] HRO, A95/AP/11, Indenture deed.
[131] Wallis and Wallis, *Eighteenth-century medics*. The apprenticeships of John Taylor Stephens in 1780 and Thomas Yeld in 1784 are recorded.
[132] HRO, A95/AP/11, Letter John Pateshall to his mother dated 4 Dec. 1801.
[133] HRO, A95/AP/11, Letter from John to his mother dated Aug. 1800.

By this time the medical schools at the London teaching hospitals were well established and St Bartholomew's had several of the most famous teachers of the time, including Robert Abernethy. [134] With family backing therefore, Pateshall was able to avail himself of the best medical education available at the start of the nineteenth century, an investment of time and money that would enable him to establish himself in Hereford. Within a few years he had an established private practice in Hereford and also ran the local private asylum from 1813 until his death in 1833.

Table 2.6: Expenses of John Pateshall in London in 1801.

		£ s d
Dr Powillo	Materia Medica, Chemistry	6 6 0
Dr Roberts	Practice of medicine, Clinical lectures	5 5 0
Mr Abernethy	Structure of the Human Body	15 15 0
	Theory & practice of surgery	5 5 0
Dr Thyme	Theory & practice of Midwifery	6 6 0
Payment to be a pupil at hospital for 4 months		18 18 0
Books etc. Instruments Dead subjects, limbs etc Medical Society & Library		7 15 0 2 12 0 5 9 0 1 3 0
Washing Books, Shoes, Clothes Travel etc.		1 7 6 5 2 10 4 7 5
Total		**85 10 11**

Source: HRO, A95/AP/11, Letter from John Pateshall to his mother dated August 1800.

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[134] Lawrence, '*Medical education*', pp. 48-49 and Loudon, *Medical care and*

Provincial infirmaries also offered some opportunities for hospital experience. When the Hereford General Infirmary opened in 1776, the rules allowed the honorary physicians and surgeons to take on a maximum of two pupils each for instruction at the Infirmary. The honorary practitioner received the fee paid by the pupil. The rules expressly stated that the pupils were not permitted to prescribe or perform any operation, being limited to dressing wounds under the supervision of their master.[135] The role of medical personnel in the Infirmary is discussed further in Chapter 4.

2.4 The development of a provincial profession

The preceding discussion has demonstrated that a medical career could be profitable and carried considerable status in a provincial town. The elite of the local profession took an active part in local politics and several were members of the oligarchic Hereford corporation, which, prior to its reform in 1836, consisted of thirty elected 'principal citizens'.[136] In addition to John Cam, seven more medical practitioners were elected between 1778 and 1826; John Palmer in 1778, Robert Hathaway in 1780, John Matthews in 1786, John Griffiths in 1795, Samuel Hughes in 1803, John Scudamore Lechmere-Pateshall in 1807 and John Bleek-Lye in 1818.[137] Most but not all of these men were physicians and biographical details suggest they were all men of gentry status. Robert Hathaway and John Matthews are both recorded in the medical register of 1783 although it is likely that neither man was earning a living from medicine at that time as both were landowners. Hathaway, recorded in the *Medical register* as an apothecary, had married a wealthy heiress while Matthews came from a county family and was a

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general practitioner, pp. 48-52.

[135] *Rules and orders for the government of the General Infirmary at Hereford (1775),* rule 94, p. 23.

[136] D. J. Mitchell, 'Hereford in the Age of Reform', pp. 91-114.

[137] HL, LC 352.02, R. J. Powell, 'History of the corporation of the city of Hereford, 1500 to the present day', (manuscript).

qualified MD. He had trained in London where he became fourth physician at St George's and a candidate for the Royal College of Physicians before returning to Herefordshire in 1783. [138] Matthews served as MP for the county from 1802 to 1806, as colonel to the County Militia and was one of four 'doctors of physic' listed in the commission for the peace for Herefordshire for 1792. The others were John Cam, Thomas Benjamin of Kington and Martin Dunne who practised in Ludlow. [139] Samuel Hughes and John Bleek-Lye were also MDs, and both served as honorary physicians at the Infirmary. In his capacity as an alderman Bleek-Lye was also very influential in many of the town charities and in a business capacity was also involved in banking.[140] In Kington medical practitioners were important in the pre-banking period as providers of mortgages, showing that they were men of substance in their small communities who had capital to spare. [141]

As noted earlier, John Scudamore Lechmere-Pateshall came from an established and prosperous family and was able to build on these foundations in developing his career in private practice and at the private Hereford Lunatic Asylum. His widowed mother, Anne, was one of the first subscribers to the General Infirmary and also considered a medical apprenticeship for John's younger brother although he finally entered the East India Company. One of her other two sons, Sandys, entered the navy where he rose to the rank of Admiral before retiring to Hereford where he was also elected to the town council. Anne's fourth son joined the clergy. [142] Medical practitioners were also influential in Leominster where four aldermen and twelve councillors governed the town and elected a mayor annually. In 1837 the mayor was the surgeon, Thomas Fairchild

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[138] Lane, 'Medical practitioners', p. 358 and Foart Simmons, *Medical register.*
[139] HRO, Q JC/3, Commissions of the peace, 1792.
[140] *Hereford Journal, 23 Jan. 1864,* obituary of John Bleek-Lye.
[141] Sinclair and Fenn, *Border janus*, p. 20.
[142] HRO, A95/AP/11, papers of Ann Pateshall.

Watling, and two other surgeons, Hugh Lewes and James Swift, were also on the council. [143]

Several Herefordshire practitioners had army or naval service, typically joining the services fairly soon after completing their apprenticeship. James Price served a five-year apprenticeship in Hereford with John Griffiths from 1799, paying a premium paid of £150 that reflected Griffiths' status in the town. On completion of his apprenticeship in 1804, Price became an army surgeon in the artillery for six years, serveing in Buenos Aires, India, Corunna and Walcheren before returning to Hereford. He set up in private practice and became one of the Medical Officers for the Hereford Poor Law Union.[144] Information recorded in the 1841 census shows that he was well established, living with his wife and daughter in a house in St. Owen Street, the premier area of Hereford, where he kept four servants. [145] His obituary noted that he managed the Medical Book Society for forty-five years and at his death in 1863 was described as ' the father of the profession for this city'. [146]

The most notable medical dynasty in Herefordshire was that of the Cams who practised medicine for at least four generations. The *Medical Register* of 1783 records three Cams in Hereford, one physician and two surgeons.[147] The physician, John, had a Cambridge MB and was one of only two physicians in the town while William and Thomas were recorded as surgeons. John was a member of the town council, serving as mayor in 1774 and all three gained honorary appointments at the General Infirmary when it opened in 1776. [148] Thomas had three sons, all of whom became surgeons as did one of his grandchildren. Other

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[143] HRO, *Robins directory of Herefordshire, 1837* (London, 1837).
[144] A. W. Langford, 'Some Herefordshire medical history', *TWNFC,* 36 (1958), pp. 56-66, pp. 63-64.
[145] 1841 Census, Hereford City, St Owen parish.
[146] Langford, 'Some Herefordshire medical history', pp. 63-64.
[147] Foart Simmons, *Medical register, 1783.*
[148] HRO, S60. Hereford Infirmary *Annual Report 1776.*

notable medical families include the several members of the Wyke family who are recorded as practising in the west of Herefordshire, Shropshire and Wales during the eighteenth century. James Gwynne and his son, also James practised in Kington and George Rootes and his son William worked in Ross-on Wye. [149]

Even without influential family connections, practitioners were able to establish themselves in a successful practice. For example, Henry Barnard is recorded in the 1841 census at the start of his career as aged 26 and living at home with his mother and sister. In the early 1840s he put in a tender for Monmouth medical district to the Hereford Poor Law Guardians and although unsuccessful at that attempt, by 1848 he was working for the Union. [150] Practitioners with no local links were also able to establish successful careers. Notable among these are the Gilliland brothers from Ireland. John Gilliland is first recorded working as a partner with John Pateshall in his private practice but was able to take over as superintendent of the private Hereford Lunatic Asylum on Pateshall's death. Soon afterwards his younger brother, William, who was a physician, came to Hereford and took over the running of the Asylum although John remained the licence holder. In 1838 William was elected as honorary physician to the infirmary in a close contest with Dr Strong and served the institution for 28 years.[151]

Henry Graves Bull came to Hereford in 1840 after training in Edinburgh and Paris.[152] He set up in private practice in the town and applied for a vacancy at the Infirmary the following year. He was not successful on that occasion but instead worked at the dispensary, eventually obtaining an Infirmary appointment in 1864, which he held until his death in 1884. [153] He was an active member of

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[149] Wallis and Wallis, *Eighteenth-century medics.*
[150] HRO K42/215 and *Provincial medical directory 1848* (London, 1848)
[151] Langford, 'Herefordshire medical history', pp. 56-66.
[152] C. W. Walker 'Henry Graves Bull', *TWNFC,* 36 (1958), pp. 66-75.
[153] C. Renton, *The story of Herefordshire's hospitals* (Logaston, 1999) p. 28.

the Woolhope Club that was established in Hereford in 1851, contributing articles on scientific and natural history topics. He was supported many philanthropic associations including the Hereford Society for Aiding the Industrious, the Hereford Friendly Society and the two libraries in the town.[154]

From the eighteenth century medical book clubs and libraries began to be established in London and the larger cities, providing members with access to up to date medical books and journals in addition to opportunities for more informal social exchange.[155] In the nineteenth century these clubs expanded rapidly throughout the provinces and the medical book club established in Hereford by James Price about 1818 was a part of this phenomenon. The expansion in local clubs was due in part to the failure of the London-based national associations to champion the concerns and interests of provincial practitioners but they also provided opportunities for practitioners to develop a more visible local professional standing. Unfortunately little is known of the detail of the activities of the Hereford book club. In 1832, Henry Beavan, a local surgeon holding no honorary appointments, proposed a motion at the Infirmary governors' meeting that all post-mortem examinations carried out in the hospital be open to all medical gentlemen who were personal subscribers to the institution. The suggestion was rejected indicating that the needs of the majority of local practitioners for training opportunities were not strong enough to override the interests of the honorary appointees who wished to restrict access to hospital cases. An additional concern may have been public sensibilities about the dissection of corpses.[156]

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[154] Walker, 'Henry Graves Bull', p. 68.
[155] H. Marland, 'Early nineteenth-century medical activity: the Huddersfield case', *Journal of Regional Studies*, 6 (1985), pp. 37-48.
[156] Langford, 'Herefordshire medical history', p. 63.

Hereford practitioners supported the campaign for a national association of legally qualified practitioners that became increasingly vociferous during the 1840s. In 1844, sixty-nine of them signed a petition to parliament in relation to the proposed Medical Bill. [157] The Hereford Medical Association held its inaugural meeting in 1858. The Association was only open to those legally qualified under the 1858 Act and its first concerns were to invite all those falling within this category to join and to investigate possible instances of anyone working within the county who was not eligible to do so. There was considerable activity over the next two years investigating five or six possible illegal practitioners and at least one was referred to the executive Medical Council for England although it appears that none were ever prosecuted. The minutes of a meeting held in October 1860 record the members' view that Act had proved 'useless for the suppression of illegal practice', and that Hereford had been fortunate to be able to gain this experience without incurring the costs of a wasted prosecution. The meeting nevertheless approved of the Association, recording that 'it is a pleasure to acknowledge the advantages it has already given us in an official Registration and the exemption of compulsory civic duties, and the still greater benefit it promises in the future by a complete reorganisation of the Profession'. [158]

Summary and Conclusion

At the end of the eighteenth century there were some forty-two medical practitioners in Herefordshire, most of them based in Hereford and in the surrounding market towns. Patients with the means to pay for medical services had a choice of local practitioner open to them but the choice was much more

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[157] *Ibid.* pp. 56- 66. A copy of the petition is with the papers of Herefordshire Medical Association.
[158] Minute book of Herefordshire Medical Association. Private collection. I am grateful to Dr John Ross for access.

limited in the rural areas. Practitioners provided services across the social spectrum, from tradesmen to the local gentry. Some individuals, including several clergymen, paid for services for a number of people, including their extended family and employees. Services for paupers were funded by the responsible parish or Union and provided by local practitioners. Surgeon-apothecaries, trained through the apprenticeship system provided the majority of services. The limited number of physicians practised from Hereford or the market towns.

Over the next seventy years the number of practitioners increased faster than the rise in population so that the ratio of population to practitioner fell over the period. In particular, the number of practitioners in rural villages increased, due in part to the employment of Medical Officers by the rural Poor Law Unions. Under the New Poor Law, arrangements for medical relief to paupers became more formal with Medical Officers playing a key role in the system for assessing eligibility for relief as well as providing medical services. On occasion, Medical Officers were challenged for providing excessive services, particularly in the issuing of tickets for extra food. They were also investigated when it was alleged that they provided an insufficient medical service. Unions sought to limit spending on medical services through agreeing fixed price contracts with Medical Officers and in some instances had difficulty in filling the posts advertised from local practitioners. A number of posts were filled from candidates from outside the county. In addition to an increasing number of opportunities for paid employment, medical charities also started to offer honorary appointments. These are discussed further in Chapters 3 and 4.

Medical practitioners came from a range of backgrounds, including the local gentry and were integrated into the elite of provincial society. A number of physicians were named on the commissions for the peace and both physicians and surgeon-apothecaries served on the municipal corporations in Hereford and

Leominster. Medical practitioners were also active in developing their own professional activities and a local Medical Association was started in 1858.

Chapter 3

Medical Services: philanthropic provision

This chapter considers the charitable provision of medical services within the context of other philanthropic activity in the county. The ways in which charitable services interfaced with Poor Law and mutual provision are identified and explored to show how organisations within the different sectors worked together. Examples are given of instances in which the boundaries between the sectors became blurred and how this was dealt with, and how the different sectors co-operated to support new developments. The ideological assumptions underlying charity and public provision are also considered. Section 3.1 discusses medical charities within the context of general philanthropic activity in the county. In the late eighteenth century a variety of attempts were made locally to reform existing charities. This period also saw the formation of the two largest endowments in the county and the launch of subscriptions to raise funds for several projects, including the rebuilding of the cathedral and almshouses. Section 3.2 considers the operation of the Jarvis Charity and the interrelationship between the medical services it provided with the public provision arranged through the Poor Law Medical Officers. After 1834 several new organisations providing medical services were established in Hereford, principally the Poor Law Medical services, the charitable Dispensary and several mutual Medical Clubs. Section 3.3 discusses the links and interactions between charitable and public provision and widens the discussion to include the role of mutual societies.

Charity thrived in early modern Britain and the funding of the subscription infirmaries and dispensaries is one of the most notable legacies of eighteenth-century philanthropy.[1] Many of these foundations have evolved into the hospitals still operating in the twenty-first century and in both Hereford and Worcester the

eighteenth-century hospital buildings were still being used by the NHS until 2002.[2] Voluntary hospitals developed from the early eighteenth century with the Westminster Hospital founded in 1720 and the first provincial infirmary at Winchester opening in 1736.[3] By 1800 there were some thirty provincial infirmaries in England. Most of these were the only hospitals in their vicinity but in larger towns and cities, London in particular, specialist hospitals also developed. This trend towards specialisation and increasing numbers of hospital beds continued in the first half of the nineteenth century with the philanthropic model dominating institutional provision. The lunatic asylum was one type of specialist institution to develop although in contrast to other medical services, private institutions remained the dominant model in this sector until the middle of the nineteenth century when public asylums began to develop. Trends in lunacy provision are discussed in Chapter 5.[4] The first dispensary opened in London in 1770 and the concept soon spread to other cities.[5] In contrast to hospitals, dispensaries concentrated on providing outpatient and home care and became associated with the origins of the public health movement. Both these forms of charitable institutions provided services free to patients, medical expertise being provided via local physicians and surgeons working on an honorary basis with costs met by income raised from subscriptions and the interest on legacies. These institutions were supplemented by many other smaller philanthropic organisations working in the general field of medical relief that provided a variety of services including sick visiting and support for expectant mothers.[6]

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[1] Owen, *Philanthropy*, especially pp. 36-61. and Porter 'Gift relation'.
[2] In both Hereford and Worcester the eighteenth-century buildings were used by the NHS until 2002 when services moved into new hospitals built under the private finance initiative.
[3] Standard works on hospitals include Woodward, *To do the sick no harm,* Granshaw and Porter (eds), *The hospital in history* and Waddington, *Charity and the London hospitals*.
[4] Scull, *Most Solitary of Afflictions*.
[5] Loudon, 'Origins and growth of the dispensary movement'.
[6] Owen, *Philanthropy,* pp.121-124 and Prochaska, 'Philanthropy'.

It has been argued that a significant change took place in the nature of philanthropic activity from the late seventeenth century; a move characterised by the shift from the personal endowment charity to the new organisations of 'associated philanthropy'.[7] Mirroring the developments in commercial enterprise that had lead to the rise of the joint stock company, new charitable organisations were created that were based on collective rather than individual effort. The typical charity of the earlier period was based on a personal endowment, more often than not set up on the death of a benefactor. The initial gift was invested in land or securities and the income used for a variety of purposes to alleviate suffering or to provide education. In contrast, a typical charity of the later period was likely to be a subscription charity such as a local hospital, funded by small, regular gifts from a large number of supporters. Many charities that operated on a national basis were also established from the eighteenth century onwards.[8]

Changes in structural form were influenced by shifts in the underlying justification for charitable giving that Donna Andrew has described as a move from a tributary to a proprietary relationship between donor and recipient.[9] The tributary discourse was based on the principles of Christian stewardship. To give was intrinsically good but poverty and wealth were in God's gift and it was the responsibility of the rich to give alms to render material support to the poor. In return the poor would pray for intercession from God. Much charity was posthumous charity, established on the death of a donor. In contrast to this, although philanthropy was still encouraged and attracted social approval, the proprietary discourse emphasised the freedom of the potential donor to decide whether or not to give and to exercise more discretion in how they gave and who

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[7] Owen, *Philanthropy*, pp. 69-77and D. T. Andrew, *Philanthropy and police: London charity in the eighteenth century* (Princeton, 1989) p. 49.
[8]These included many charities with an educational focus, including the Society for Promoting Christian Knowledge (1699), the National Society (1809) and the British and Foreign School (1808).

they gave to. Anne Borsay emphasises the importance of Enlightenment ideals and the development of the commercial economy as factors underpinning the change. Charity was no longer an obligation arising from the principles of stewardship and reciprocity that underpinned medieval concepts of social organisation but was exercised an 'an optional badge of civility'.[10] Philanthropic activity was an integral part of polite culture, embraced by both the established elites and the upwardly mobile middling sort.[11] Charitable work was undertaken by the living and had a wider social function than the pursuit of the specific activities of individual organisations. It was directed at broader aims in the national interest including the 'maintenance of civil order, a civilised society, and a refining process.'[12] By the nineteenth century more attention was given to thinking about who charity should help and, in place of the non-discriminatory nature of earlier giving, consideration was given to assessing the rights of potential beneficiaries to receive charitable help. These ideas were influenced by more general attitudes towards the poor. While the labouring and impotent poor were deemed deserving recipients of aid, it was felt that the able unemployed should be denied charitable help. This ideology was underpinned by laissez-faire political economy, which argued that such an approach would benefit the country by encouraging an unregulated labour market where the unemployed would move to the sectors of the economy needing additional labour. Charitable help should not subsidise low wages and philanthropic effort should be focussed on helping the industrious poor.[13]

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[9] Andrew, *Philanthropy,* pp. 11-22.
[10] Borsay, *Medicine and charity,* pp. 183-185.
[11] Morris, 'Voluntary societies and British urban elites, pp. 95-118 and Porter, 'Gift relation', pp. 8-20.
[12] Andrew, *Philanthropy,* p. 6.
[13] Porter, *Health, civilisation and the state,* pp.114-117.

3.1 Philanthropic activity in Herefordshire c. 1770-1850

In Herefordshire, the period to 1850 saw the development of one voluntary infirmary and three charitable dispensaries within the county. The subscription appeal for the General Infirmary in Hereford was launched in 1774 and extended to collect monies for a lunatic asylum in 1777. Although their origins were similar the two organisations had different experiences in terms of financial stability and success in achieving their charitable aims. The operation of the Infirmary is considered in detail in chapter 4 and lunacy provision in chapter 5. The first dispensary opened in Ledbury in 1824 and was followed by one in Ross-on-Wye in the following year. A dispensary was opened in Hereford in 1835. In addition to these subscription charities an endowed charity founded from a bequest from George Jarvis provided medical services to three villages and became a well-known example of the potential shortcomings of misdirected charity. The steps taken to establish a framework for entitlement to benefit from the charity's funds and to establish what was legitimate charitable expenditure shed light on contemporary opinion about the purpose of philanthropic activity and how it was expected to fit within the overall welfare system. Surviving evidence of smaller charities with medical aims is very limited for the county although it is clear that several were established.

A summary of the largest endowments within the county providing details of the name of the charity, the parish in which it operated and the earliest known date of the endowment is set out in Appendix 4.[14] The prime source of

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[14] The law relating to endowed charities meant that revisions to obsolete trusts or those not operating effectively could only be addressed through the Court of Chancery, a procedure that was both tortuous and expensive. Pressure for a more effective way of administering endowments began to emerge from the early years of the nineteenth century. The Charitable Donations Registration Act of 1812 required the central listing of endowments, and the first fundamental reforms began in the sphere of education charities. Led, among others, by Henry Brougham, William Wilberforce and Thomas Babington, an investigation was carried out into charities providing education for the poor in London which was

information used is the information compiled by the Brougham Commissioners in the 1860s and 1870s that was based on earlier surveys in the 1830s.[15] The endowed capital is recorded as realty (land and buildings) or personalty (stocks and other investments). The estimated value of personalty at the time of the survey is also recorded as is income deriving from both realty and personalty, and the charitable purpose to which the income was applied. The total estimated income of the charities listed was £11,765 of which £5,583 (48 per cent) derived from realty and £6,182 (52 per cent) from personalty. Table 3.1 below summarises the charitable purposes to which these funds were applied. Approximately one third of funds from endowments were applied to the provision of almshouses or the support of their residents, with a further one third applied for educational purposes.

Table 3.1: Income of the major endowed charities in Herefordshire c. 1836.

	£	%
Almshouses and support of inmates	4,039	34%
Education	3,730	32%
Distribution of money or in kind	1,707	15%
Medical purposes	1,454	12%
Support of the clergy, sermons, bibles etc	359	3%
Apprenticeships and other purposes	476	4%
Total	**11,765**	**100%**

Source: Appendix 6 and E. Clark, *The Reports of the commissioners in England and Wales relating to the county of Hereford, 1819-1837* (London, 1837).

The next largest category is the distribution of money or goods to the poor, (15 per cent), followed by medical charities (12 per cent). The remaining funds were spent on various schemes for the support of the clergy or for funding the

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later extended to a survey of educational charities in England and by 1819 was to cover all endowed charities. It was finally completed in 1840.

[15] E. Clark, *The reports of the Commissioners in England and Wales relating to the county of Hereford, 1819-1837* (London, 1837). See Owen, *Philanthropy,* pp. 182 -191 for a discussion of the national surveys.

preaching of sermons (3 per cent), and schemes to fund apprenticeships (4 per cent).

The oldest endowments in the county date back to the thirteenth century, with the provision of almshouses at St Ethelbert's Hospital (1230) and the Lazarus Hospital (1290) in Hereford and St Catherine's Hospital (1232) in Ledbury. All these were attached to religious orders and eventually came under the management of the Dean and Chapter of the Bishopric in Hereford. The next substantial endowments date from the early years of the seventeenth century when there was a flurry of endowments for the provision of almshouses with four more established in Hereford, all of which were managed by the municipal corporation.[16] The early seventeenth-century also saw the first large endowments for educational purposes including the charities of Dean Langford (1607) and Philpotts (1615) in Hereford and the Lady Hawkins School (1619) in Kington. The interest in endowments for educational purposes continued into the eighteenth century. The Bluecoat School was established in Hereford in 1710, the Free School at Lucton in 1711, the Elizabeth Hall charity in Ledbury in 1706, the John Smith Charity at Clifford in 1722,and Scott's Bluecoat School in Ross-on-Wye in 1786.

The last quarter of the eighteenth century saw the creation of the two largest recorded endowed charities in the county. The first of these was the General Infirmary, recorded as an endowed charity although it was not established on the death of a single donor but was created from one off gifts and legacies from many individuals. The first hospital appeal was made in 1774 and by the time of the survey in the 1830s the endowments had an estimated value of £35,412, representing the value of one off donations and legacies given to the charity. A few years later, in 1793, the largest of the county's endowed charities

was established on the death of George Jarvis. Effectively dispossessing his family, Jarvis left wealth estimated in the returns at £76,015 for use for the benefit of the poor of three Herefordshire villages.[17] The Jarvis Charity became synonymous with the difficulties that could arise from the personal endowed charity. These included problems in effectively distributing the resources of the charity according to the wishes of the donor, problems in establishing a structure for the charity to operate within and the cost of legal alteration of the terms of an endowment. The problem of what to spend the funds available on challenged the acceptable notions of what was legitimate charitable relief and destabilised the normal power relationships within the communities concerned. The fact that the courts upheld the establishment of the charity in the face of claims from Jarvis's family highlighted concerns about the rights of relatives to inherit wealth and fears of wrongful disinheritance. This concern was addressed to some extent by the Mortmain Act of 1736, which had been drawn up to prevent the accumulation of large amounts of property in the hands of corporations. Under the provisions of the Act, endowments that left money for investment in property were held to be illegal. [18]

The Jarvis Charity was the only endowed charity other than the Infirmary to provide medical relief. All the other endowments, both earlier and later, continued to operate in the traditional spheres of almshouses, education and the distribution of money or gifts in kind, following a similar pattern to that outlined for the rest of the country. Early endowments were mainly for the provision of almshouses or alms and were frequently religious in nature. From the seventeenth century onwards, educational charities developed, at first based on

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[16] These were William's Hospital in 1601, Price's Hospital in 1604,Trinity Hospital in 1607and the Coningsby Hospital in 1617. Another almshouse, Webb's Hospital, was set up in Ross-on-Wye in 1612.
[17] R. Pantall, *George Jarvis (1704-1793) and his notorious charity* (Leominster, 1993).
[18] Owen, *Philanthropy*, pp. 87-88.

the charity schools and later expanding to encompass a variety of different models. The voluntary General Infirmary and its associated lunacy charity developed in the eighteenth century and from 1800 the dispensary movement and a proliferation of small-scale local charities arose which were involved in a myriad of welfare issues. This was broadly in line with national trends.[19]

Philanthropic activity was time-consuming and while establishing a charity on their death released the benefactor from further effort, charity was only dispensed through the good offices of those who acted as trustees and administrators. It was not until the Charitable Trust's Act of 1853 that steps were taken to establish a permanent body to administer the nation's endowments. This act established the Official Trustees of Charitable Funds, who invested funds on behalf of trustees and would remit the income to them for distribution. [20] Up until this time, responsibility for investing capital and distributing charitable funds rested with trustees who were normally members of the local elite or other family members. The aristocracy, gentry, MPs, municipal corporations and the clergy were the main groups to shoulder this responsibility and philanthropic activity was both a demonstration of power and one of its responsibilities and rewards.

Although it has been argued that the fashion for personal endowments declined in the eighteenth century, the evidence shows that they remained a popular charitable vehicle in Herefordshire and considerable sums continued to be left to charity in this way. For example, in 1787 Mary Morgan of Tredegar, left £1,800 to be invested in government securities, the interest to be used to provide new clothes and fuel for the deserving poor as identified by the overseers and minister in the villages of Kingstone and St Weonard's. Despite the national coverage given to the Jarvis Charity between 1793 and 1800, personal endowments continued to be established within the county. William Miles, who

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[19] *Ibid.* pp. 71-77.
[20] *Ibid.* pp. 202-208.

died in 1803, left £200 to be invested to provide bread and beer to the poor of Ledbury on the 21 January each year. In 1821, George Cope, Canon Residentiary of Hereford left £1,300 to be invested to provide bibles and prayer books, blankets and cloaks and stout flannel waistcoats in a three-year rotation to the poor of five parishes.[21] These endowments continued in the spirit of medieval charity, aiming to provide the poor with the staples of life such as food, clothing and spiritual comfort. Cope also left £200 to the Infirmary and others also took advantage of both old and new charitable vehicles. John Morris, who died in 1832, left £10,000 to the Infirmary, the largest single donation the institution ever received. His will also made provision for £40 to be spent on distributing bread to the poor of Kington each Sunday and an endowment to improve an existing educational charity in the village of Brilley.[22]

The continued enthusiasm for traditional forms of charitable giving may have been encouraged by the efforts made to improve the effectiveness of existing endowments. The Hereford Improvement Act of 1774 was primarily concerned with the paving, repair and lighting of the city streets but also included provisions for 'the better application of charity money for setting the poor people thereof to work'. This referred in particular to the reform of Lord Scudamore's charity, established in 1698, which had left money for the Bishop of Hereford to use to provide employment for the poor. Earlier attempts had been made to reform the charity in 1763 when Francis Campbell, MD, acting on behalf of the city corporation, proposed the funds be used to employ a person 'skilled in linen or woollen manufactures' to train and employ people in these industries'. By 1774 this had proved ineffective and the Hereford Improvement Act put the funds

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[21] Clark, *Reports of the Commissioners*. The detailed examples given are drawn from this source.

[22] An earlier donor, John Harris, had left a schoolhouse and £5 a year towards the education of the poor and John Morris left £100 for the erection of a house for the schoolmaster and charged the Court of Brilley estate with payment of £50 per annum for his salary.

under the control of the lighting commissioners to use for any scheme to put the poor to work. Despite these attempts to widen the scope of legitimate uses of the charity, the charity commissioners of the nineteenth century noted that there had been 'considerable difficulty in rendering this charity serviceable to the poor'. [23] Between 1805 and 1820, £1,300 was lent to Mr Gough to establish a flannel factory on the security of a mortgage on his property, and in 1820 £1,200 was lent to a glover, Mr Benbow. Both these attempts to establish a commercial concern failed and in 1836 the fund was invested in 3 per cent consolidated stock. In 1836, the trustees, still frustrated in their attempts to make effective use of the charity's funds, were considering applying for a further Act of Parliament to allow them to use the funds to build a general workhouse for the newly established Hereford Union. This did not happen and the charity's funds continued to be applied for educational purposes.

Philanthropic activity played an important and integral part in the overall improvements achieved in this period with considerable funding coming from donors who continued to make use of the older form of charitable endowment well into the nineteenth century. For example, both subscriptions and individual gifts were drawn on to improve the fabric of the almshouses. In 1770, a subscription was started to fund the rebuilding of the old St Giles' almshouse, which had fallen into disrepair. This is the earliest example of a public subscription for charitable purposes in Hereford. [24] In 1787 Alderman Cox left £300 to be invested; the interest from £200 to be distributed amongst the poor of All Saints parish and the interest on the remainder to go towards the support of Price's Hospital. In 1792, William Hill provided an alternative building to replace the old Pye's almshouses established in 1615 in Ross-on-Wye without establishing an endowment. Thomas Russell, town clerk for Hereford, died in

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[23] Clark, *Reports of the Commissioners'*, p. 14.
[24] *Ibid.*

1823 leaving £500 for Trinity Hospital, £300 for St Giles' Hospital and £200 for Price's Hospital to be used either as capital or to provide income. Despite the generosity of Russells' bequest, there were insufficient funds to rebuild Trinity Hospital and a further public subscription was launched to raise the balance needed. The corporation gave £100 and the subscription raised a further £200 towards the total cost of rebuilding of £881 12s 8d.

Another major project undertaken in the county at the end of the eighteenth century was the rebuilding of Hereford Cathedral following the spectacular collapse of the west tower and front on Easter Monday, 1786. There had been concern about the tower's stability for at least ten years and an ongoing maintenance programme was in place under Thomas Symonds.[25] Symond's team included William Parker, the architect for the General Infirmary and surveyor to the Hereford Improvement Commission.[26] Hereford Cathedral was one of the poorest foundations in the country and the rebuilding placed an enormous burden on the cathedral staff. The original estimate for repairs was £6,800 but the final cost was close to £16,650. [27] Donations from the bishop, dean and chapter were supplemented by a public subscription launched through the *Hereford Journal,* which raised over £5,000 in 6 months. A further £4,000 was raised by Act of Parliament on a mortgage and the balance from further borrowings. In 1793 a second subscription was launched to finance the construction of a tower and the

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[25] Symonds was a local man whose also worked for Richard Payne Knight at Downton Castle, on the new city gaol and for the Pateshall family at Allensmore Court.

[26] Whitehead ,'Architectural history', pp. 258-275. Symonds was dismissed following the collapse and James Wyatt, who was well known for his work on several Oxford Colleges, undertook the restoration. Wyatt rebuilt the west front in a gothic style that was approved by local men such as Uvedale Price of Foxley but was not well received nationally and was later substantially remodelled.

[27] H. Tomlinson, 'From restoration to reform, 1660-1832', in Aylmer and Tiller (eds), *Hereford Cathedral*, pp.109-155, p. 140.

burden of financing the costs of the rebuilding plagued the cathedral well into the nineteenth century.[28]

It is clear from the above that a significant number of major philanthropic ventures were launched in Hereford from 1770 to 1800. The tangible results included both the remodelling of existing buildings including the Cathedral and almshouses and the construction of new premises such as the Infirmary building. Efforts were also being made to make more effective use of existing endowments and although personal endowments continued to be directed towards the provision of small amounts of cash, blankets and food, the corporation was attempting to channel funds available into setting up schemes to provide work for the poor. However, attempts to reform the terms of existing endowments required legal sanction and could be very expensive. In contrast, funds raised by subscription were not subject to any legal restriction. It was up to the trustees and, in the case of the Infirmary, the governors, to determine what the funds should be applied to. This was one reason why the subscription model was attractive to philanthropists.

3.2 The Jarvis Charity

The potential shortcomings in the operation of the private endowment charity were most vividly illustrated in the county through the operation of the Jarvis Charity, which had been established for the benefit of the poor in three rural parishes, Bredwardine, Staunton-on-Wye and Letton.[29] George Jarvis left the charitable trust the sum of £30,000 plus the residue of his estate, which together totalled some £76,000. The will expressly noted that no funds were to be spent on the capital costs of buildings. Instead the funds were to be invested in government securities and the income distributed to the poor. The potential

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[28] *Ibid.* p.142.
[29] Pantall, *George Jarvis* summarises the charity's origins and operation.

difficulties in these arrangements were several. Firstly, Jarvis's surviving relatives, a daughter, four grandchildren and two great grandchildren, chose to contest the terms of the will as it more or less disinherited them. Secondly, the size of the trust was excessive for the charitable purposes specified. The combined population of the three villages was estimated as 1,180 and the number of poor eligible for relief at only 578 people. [30]

George Jarvis had been born in Staunton-on-Wye, the youngest of six children born to yeoman farmers. By the time he was five, the family had moved a few miles to the village of Bredwardine where George was brought up before joining his elder brother in London as an apprentice currier in Snow Hill close to Smithfield market. [31] The Jarvis family continued to live at Bredwardine for some years although George's parents were both buried in the neighbouring parish of Letton, the third to benefit from his charitable trust. Jarvis became a wealthy man and in 1759 his only child, Mary, married Sir William Twysden Baronet of Roydon Hall in Kent. The couple had four children, three sons and one daughter, before Sir William's death in 1767. [32]

Although Jarvis's final will did contain family bequests, these did not comprise the majority of his estate. His daughter who was left just £200 per annum took the lead in contesting the will. Two of the grandchildren, Sir William Jarvis Twysden and Frances, Countess Eglington were left nothing while the other two were each left £1,000. The eldest great-granddaughter, Mary, was to receive £20,000 plus the accumulated interest on reaching twenty-one. Her younger sister, Susanna was to have £10,000 at twenty-one if the bequest to her sister failed. Within a month of Jarvis's death the family was disputing the will in

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[30] *Ibid.* pp. 39-41.
[31] *Ibid.* pp. 3-9.
[32] *Ibid.* pp. 18-21.

the Ecclesiastical Courts but this and later attempts to have the will overturned failed,[33]

One of the grounds for dispute was that Jarvis had made several wills, the earliest of which, dated 1783, left his estate to his family.[34] Various minor amendments were made up to 1788 when the first mention of the Herefordshire charity is made. Two years later, his last will and testament effectively disinherited his daughter, eldest grandson and granddaughter. The reason for the change was not made explicit but is likely to have been influenced by scandals affecting two of his grandchildren.

By the time of his marriage to Jarvis's daughter Mary, Sir William Twysden was already facing financial difficulties and on his death the estate was encumbered by significant debts. While responsible for the estate during her son's minority, Mary had applied to her father for some financial help, which he had refused. Despite this, Mary managed to maintain the estate intact until William came of age but debts soon began to mount and within three years the estate was mortgaged to his grandfather for £6,000. Two years later William eloped to Gretna Green with a fifteen year-old heiress, Frances Wych, who inherited £10,000 on her marriage. The couple left for France to avoid their creditors and in November 1788 the majority of the estate was sold to pay off creditors and provide an annuity for Mary.[35] Jarvis's granddaughter, Frances, became embroiled in a different sort of scandal. She was twenty when she married the Earl of Eglington, then aged fifty-seven in 1781. The couple had two daughters but the marriage ended in divorce in 1786 due to her infidelity with the Duke of Hamilton. Hamilton was married and even after Frances' divorce the

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[33] *Ibid.* pp. 36-37.
[34] Jarvis's 1783 will left the residue of his estate to his daughter Mary, provided £10,000 for his granddaughter, £5,000 each for the two grandsons and various bills of sale and leases to Sir William, probably associated with the mortgage Jarvis held on Roydon Hall.
[35] Pantall, *George Jarvis*, pp. 22-26.

affair caused a scandal, being reported in *Town and County Magazine* in 1788 where they appeared as 'The Candid Wife' and 'His Caledonian Grace'. The couple lived together for several years before Hamilton returned to his wife.[36]

In addition to claiming that they were entitled to some benefit from Jarvis's estate, the family also argued that the income generated from the capital left to the trust exceeded the charitable purposes of the bequest. As the trust's income exceeded the total of poor rates in the three parishes they claimed that it would be difficult to distribute the income according to the terms of the will. When the trustees came to consider the operation of the charity in 1800 once all the legal challenges had failed, this indeed proved to be the case.

The Bishop of Hereford and the two MPs for the county, Sir George Cornewall and Thomas Harley were appointed as trustees for the charity. By 1800 the funds had accumulated to £73, 544 to be distributed among the three parishes in the proportions stipulated by Jarvis.[37] The Trustees of the charity were in difficulty about how much they could spend, what they could spend it on and who should benefit. In order to clarify the operation of the charity they drew up a set of proposals for expenditure in each of the three parishes, which were sanctioned by the Lord Chancellor in 1802.

Table 3.2 sets out the proposals together with a note of the numbers of poor estimated in the three parishes. The total amount estimated for distribution was £2,313.[38] The problem facing the trustees was essentially that the charity had been established to distribute traditional benefits such as food, clothing and fuel to a small number of potential beneficiaries, but the funds available exceeded those needed for these purposes. The degree of the mismatch between resources available for distribution and potential beneficiaries was quite

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[36] *Ibid.* pp. 26-28.
[37] These were 13/30 to Bredwardine, 11/30 to Staunton-on -Wye and 6/30 to Letton.
[38] Pantall, *George Jarvis*, p. 40.

unprecedented. For example, in Staunton-on-Wye, poor relief amounted to some £224 5s a year, just over a quarter of the funds available via the Jarvis Charity.[39]

Table 3.2: 1802 scheme for the distribution of the Jarvis Charity funds.

	Bredwardine £	Staunton-on-Wye £	Letton £
Physic and attendance on the poor	50	40	20
Clothing, bedding & bed clothes	330	300	170
Fuel	135	95	45
Food	281	263	144
Schooling	60	50	25
Apprenticeships	60	50	25
Salary of a clerk	25	15	10
Gratuities to servants and apprentices for good behaviour	61	34	23
Total	£1,003	£848	£446
Proportional distribution	43.4% (13/30)	37.3% (11/30)	19.3% (6/30)
Total population Estimated poor in need	405 253	545 281	230 44
£ per head of poor (approx.)	£3 19s	£3 4s	£10 3s

Source: R. Pantall, *George Jarvis (1704-1793) and his notorious charity* (London, 1993) p. 40.

Quite apart from any sympathy for Jarvis's descendants, the charity's operation did not satisfy the age's criteria for charitable giving. In an agricultural area where wages were typically 8s a week for men and 3s a week for women and children, the availability of charitable help on this scale was considered ill advised. The excessive amounts available for distribution were more likely to demoralise the recipients and encourage idleness, discontent and improvidence than to provide a safety net against starvation and poverty. Mindful of this, the trustees were careful to set down rules excluding various categories of people from claiming from the charity.[40] Only those who had been resident in one of the

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[39] *Ibid.* pp. 43-49.
[40] *Ibid.* p. 43.

three parishes for at least two years was eligible for relief while anyone with a freehold worth more than £10 a year or who paid an annual rent of £15 or more to rent their premises was excluded. Those on parish relief and unmarried mothers were also excluded and there were numerous rules under which potential beneficiaries could be excluded on the grounds of inappropriate behaviour. These rules clearly show that the trustees were concerned not to encourage those that could from working or sanction any immoral behaviour.

In the early years of the charity, relief was organised independently by the three parishes. Coal was distributed at the start of the winter and some food relief was given on a weekly basis, including bread, sugar and tea. Wheat was distributed twice a year, in January and again at Easter, beef was given in January and mutton every six or seven weeks. Provision for education began with the appointment of a schoolmaster at Staunton-on-Wye in 1815. As Jarvis had expressly requested that none of the charitable funds were to be used to erect any public buildings, the schoolroom was rented to the charity by Sir John Cotterell, one of the trustees, whose estate at Garnons was in the vicinity of the three villages. Cotterrell built a purpose built school at Bredwardine in 1822. [41]

The 1802 scheme allowed a total of £110 for medical relief, just under 5 per cent of the funds available. At first, the charity did not employ its own doctor but used the services of the nearest medical practitioner who was based some ten miles away. The charity soon found that expenditure exceeded the indicative amount allowed. In 1835 the trustees agreed to appoint a full time doctor and Thomas Kidley, a surgeon, was appointed as Charity Medical Secretary at a salary of £200 a year. He also received free accommodation and funding for medicines to supply a dispensary. At the same time as appointing Thomas

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[41] *Ibid.* p. 44.

Kidley, the trustees also appointed a clerk, Thomas Allen and centralised the administration of relief under these two officers. [42]

A set of rules was drawn up in 1837 that included the provision that a list of beneficiaries should be drawn up annually and time allowed for the trustees to establish 'the necessitous condition and moral conduct of such persons who may be petitioners'. In an effort not to further undermine parish officers, the clergyman of each parish was sanctioned to look into the operation of the schools. These attempts to engage with the local elites failed and by 1838 complaints against the medical officer and the schoolmaster had begun to be voiced, led by the local rector. In 1840, supporters of the two officers drew up a petition, which was presented to the trustees but in November of the following year Rev. Charles Webber and his supporters submitted a written complaint of gross abuse in the distribution of charity relief. This included allegations of indecency with patients and pupils, drunkenness and foul language against the surgeon, the schoolmaster and the schoolmaster's wife. The charity's trustees, the Bishop of Hereford, Sir John Cotterrell and Tomkyns Dew held an inquiry that resulted in the dismissal of both officers. Peter Broome Giles, of Hope Court, near Ludlow, was elected as the new surgeon at a salary of £200 a year plus £30 for rent and £170 to cover the cost of medicines. [43]

In addition to local censure, by 1841 the charity had also come under scrutiny from the Charity Commissioners. In 1851 James William Farrer visited Hereford to investigate the operation of the charity and report to the Attorney-General. By this time the charity's investments were worth £100,015 and yielded an income of some £3,000 a year. In summary, the proposals put forward were to limit the sum spent on relief in the parishes to £1,200 a year, to allow £150 for medical relief and to contribute £50 a year to the General Infirmary to allow them

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[42] *Ibid.* p.45
[43] *Ibid.* pp. 51-56.

to send patients there. In addition, one of the stipulations of Jarvis's will was overruled and it was recommended that money was spent on purchasing land and building a dispensary and accommodation for the medical officer, an infant school in each parish and a separate boys and girls school and almshouses.[44]

The proposals were submitted to parliament as 'An Act for the Regulation of Charity founded by George Jarvis, for the Benefit of the Poor Inhabitants of the several Parishes of Bredwardine, Staunton on Wye and Letton, all in the County of Hereford; and for other purposes'. The bill passed in1852 set out fairly detailed rules for the administration of the charity.[45] Despite these further attempts to guide the charity into appropriate uses, the bad publicity surrounding the charity endured and Gladstone specifically mentioned it in his speech on charities as in 1863. The text was reported in the *Hereford Times* on 9 May 1863.

> The population of these three parishes, at the first census after Jarvis's death, taken in 1801 was 860 and in 1851 it was 1,222. What was the reason for this increase in population? Had employment increased there? No! Had manufactures been established? No! Had trade come there? No! Were wages higher in these parishes? No, they were lower by 2s a week! Were the dwellings good? No, they were the most miserable and scandalous that disgraced any part of the country. The people went into them naturally enough to wait for the doles; for the gifts which Jarvis's misguided benevolence were distributed to them pretty well doubled the income of the agricultural population of those parishes! And, last of all, have the morals of these poor people improved? The statement of

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[44] *Ibid.* pp. 57-61.
[45] *Ibid.*

> the authorities who have investigated the case is this- that
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> the morals of these parishes were such as they are
>
> forbidden to describe!

This speech reflects many of the ideas underlying the provision of charity and poor relief at the end of the 1830s. The New Poor Law had been introduced in 1834 based on the principles of deterrence and less eligibility. While a minimal subsistence would be provided for those genuinely unable to work, relief was to be witheld from any who were considered able to take on paid work. The injudicious provision of charity both encouraged vice and was detrimental to the development of individual and national prosperity.

The detail of schemes authorised by the trustees altered as contemporary ideas about the proper and useful purposes of charitable expenditure did. As noted, in the early years of the charity much of the authorised spending overlapped with provision already in place under the Old Poor Law arrangements. The charity provided an alternative route to claiming similar benefits. The small amounts earmarked for education and apprenticeship were the only measures of possible longer-term benefit available to the charitable trustees. The reorganisation of the charity in 1835 agreed more resources should be used to provide medical services. By this time other voluntary dispensaries had opened in the county and the reform of the Poor Law had introduced the concept of the paid Medical Officer. The trustees therefore introduced revised arrangements that fell within the framework of contemporary medical welfare policies.

The administration of the New Poor Law brought additional complications as Letton and Staunton-on-Wye were in Weobley Union while Bredwardine fell into Hay Union which was made up of a majority of Welsh parishes. When Weobley Union was set up in 1836, the parishes of Staunton-on-Wye and Letton

were not assessed for the cost of medical relief as the Jarvis Charity had already appointed a surgeon. The parishioners were not eligible to claim services from the Union's Medical Officer as they were expected to receive these from the charity's surgeon.

The Weobley Guardians were eager to ensure that individuals were not claiming support from more than one source. In March 1837, they received a list of paupers resident in the villages who were receiving relief from the charity and stopped payments to any who had also been approved to receive relief from the Union. [46] The early years of operation of the New Poor Law appear to have been without incident but in April 1842, a complaint was made against Mr Lomax, the Weobley Union Medical Officer, for failing to attend James Griffiths who had moved from Norton Canon to Staunton-on Wye. Lomax had previously attended Griffiths but stopped treatment when he moved. The matter came to the attention of the Poor Law Commissioners who asked the Union to investigate the arrangements for the treatment of paupers in the two villages in Weobley Union to ensure that they were adequate. If necessary, the Union was to arrange for provision and charge the parishes accordingly. [47] The guardians wrote to the Jarvis Charity trustees to clarify the arrangements in place. The secretary responded that the terms of the charity's rules were that the surgeon supplied services to the poor but not to those in receipt of parochial relief. Effectively this meant that no provision was in place for the paupers in the villages and the Union asked Giles, the charity's surgeon, to take on the care of the pauper patients. After some negotiation he eventually agreed to do this on the basis of a payment of 10s for each case. Giles first account was scrutinised carefully and two cases were disallowed on the grounds that they were not paupers and should therefore be treated as part of his contract with the Jarvis Charity but after this the system

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[46] HRO, K42/475, 13 March 1837, Weobley Union minutes.

settled down. The following year Giles was appointed on a fixed salary of £15 a year.[48]

This episode demonstrates the Poor Law Commissioners' belief in the Union's responsibility to ensure that arrangements were in place for paupers. However, the Union was able to take advantage of factors in the local situation to agree a flexible solution with the Jarvis Charity. The solution arrived at did not disrupt the well-established service provision in the rest of the Union and enabled the service to the parishes south of the Wye to be integrated with the services provided by the charity. The appointment of one surgeon, on a fixed price tender, responsible for paupers under the Union contract and non-paupers under the charitable contract minimised as far as possible the potential for disputes as to which organisation should be charged for services to individual patients. The solution did effect the ratepayers of the three parishes who had to start to fund medical services provided to paupers.

3.3 The mixed economy for medical services

The relationship between Weobley Union and the Jarvis Charity provides an insight into who was entitled to relief and who should influence this. In 1836 the main issue of concern was that paupers might claim relief from more than one source but in 1842 it was whether or not there were any properly regulated arrangements in place for their support at all. Both these situations were unacceptable. These issues of entitlement were normally avoided by the convention that Poor Law authorities provided relief to paupers and philanthropic organisations to the non-pauper poor. However, by the 1820s and 1830s this simple rule was coming under strain. Expenditure on poor relief had increased substantially and there was a view that the Old Poor Law arrangements were not

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[47] HRO, K42/476, Apr. to July 1842, Weobley Union minutes.
[48] HRO, K42/475, 20 March 1838, Weobley Union minutes.

addressing the problems of poverty. The issue of support to the non-pauper poor became increasingly important. One way this concern was manifested in relation to medical services was through consideration given to the development of dispensaries and support for mutual medical clubs.

Dispensaries began to be established in England from the middle of the eighteenth century.[49] The opening of the General Dispensary at Aldersgate in London in 1770 stimulated further developments and the 1783 *Medical register* reported six provincial dispensaries. By 1800 there were 16 general dispensaries in London and 22 in the provinces. Most operated according to similar rules, with subscribers contributing an annual fee in return for which they gained the right to recommend patients for treatment. Medical services were provided free to patients, expertise provided free by honorary medics and the cost of medicines covered by the charitable funds. Many of the early provincial dispensaries were in the newly industrialising areas and developing towns such as Manchester, Birmingham, Bradford, Newcastle-upon-Tyne and several towns in Yorkshire and Lancashire.

The first dispensary to open in the county was at Ross-on-Wye in 1825. Detailed records have not survived but it undoubtedly benefited from a high level of local support including that of a local solicitor, James Wallace Richard Hall. Hall became vice-chairman of the New Poor Law Union, supported the establishment of a British and Foreign School in the town in 1836 and by the 1850s was a trustee of Baker's charity, treasurer of the almshouse at Webbe's Hospital and a churchwarden.[50] Ledbury dispensary which was established in

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[49] Loudon, 'Origins and growth of the dispensary movement', pp. 323-342.
[50] H. Hurley, 'The Forgotten Man of Ross', *TWNFC*, 45 (1985), pp. 305-310. Among Hall's other personal gifts to the town was a new pair of gates for the graveyard. He was also active in a variety of other schemes including being a founder member of the Forest of Dean Bank, an early promoter of the Hereford, Ross and Gloucester Railway Company and a Director of the Hoarwithy Bridge Company.

1826 also benefited from the support of an active local philanthropist, John Biddulph.[51]

No dispensary was established in Hereford until 1835, again promoted by an active philanthropist, the Reverend John Venn, rector of the parishes of St Owen and St Peter from 1833. Venn's father and brother were both Anglican ministers and his father had been a member of the Clapham Sect together with William Wilberforce and Henry Thornton.[52] Venn's first charitable venture was to open the St Peter's Literary Institute in 1833 providing a reading-room, lending library and adult education classes. Two years later the Hereford Dispensary was founded and run from St Peters' church. It was funded by subscriptions with medical services provided on a voluntary basis by several of city doctors, including Henry Bull. Venn later promoted the Hereford Friendly Society and was instrumental in founding the Hereford Society for Aiding the Industrious, which became the main vehicle for charitable activity in the town in the nineteenth century.

The first President of the Society was the Bishop and the Dean, Mayor and the two MPs for Hereford were elected as Vice-Presidents. In its first year of operation, the Society purchased land which it rented to families as allotments, established a small loan scheme and operated a scheme to buy coal in bulk in the summer to be made available to the poor at reasonable prices in the winter. From 1844 it operated an extensive soup kitchen and following the repeal of the Corn Laws in 1846 it built a corn mill which sold grain at cost price. From 1851, the waste steam from the mill was recycled to heat the water at the adjoining public baths. The first Annual Report of the Society summarised the principles on which its work was based:

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[51] HRO, B 092/61, Ledbury overseers and Board of Health, 1831-1832 and HRO, G2/IV/J, Biddulph diary, 1832.
[52] J. O'Donnell, 'John Venn and the Hereford Society for Aiding the Industrious', *TWNFC,* 46 (1990), pp. 498-516.

> That the truest charity is that which enables the working man to maintain himself and his family in comfort and independence by his own prudence and industry. That the upper classes are bound by all considerations of benevolence, of morality, and, above all, of religion, to try and place every working man in a situation which will enable him to do this.[53]

His speech to the Annual general meeting in 1841 included the following words:

> Every inhabitant of this City must have perceived and mourned over the sad state of our poor...It is obvious that a great deal of charity is continually being given away, by bequests and by private individuals, and occasionally, also by public contributions but yet the sad state of the things described above is far from improving. The persons depending upon charity are becoming more numerous and more importunate; whilst the industrious, discouraged by their sufferings, and observing the success of clamorous appeals to the pity of the charitable, are in danger of losing their own spirit of independence, the rich themselves are also beginning very generally to feel that the whole system is radically bad, and to wish for a better to be introduced... [54]

The changes introduced by the New Poor Law had led to a reduction in the provision of outdoor relief, reducing opportunities for poor families to ride out bad times. Some of the initiatives put in place by the Society sought to fill this gap in order to enable families to continue to live without recourse to the workhouse. In relation to medical services, there was a concern that the services available free of charge to paupers might exceed those that the non-pauper poor were able

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[53] *Ibid,* pp. 500-502.
[54] *Hereford Times*, 24 Feb. 1841.

to purchase for themselves. After 1834 individual parishes no longer had the flexibility to pay for medical services for the non-pauper poor from local rates but the problem of the affordability of medical care remained an intractable one that could not be ignored. One method authorised by the 1834 legislation was the promotion of Medical Clubs for the independent labouring classes. The main function of these clubs was the provision of insurance to cover the loss of income that could result from a period of illness, but they also arranged for and financed payment for medical treatment. Medical clubs developed from the seventeenth century as part of friendly societies run by the subscribing members. In the nineteenth century some became more closely linked with philanthropic ventures or initiatives promoted by the New Poor Law authorities.[55]

In1835 the Poor Law Commissioners issued a circular calling on Unions to promote the concept of medical clubs. These were to be self-supporting and independent of parochial relief. The Commission reviewed the rules of many existing clubs and from this information drew up a suggested scale of subscriptions. The range recommended for an individual was between 3s 4d to 4s 6d and for a married couple between 4s and 6s. Children under sixteen were charged at 6d. Those over sixteen were normally charged as an individual member although some schemes offered a discount on the adult rate. Pregnant women were required to pay an additional 10s for which they would receive the services of a midwife. The above terms were to entitle the subscriber to medical advice and the costs of medicines and medical and surgical appliances although other items had to be provided by the sick individual. [56]

In promoting the mutual medical societies, the Unions were seeking to expand the membership of friendly societies among the non-pauper poor. Clubs

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[55] J. Lane, *A social history of medicine: health, healing and disease in England, 1750-1950,* (London, 2001), pp. 68-81 and Gorsky, 'Growth and distribution of English friendly societies'.
[56] Hodgkinson, *Origins of the National Health Service,* pp. 215-218.

provided a range of benefits that normally included payment of an income during periods of sickness with a pension at a defined retirement age and funeral expenses on death. Members subscribed on a regular basis and benefits were funded from the 'box'. Subscriptions were collected at monthly meetings and ranged from 10d to 1s as the contribution to the society's funds. A few clubs limited access by status, for example to gentlemen, farmers, mechanics and tradesmen but most were open to all occupations. From the late eighteenth century clubs in some areas became associated with trade unions and radical politics and this lead to legislation in 1793 that required the rules of societies to be sanctioned by justices of the peace. [57]

Most clubs operated a maximum age for joining and membership. Benefits were often related to length of membership prior to any claim and some provided for a lump sum payment where no claim had been made for a designated period. The length of time for which benefits were paid and the amount of benefit were linked to overall subscription levels and most clubs included a provision in their rules for the suspension of payment of benefits when the accumulated funds of the club dropped below a certain value. Benefit payments in Herefordshire were normally between 6s and 8s a week. Claims for medical relief were validated by the club and were normally certified by a medical practitioner. Little evidence of the contractual terms between medical practitioners and clubs have survived but the indications are that they were paid on a retainer basis with fees for specific examinations and treatments. Medical fees for members may have been paid out of the club's funds but at Much Marcle the rules required an additional 1d a week from members to cover these costs.[58]

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[57] Lane, *Health, healing and disease in England* and Gorsky, 'Growth and distribution of English friendly societies'.
[58] F. C. Morgan, 'Friendly societies in Herefordshire', *TWNFC,* 32 (1948), pp.183-211, p. 184.

A listing of clubs in Herefordshire dating from 1857 records 127 in the county of which almost half were based outside Hereford city or the market towns.[59] These 61 rural clubs were based in 40 separate villages showing there was good access throughout the county. Table 3.3 summarises this information.

Table 3.3: Friendly Societies in Herefordshire in 1855.

Place	Number of Friendly Societies
Hereford	27
Bromyard	1
Kington	9
Ledbury	9
Leominster	8
Ross	8
Total market towns	35
Rural areas	61
Total	**123**

Source: F. C. Morgan Friendly Societies in Herefordshire', *TWNFC*, 32 (1948), pp.183-211, Appendix 1.

Hereford, Bromyard, Weobley and Ledbury Unions all promoted medical clubs to be operated by the Union Medical Officers but a copy of the detailed rules only survives for Ledbury which was the union that did most to promote the concept. [60] 1,000 copies of the rules were published in an effort to establish widespread participation and clergymen and 'influential Inhabitants' were asked to promote the scheme in their localities as well as contributing to the philanthropic arm of the club by subscribing between 5s and £2 per annum. This subscription entitled them to become honorary members and to act as Stewards of the scheme in their own districts. The charitable funds raised were used to cover the costs of printing information leaflets and the provision of some items not

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[59] *Ibid.*
[60] HRO, K42/344, 21 Mar. 1842, Ledbury Union minutes.

covered by the regular subscription, such as leeches, bottles, trusses, bandages, vaccination costs and surgical attendance at childbirth.

The Ledbury Medical Club was aimed at the independent working class employed in agriculture, trades or handicrafts. An earnings limit was set for potential members, with domestic servants earning over £6 per annum excluded as were those individuals earning over 12s or a family earning over 20s a week. Families could opt to pay for individuals over the age of sixteen and had the option of subscribing for all or none of any children under that age. No medical grounds for refusing entry were mentioned and it was possible to start subscribing even when ill and in need of assistance so long as the new subscriber found two new healthy members to start at the same time and pay any additional admission fee assessed by a steward. 'Habitual drunkards, and persons notoriously addicted to profligate habits, or who are known to be idle and disorderly, and individuals convicted of felony ' were excluded. The Medical Officer was obliged to treat all those recommended by the Relieving Officers under the terms of the medical club. In Ledbury, services were provided on a Tuesday and a Saturday from the Medical Officer's home with treatment outside these times or at the patient's home requiring specific authorisation by a steward.

When the Herefordshire Friendly Society was established in Hereford in 1838, a philanthropic arm was also introduced. The Society was promoted by leading figures, the Bishop became the official patron and Earl Somers, MP for Hereford was elected as the first President. Honorary membership required a one off gift of 5 guineas or an annual subscription of 10s. For ordinary members there was a sophisticated scale linking subscriptions to benefit rates[61] The Herefordshire Friendly Society was linked with the promotion of the subscription medical club for the labouring classes promoted by the Hereford Poor Law Union

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[61]Morgan, 'Friendly societies in Herefordshire' p. 194.

that aimed to provide an affordable method of paying necessary medical fees. [62] Together with the charitable Hereford dispensary established in 1835, these two organisations complemented each other in their aims to help the non-pauper poor manage the consequences of ill health.

Medical clubs provided a range of benefits to the community. Society members gained access to affordable medical care. Poor Law Unions, and the ratepayers who funded them, benefited as the schemes reduced the number of those who might otherwise be forced to call on the Poor Law for help. For charitable subscribers they offered a vehicle for philanthropic activity, addressed the failure of the private market for health care while supporting and rewarding the principles of self-reliance among the poor. For medical practitioners employed by the clubs, they provided a stable income stream and enabled a proportion of the population who might otherwise not be able to fund private fees to be able to purchase services.

The close links between public, philanthropic and mutual provision were illustrated in 1837 when Ledbury Union considered a plan to combine the tenders for the pauper services and the medical club on the same subscription basis. They later concluded that this would not be workable due to the different health needs to the populations. 'Pauper patients are almost wholly very infirm and would require therefore a higher rate of subscriptions than that set down for the average of cases'.[63] The Union continued to tender separately for paupers on a cost per case basis and the independent medical clubs on a subscription basis. The operation of the two schemes was nevertheless partially integrated in that the number of medical districts was increased from three to four with the Union Medical Officer obliged to operate the club according to the rules set down by the Board.

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[62] HRO, K42/215, 16 May 1838, Hereford Union minutes.
[63] HRO, K42/342, 4 July 1837, Ledbury Union minutes.

Summary and Conclusion

This chapter has summarised philanthropic activity in Herefordshire between 1770 to 1850. The period saw the expansion of philanthropic organisations, the development of the associated charity and an expansion in the scope of charity work beyond the traditional spheres of alms, almshouses and education. The two largest endowments in the county were both established in the late eighteenth century and both provided medical care. The General Infirmary, to be discussed in the next chapter, was a new departure both in terms of its organisation as a subscription society and its aim of providing medical services on a charitable basis. It was not unique in raising money through a public subscription as this mechanism had already been used to fund the rebuilding of almshouses and part of the cost of rebuilding the cathedral. The Jarvis Charity was a traditional endowed charity but its size and the operational problems it faced challenged the notions of what constituted legitimate charitable activity. Its success was limited both by the restrictive nature of the rules surrounding endowed charities and by the limited options considered acceptable to local and national officials. The late eighteenth century also saw attempts made to reform the earlier charities established by endowment and to use them to address the general issues of 'improvement' of the period.

This chapter has also explored the interrelationships between the various sectors in the mixed economy for medical services, in particular those between Poor Law, charitable and mutual provision. The sectors did not operate in isolation from each other but were rather parts of an interrelated system. This is clearly demonstrated in the development of services such as charitable dispensaries and mutual medical clubs in the late 1830s.

Chapter 4

Hereford General Infirmary 1775-1850

At the beginning of the eighteenth century there were only a handful of hospitals in Britain, all of them in London. Of these, only two, St Bartholomew's and St Thomas's, could be termed general hospitals. Of the others, Bethlem catered for lunatics, Christ's Hospital for fatherless children and the Bridewell was a prison. The Westminster Voluntary Hospital was founded in 1720 and the first provincial Infirmary at Winchester opened in 1736.[1] By 1800, there were a further six hospitals in London and some thirty in the provinces. Without exception, these were all charitable enterprises, and the vast majority were funded and administered according to a common model. Services were free to patients, medical expertise was provided via local physicians and surgeons working in an honorary basis, with costs met by income raised from subscriptions and the interest on legacies. From the end of the eighteenth century dispensaries began to be established, specialising in outpatient and home care and by the end of the century there were some sixteen in London and seventeen in the provinces. These were also funded by charity but provided outpatient care and care in patients' homes.[2] Once again, treatment was free to patients. The number of voluntary infirmaries and dispensaries continued to increase in the nineteenth century both in London and the provinces.

A voluntary subscription Infirmary did not open in Hereford until 1776, twenty years or more after those in neighbouring counties.[3] Thomas Talbot, a clergyman, wrote the initial appeal in 1763 but there was insufficient interest or support for the

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[1] Standard works on hospitals include Woodward, *To do the sick no harm,* Granshaw and Porter (eds), *The hospital in history* and Waddington, *Charity and the London hospitals.*

[2] Loudon, 'Origins and growth of the dispensary movement'.

[3] A. W. Langford, 'The history of Hereford General Hospital', *TWNFC,* 36 (1959), pp.149-160. Infirmaries were established in Worcester in 1746, Shrewsbury in 1747 and Gloucester in 1755.

enterprise to take root until 1774 when the appeal gained renewed impetus during a local parliamentary election campaign. Within a very few months sufficient funds were collected to enable a temporary Infirmary to be opened and it operated from a rented building until moving to purpose-built premises in 1785. The rules governing the operation of the Infirmary at Hereford were closely based on the model first developed by Allured Clarke at Winchester which became the blueprint for most eighteenth-century English Infirmaries.[4] In the local context, the Infirmary was remarkable in many ways; it was the first medical charity to be set up in Herefordshire and became the largest of the local associated charities, attracting several hundred annual subscribers each year. As discussed in Chapter 3, it was also the second largest endowed charity in the county and continued to be attractive to those leaving charitable bequests. The initial appeal was able to attract a wide range of support and the new Infirmary building was among the first prestigious public buildings to be erected in Hereford City in the late eighteenth century. The Infirmary became an integral part of the mixed economy for medical services but subscriber numbers declined and the organisation faced financial difficulties at the end of the eighteenth century which were only overcome by increasing investment income earned from the investment of sums left to the charity as legacies.[5] In the 1830s a separate dispensary was established in Hereford City and outpatient services provided by the Infirmary declined. Throughout the period the charity played an important part in the local economy, providing employment, placing local contracts for supplies and food, and investing surplus funds via local banks and in various of the local Turnpike Trusts. In was also attractive to those with political interests and

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[4] J. Lane, *Worcester Infirmary in the eighteenth century* (Worcester, 1992), S. Cherry, 'The role of a provincial hospital: The Norfolk and Norwich Hospital, 1771-1880', *Population Studies,* 26 (1972), pp. 291-306 and W. B. Howie, 'The administration of an eighteenth-century provincial hospital: the Royal Salop Infirmary, 1747-1830', *Medical History,* 5 (1961), pp. 34-55.

[5] Langford, 'Hereford General Hospital'. A detailed examination of primary source material is included in section 4.2 of this chapter.

for much of the period its management was dominated by governors who were also members of Hereford corporation or clergymen.

The establishment of the voluntary infirmaries across England in the eighteenth century occurred within the context of an upsurge of philanthropic activities that also included education and prison reform.[6] The social function of infirmaries was complex. In addition to providing practical help to individual patients and opportunities for the extension of medical knowledge, they also served as a symbol of both the social obligations of the elite and their generosity in fulfilling their responsibilities to those deserving of them. [7] In addition to providing access to medical services, infirmaries offered other benefits to subscribers too, providing an opportunity for the emerging middle class to mix with the established elite and cultivate social relationships. Infirmaries were established to provide medical care to the deserving poor as nominated by individual subscribers, but the nature of the organisation required supporters to undertake many different roles in addition to the recommendation of patients, including setting policy and exercising managerial oversight.

This chapter provides a case study of the Infirmary at Hereford from its foundation to 1850. Much of the information used is derived from the published *Annual Reports* and the minutes of governors' meetings, and data extracted from subscription records is used to identify the dominant social groups among subscribers and governors and the success of the charity in attracting support. The extent to which the Infirmary fits the model of an associated charity is discussed and the complexity of the interrelationship between patients, philanthropists and medical practitioners is explored to show how power was exercised, by whom and for what purposes. Sections 4.1 to 4.3 investigate the operation of the Infirmary, its supporters, its management and the treatment it provided to patients. Section 4.4 considers

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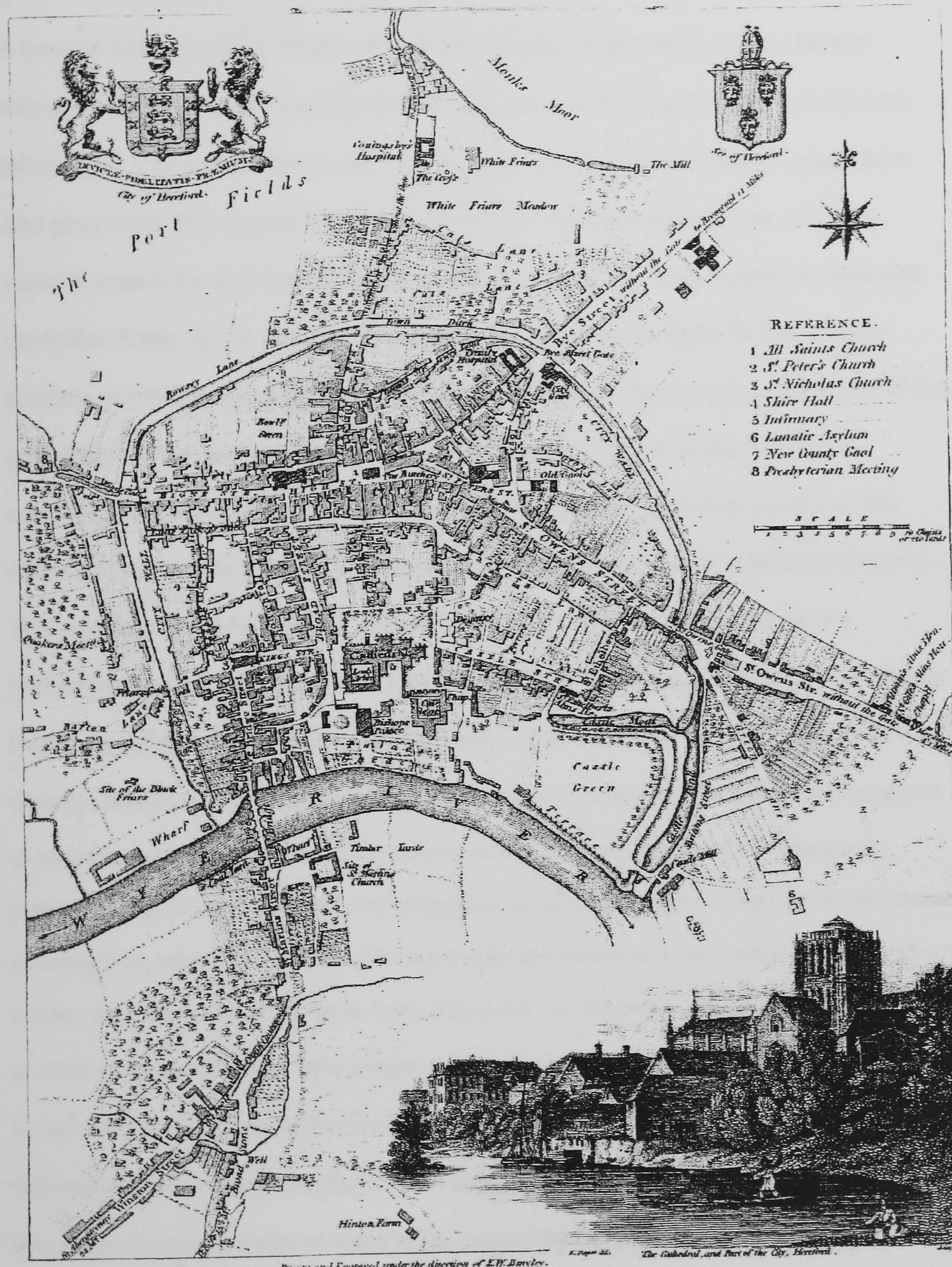
[6] Owen, *Philanthropy*, especially ch.11.
[7] Borsay, *Medicine and charity,* pp. 183-185.

Figure 4.1: Map of Hereford in 1806 showing the location of the General Infirmary and the Lunatic Asylum.

Source: *Beauties of England and Wales* (London, 1806).



possible motives for supporting the Infirmary charity.

4.1 The framework of operation

4.1.1 The Infirmary rules

A booklet setting out the *'Rules and Orders for the Government of the General Infirmary at Hereford'* was published in 1775, prior to the opening of the temporary Infirmary. [8] These regulations set out the rights and responsibilities of subscribers and governors, the procedure for the admission and discharge of patients, and various rules to be followed by those involved in the institution. Access to care was controlled firstly by the individual subscribers who were expected to put forward suitable candidates, and secondly by the weekly board, comprising a minimum of five governors who would consider the case of each prospective patient with the admitting medical representative. The model for the institution was based on the rights and responsibilities of three groups, patients, practitioners and philanthropists. This was illustrated by Rule 32, which stated that: 'only such persons as are recommended by a Subscriber whose Subscription is paid and appear to the Weekly Board, and Receiving Physician or Surgeon, to be curable, and Real Objects of the Charity, be admitted'.[9]In order to meet the criteria for admission, prospective patients had to be considered both curable and deserving of charity. Several general categories of potential patients were excluded, including pregnant women, children under seven and those suffering from infectious illnesses. The rules also specifically excluded patients suffering from chronic and untreatable conditions, including ulcers, venereal disease, cancers, consumption or other terminal conditions. The 'proper objects' of charity were those who were expected to recover. Thus, some of those from generally excluded groups, for example children suffering from a fracture, were eligible to be treated for specific complaints.[10] Wherever possible, patients were to be treated as outpatients, and those who lived

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[8] *Rules and orders for the government of the General Infirmary at Hereford* (Hereford, 1775).
[9] *Ibid*. rule 32, p. 10.

furthest away from the Infirmary were given preference as inpatients.[11] A maximum stay of two months was to be allowed.

Other rules further defined and limited those identified as the rightful beneficiaries of the charity and included provisions to exclude those who should be accessing care through some other social institution or relationship. Thus, for example, serving soldiers were not to be admitted unless the army agreed to pay for their subsistence and apprentices and domestic servants were only to be admitted if their master was willing to contribute 2s 6d a week for their care. In addition, no one who had been in receipt of parish relief in the three months prior to nomination was to be admitted as it was expected that their parish would provide access to suitable medical treatment via the Old Poor Law arrangements.[12] Charitable help at the Infirmary was to be restricted to those who were unable to access medical care through the established mechanisms operating in the private and public sectors, but who nevertheless deserved to have access to it. An addendum to the rules published in 1776 suggests that these restrictions on subscribers' freedom of nomination had met with some opposition, which in turn led the governors to provide some further justification for the restrictions. Three main reasons for the exclusions were reiterated. Firstly, the need to protect the livelihood of medical practitioners who received no payment for their work at the Infirmary. Secondly, the need for the rich to recognise their responsibilities in relation to servants and apprentices, and, thirdly, the need for parishes to accept financial responsibility for those entitled to call on them for relief. 'Infirmaries are Sick Houses, not Poor Houses; but they have a constant tendency to degenerate into the latter, instead of being solely a relief to the complicated Distress of Disease and want; with which the Industrious are often

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[10] *Ibid.* rules 44 and 45, p. 14.
[11] *Ibid.* rule 34, p. 11.
[12] *Ibid.* rules 53 and 54, p. 16.

visited, who are far from willing to be troublesome to their Parish.'[13] The Infirmary was not intended to provide for the elderly or chronically sick.

The rules made it clear that the intention of the charity was to limit the provision of medical help to the industrious poor who were normally able to maintain themselves but who were unable to afford medical treatment. This had been made explicit in the earliest promotional material calling for an Infirmary to be established in Hereford.[14] Thomas Talbot , a local clergyman, wrote two tracts in the 1760s describing the target constituency as 'the laborious, industrious poor, the most useful part of society, the riches and strength of every country, who are under the united distress of sickness and poverty'. These were the people who had 'the misfortune to be too necessitous to supply themselves and yet not indigent enough to be taken on the parish'.[15] In practical terms the Infirmary was there to provide medical treatment to those who would otherwise not be able to afford it, in order to return them to a healthy state and enable them to remain independent of the parish.

In addition to an interest in the physical health of patients, it has been argued that the infirmaries were also interested in their moral well being.[16] Donna Andrew contends that a function of much charitable giving in the eighteenth century was the promotion of a civilised society and the maintenance of civil order and that infirmaries were part of the more general project to reform manners and encourage polite behaviour.[17] These sentiments were also suggested in the rules, some of which related to patient behaviour. Those patients who were able to were expected to attend prayers and to undertake some of the domestic work, such as helping the nurses and servants with washing and ironing linen, cleaning the wards and caring for other patients. Patients were to stay within the bounds of the Infirmary unless

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[13] *Ibid.* The printed addendum is included at the back.
[14] T. Talbot, *Three addresses to the inhabitants of the County of Hereford, in favour of the establishment of a PUBLICK INFIRMARY, in or near the City of Hereford* (Hereford, 1774). The three addresses were first issued in 1763, 1764 and 1774.
[15] Talbot, *Three addresses,* 1763 address, pp. 1-2.
[16] Porter, 'Gift relation', pp. 166-167.

given permission to leave and to behave in an acceptable way. Abusive language, cards, dice, gaming and smoking were all expressly forbidden. [18] The intention was clearly that the Infirmary would operate in an ordered way with patients following a code of behaviour based on work, prayer and civility. Vagrants and beggars were expressly excluded; 'none shall be assisted with Advice or Medicines who shall ask Alms in or about the Infirmary, or who shall beg elsewhere within the Town'.[19] The rules were displayed in every ward and read aloud to patients once a week.

4.1.2 Subscriber rights and responsibilities

At Hereford, subscribers' rights accrued to those contributing a minimum of one guinea on an annual basis for which they could recommend one inpatient and one outpatient each year. For each additional guinea subscribed, an additional inpatient and outpatient could be recommended up to a maximum of five in any year and one at any time. [20] Those subscribing a minimum of 2 guineas per annum or a lump sum of £20 were designated as governors and gained additional rights to participate in the administration of the Infirmary.[21] Day to day supervision was exercised through the activities of the weekly board, which was comprised of a minimum of five governors and met every Thursday morning at 10am.[22] The receiving physician or surgeon examined potential patients before their case was considered against the admission criteria by the weekly board who decided whether or not to admit the patient. The medical staff only had the right to admit patients without the authority of the governors in cases of emergency and two beds were normally kept free for such eventualities. [23] The weekly board were responsible for the general functioning of the institution and two of their members visited the premises daily, supported by the

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[17] Andrew, *Philanthropy,* p.6.
[18] *Rules,* rule 46, p. 14.
[19] *Ibid.* rule 43, p. 13.
[20] *Ibid.* rule 31, p. 10.
[21] *Ibid.* rule 2, p. 3.
[22] *Ibid.* rule 8, p. 4.

honorary 'Visiting Apothecary' who was appointed from among the subscribers to review the work of the paid house apothecary.[24] The weekly board also appointed or discharged nurses and servants and could, with ten members present, suspend the matron, apothecary or secretary.[25] Some privileges were not delegated to the weekly board but were reserved for all governors, the principal ones being the election of candidates to the key posts of physician, surgeon, treasurer, apothecary, secretary and matron and the approval of any amendments to the rules of the charity.[26]

4.1.3 Supporters of the Infirmary

The initial appeal asked both for donations to establish the charity and for annual subscriptions to maintain it. The donations made in the period to 1785 were used to fund the hospital building but those received later were mainly invested in government bonds to generate investment income for the charity. Appendix 5 lists all donors who gave £20 or more to the charity from its inception to 1850, using information taken from surviving *Annual Reports* and the *Hereford Journal,* noting the date of the donation and whether or not it was a legacy. [27] During the early months of the appeal, from February to May 1775, newspaper publicity was used to the maximum. Full details of the names of all donors were listed on a weekly basis together with the amount given and the total of the fund and annual subscriptions pledged to date. The main resolutions of the Infirmary committees charting progress made with planning were also reported.

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[23] *Ibid.* rule 33, p. 10.
[24] *Ibid.* rule 10, p. 4 and rule 13, p. 5.
[25] *Ibid.* rule 17, p. 6.
[26] *Ibid.* rules 16 and 18, p. 6.
[27] There is a complete run of *Annual Reports* for the Infirmary from 1799 to 1850 which allow the year of each donation received after 1799 to be traced. *Annual Reports* also survive for 1785 and 1788, which list all gifts of £20 or more received to those dates and these have been used to provide a range of years between which each donation was received. Reports in the *Hereford Journal* between February and June 1775 enable some donations to be confirmed as pledged in that year. I am grateful to Charles Renton for access to copies of the reports for 1785 and 1788.

Appendix 5 shows that by the end of 1775, donations totalling £3,172 had been pledged, of which £2,600 arose from donations of £100 or more. The largest donation was £500 from Thomas Talbot, the original promoter of the charity, who promised payment on his death. Thomas Foley and George Cornewall, the sitting MPs for the constituency of County Hereford both gave £200 as did the governors of Guy's hospital, who were major landowners in the county. Reverend Bach from Leominster and Michael Biddulph both gave £150 and a further 12 donors gave £100. Three of these were sitting MPs for other Herefordshire seats; John Scudamore and Richard Symonds represented Hereford City and Viscount Bateman, who had paid for the publication of Talbot's addresses, represented Leominster. A further two donors also had parliamentary interests in the county in 1774, the Marquis of Bath who controlled the two seats in the pocket borough of Weobley and Thomas Harley who had stood as an unsuccessful candidate for the County Hereford seat in the 1774 election. [28]All of the other donors of £100 have local addresses and for most of these strong local connections are confirmed. Among them was Richard Payne-Knight, the well-known classical scholar and critic who rebuilt Downton Castle in the picturesque style and who served as MP for Leominster from 1780 to 1784. His friend and fellow enthusiast for landscaping, Uvedale Price of Foxley, also gave £100, as did John Egerton, Bishop of Durham, who had promoted the pleasures of river trips down the Wye while Rector at Ross-on-Wye from 1745 to 1771. The remaining principal donors were John Freeman of Letton, who became the first Chairman of the governors, his son John, the corporation of Hereford and Mrs Bourne of Whitney Court, who was the only woman among this group. A further two members of the Biddulph family and Mrs Cocks donated £50 each. In June 1775 the *Hereford Journal* reported that total benefactions of £3,483 had been promised

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[28] Brief biographical details are also summarised in Appendix 5. Sources used include Namier and Brooke, *History of parliament* and Williams, *Herefordshire members*.

together with annual subscriptions of £714 per year.[29] Table 4.1 below shows the relative importance of the various sizes of donations. The 18 donors pledging £100 or more account for 75 per cent of the total capital pledged while the smaller donations of under £20 contribute only 9 per cent of the total. The 37 donors who gave £20 or more, and therefore became eligible to become life governors at the institution, together contributed 91 per cent of the appeal funds. The additional £311 reported in the *Hereford Journal* is assumed to have come from donors giving under £20 each, indicating that there was broad support for the Infirmary from among the community.

Table 4.1: Donations to Hereford Infirmary to June 1775.

Size of donation	£100 & over	£20 to £99	Under £20	Total
Numbers of Donors	18	19	98	135
% of total donors	13%	14%	73%	
Amount of donations	2,600	572	311	3,483
% of donations	75%	16%	9%	

Source: Appendix 5 and *Hereford Journal,* 7June 1775.

By the time the Infirmary moved to its new purpose-built premises in 1785, a further £1,900 had been given as one off donations of £20 or more. The majority of this came from six legacies totaling £990, three of which were above £100. Lord Foley, who had contributed £200 to the initial fund in 1775, left a further £300 on his death in 1777, but neither Sara Swift of Worcester who left £500 or Sir Francis Charlton who left £100 had previously been major donors to the institution. Another three donations (rather than legacies) of £100 were also received in this period. The donors were Charles, 10th Duke of Norfolk who had married into the local Scudamore family in 1771; Rowles Scudamore, a Bristol based merchant with family links in the county and the Dowager Lady Conningsby of Hampton Court near Leominster.

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[29] *Hereford Journal*, 7 June 1775.

Roy Porter has argued that it was the major landowners and upper clergy who contributed the majority of the funds to establish the eighteenth-century provincial infirmaries.[30] The evidence for Herefordshire confirms that it was the leading members of local society, the few aristocratic families, all those with parliamentary interests and the major landowners who contributed the very largest sums and the majority of the fund. However, these were a minority of the total numbers subscribing to the initial building fund appeal. By 1785 there had been 24 gifts that exceeded £100, contributing £3,590, but a further 40 between £20 and £99.[31]

Table 4.2 presents the social status of all those who contributed £20 or more to the Infirmary appeal between 1775-1785 in order to examine how successful the appeal was in attracting support from across local society. The analysis does not include those giving amounts of less than £20 as although it is clear that smaller amounts were given to the appeal, records of donors or of the total amount contributed have not survived. The largest proportion of donors are those individuals recorded as esquires, who made up 58 per cent of the donors and 34 per cent of the total fund, giving on average just over £50 each. The 7 women recorded with the title Mrs most likely also belonged to this group, making a total of 69 per cent of the total number of donors and 50 per cent of the total value of the fund. This group includes a wide range of individuals from among the country gentry, ranging from some of the leading members of the elite such as Uvedale Price and sitting MPs to more modest individuals. Eight clergymen are recorded as donors, 13 per cent of the total number, donating 17 per cent of the fund. If Thomas Talbot's donation of £500 is excluded, the average donation by the clergy is also just over £50. Only 6 members of the nobility contributed but their gifts averaged £167. Knights and Baronets made up 6 per cent of donors with an average donation of £87 and there were two institutional

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[30] Porter, 'Gift relation', pp. 158-159.
[31] Appendix 5.

donors, Guy's Hospital and Hereford corporation who donated £200 and £100 respectively. In summary, therefore, it was the untitled gentry who contributed the majority of the funds raised from individual donations of £20 or more and who were also the most numerous group, followed in importance by the clergy.

Table 4.2: Social status of donors of £20 or more to Hereford Infirmary to 1785.

Category	Number	% of total donors	£ given	% of £ given	Average £ given
Mrs	7	11	810	16	£116
Esquires	37	58	1,730	34	£51
Clergy	8	13	882	17	£110
Knights & Baronets	4	6	350	7	£87
Nobility	6	9	1,000	20	£167
Institutions	2	3	300	6	£150
Total	64	100	5,072	100	

Source: Hereford Infirmary *Annual Report* 1785.

A number of studies have examined the social status of annual subscribers to eighteenth-century infirmaries and this body of evidence suggests that patterns varied across the country.[32] Table 4. 3 provides a summary of the social background of annual subscribers to Hereford Infirmary in 1785 and includes comparative information for the infirmaries at Exeter and Northampton taken from a study by Amanda Berry. In order to improve the degree of comparison, the categories used by Berry have been applied to the Hereford data.[33]

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[32] Particular use is made in this section of the following studies, Berry, 'Patronage, funding and the hospital patient', Borsay, *Medicine and charity* and Lane, *Worcester Infirmary.*

[33] Berry, *'Patronage',* p. 43. The comparative figures used are those calculated by Berry as averages over a number of years.

Table 4.3: Social status of subscribers to Infirmaries at Hereford, Exeter and Northampton.

Category	Hereford 1785 No. of Subscribers	Hereford 1785 % of subscribers	Exeter % of subscribers samples 1750-1815	Northampton % of subscribers samples 1750-1815
Mr, Mrs & Miss	133	53.9	48.0	41.4
Knights, Esquires & Gents	50	19.4	24.1	23.8
Clergy (all)	49	19.8	17.2	21.4
Unknown	4	1.7	4.6	3.5
Nobility	9	3.6	3.5	5.8
Military & Professional	4	1.6	3.0	4.0
Total	249	100	100	100

Source: Hereford Infirmary *Annual Report* for 1785 and Berry 'Patronage', p. 43.

At Hereford, 54 per cent of supporters were commoners, the highest proportion at any of the three infirmaries, with the remaining subscribers mainly being gentlemen or clergymen with approximately 20 per cent in each category. At both Northampton and Exeter the proportion of subscribers who were esquires and gentlemen was higher than at Hereford and at Northampton the proportion of the clergy was also higher than Hereford. At Hereford, 15 per cent of recorded subscribers were female, compared to Berry's calculation of 17 per cent at Exeter and 21 per cent at Northamptonshire for selected years in the period 1750-1815. These figures all exceed the proportion of female subscribers identified by Joan Lane for four infirmaries in the Midlands in 1787 which ranged from a low of 6.3 per cent at Stafford, to 14.9 per cent at Worcester.[34] The support given to the Infirmary by commoners through their annual subscriptions was therefore crucial to the financial success of the charity at Hereford, although this group were not identified as important among those giving one-off donations of £20 or more.

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[34] Lane, *Worcester Infirmary,* p.17. The other figures identified were 10 per cent at Birmingham and 11.8 per cent at Oxford.

Table 4.4 examines the social status of the 134 people subscribing 2 guineas or more who qualified as governors of the institution. This shows that while governors came from all social groups, it was commoners, with the title Mr, Mrs and Miss, who are comparatively under-represented. Of the 133 subscribers in this category, only 40 subscribed at the level required to qualify as governors, in contrast to all those in the category of Knights, esquires and gentlemen and 71 per cent of subscribing clergymen. Although they made up 54 per cent of subscribers, commoners only made up 30 per cent of the total of governors, the majority of who were members of the gentry or clergy.

Table 4.4: Social status of subscribers of 2 guineas or more to Hereford Infirmary in 1785.

Category	Number subscribing	% subscribing
Mr, Mrs & Miss	40	30
Knights, Esquires	50	37
Clergy (all)	35	26
Nobility	4	3
Medical	5	4
Total	134	100

Source: Hereford Infirmary *Annual Report* 1785 and Appendix 7.

Support for Hereford Infirmary came overwhelmingly from local people. Table 4.5 shows that 94 per cent of all subscribers in 1785 were listed as resident in Hereford or Herefordshire. Although 6 per cent were listed in the subscription lists as resident out of the county, a clear link between several of these subscribers and the county can be established. One was Francis Biddulph, partner in the firm of bankers to the Infirmary who maintained a family seat near Ledbury and another was John Harley, younger brother of the Earl of Oxford, who is recorded as Dean of Windsor but later became Bishop of Hereford. The predominance of local networks of support

is similar to that recorded for the Devon & Exeter hospital, the Northampton Infirmary and for Worcester Infirmary.[35]

At the time of the launch of Hereford Infirmary appeal, there were no similar institutions in Wales and a direct attempt was made to attract support from the surrounding Welsh counties where many of the leading Herefordshire families also had some influence. An address was drawn up and published in the *Hereford Journal* and other papers circulating in the neighbouring Welsh counties of Monmouth, Brecon and Radnor.[36] Despite these efforts, there is no evidence of significant support from outside the county, even from families with Herefordshire connections.

Table 4.5: Place of residence of subscribers to Hereford Infirmary in 1785.

Place of residence	Number recorded	Number recorded	%of total subscribers
Hereford		109	44%
Herefordshire		124	50%
Worcester	2		
Gloucester	3		
Other	1		
Bristol	5		
London	5		
Total other places		16	6%
Total subscribers		249	100%

Source: Hereford Infirmary Annual Report 1785.

For some donors, the donations made to Hereford Infirmary were a part of a wider support for similar institutions. Joan Lane identified several donors to Worcester Infirmary who also gave to the Herefordshire Infirmary. These include Thomas Foley, one of the original subscribers to Hereford, who had donated £100 to the Worcester Infirmary appeal in 1761 and subscribed five guineas a year to that charity and Edward Foley of Stoke Edith who also supported both institutions. Michael Biddulph of Ledbury Park contributed three guineas a year to Worcester and

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[35] Berry, 'Patronage', pp. 30-35 and Lane, *Worcester Infirmary,* pp. 10-14.

the Reverend Benjamin Biddulph of More Court also supported both establishments in addition to contributing to Stafford Infirmary. Lady Francis Coningsby who donated £100 to Hereford had been a subscriber to Worcester since 1754 while Edward Garlick, a Bristol merchant who gave £20 to Hereford, had provided the purchase price of the land for the new Infirmary at Worcester.[37] The importance of local networks of patronage for the provincial infirmaries is therefore well established. The main exceptions to this pattern that have been identified are the Bath Infirmary and the London based charities that drew support from the many individuals attending the social season in those cities.[38]

Table 4.6 shows the numbers of subscribers and the proportion of them that subscribed at a level to become governors for selected years between 1785 and 1850.

Table 4.6: Governors of as a proportion of total subscribers at Hereford Infirmary for selected years.

Year	**1785**	**1805**	**1815**	**1825**	**1836**	**1844**
Number of Governors	134	70	136	149	152	160
Total subscribers	249	176	246	297	302	283
% of subscribers that were governors	54%	40%	55%	50%	50%	56%
Value of subscriptions in year £	£555	£401	£539	£640	£616	£608
Proportion of subscriptions from governors	79%	82%	79%	76%	74%	79%

Source: Hereford Infirmary *Annual Reports* for 1785,1805,1815,1825,1836 and1844.

In 1785, 54 per cent of all subscribers gave at a level that entitled them to become a governor. This proportion fell to 40 per cent in 1805 but then increased to

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[36] *Hereford Journal*, 15 Aug. 1775.
[37] Lane, *Worcester Infirmary*, p.14.
[38] Borsay, *Medicine and charity*, pp. 276-277 and Andrew, *Philanthropy*, pp. 74-97.

between 50 and 56 per cent for the remainder of the period. The total number of subscribers recorded in 1785 was 249, dipping to 176 in 1805 before rising to 246 in 1815 and stabilising at about 300 to 1844. The maximum number of annual subscribers listed in the selected years is 302 indicating that patronage of the Infirmary was limited to a relatively few individuals. The proportion of subscription income that came from governors was between 74 and 82 per cent throughout the period. It would appear, therefore, that the additional privileges accruing to governors were attractive to a large proportion of those subscribing. These privileges mainly related to the opportunity to participate in the managerial affairs of the charity, and the extent to which governors chose to exercise these rights is discussed in section 4.2.

The clergy were always significant supporters of the Infirmary at Hereford. Thomas Talbot was the original promoter and provided the largest of the initial donations to the charity appeal and the donation of £5,000 from George Harris in 1799 transformed the financial fortunes of the institution. In addition to providing financial support the clergy also participated as active governors and as figureheads for the charity and undertook the pastoral care of patients. The rules made it clear that the weekly board were charged to 'take Care that Patients of all persuasions may be attended in the manner they desire, and have leave to repair to their respective Places of Worship twice every Sunday'. [39] Although this indicates that there was no intention of a monopoly by the established church, in practice the Bishop and cathedral clergy exercised significant influence. The original rules of the Infirmary referred to the visiting clergy who were 'to visit the Sick and administer the Sacrament when required, and to read prayers on Monday, Wednesday and Friday, and to administer the Sacrament regularly the First week in every other Month'. [40] In recognition of the value of their services to patients, the visiting clergy who

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[39] *Rules*, rule 97, p. 24.
[40] *Ibid*.

subscribed one guinea were to have the full rights of a governor. [41] The arrangements for the provision of these services for the early years of the Infirmary are not clear but in 1795, the Bishop of Hereford launched a subscription to fund a permanent chaplain for the Infirmary. A sum of £14 13s was raised from twenty-eight contributors from among the clergy and from this time on the established church funded a dedicated chaplain to work at the Infirmary.[42]

4.2 Financial performance and management

4.2.1 Financial performance

The financial fortunes of Hereford Infirmary can be traced from the printed *Annual Reports* and references to financial matters in the minute books. Appendix 6 presents summary income and expenditure accounts prepared from information in the accounts published in the *Annual Reports*. These record income and expenditure received on a cash basis. One-off donations and investments purchased have been excluded in order to generate an assessment of whether the charity's regular income was sufficient to cover its expenditure, shown by the surplus or deficit calculated for the year. There is an unbroken run of reports from 1799 to 1850 plus three earlier reports for 1785, 1788 and 1791. The net surplus for the period 1799 to 1850 amounted to £1,476 with annual deficits recorded in 23 of the 51 years. Figure 4.2 presents the total income and expenditure figures for 1799 to 1850 from Appendix 6 to illustrate the general trend over the period.

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[41] *Ibid.* rule 12, p. 5.

[42] Revd Garbett served from 1802 to 1827, Revd Gretton from 1827-1840 and Revd Joseph Henry Barker from 1840.

HEREFORD INFIRMARY INCOME AND EXPENDITURE 1799-1850

Figure 4.2: Hereford Infirmary: total income and expenditure 1799-1850

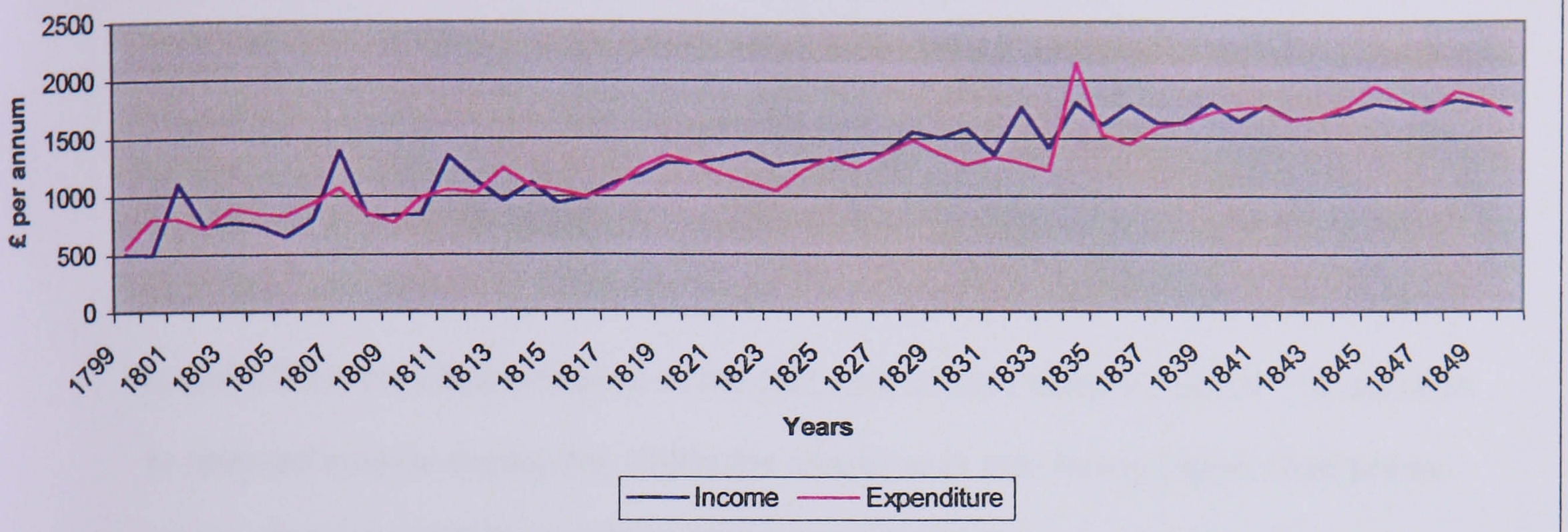


Figure 4.3: Hereford Infirmary: sources of income 1799-1850

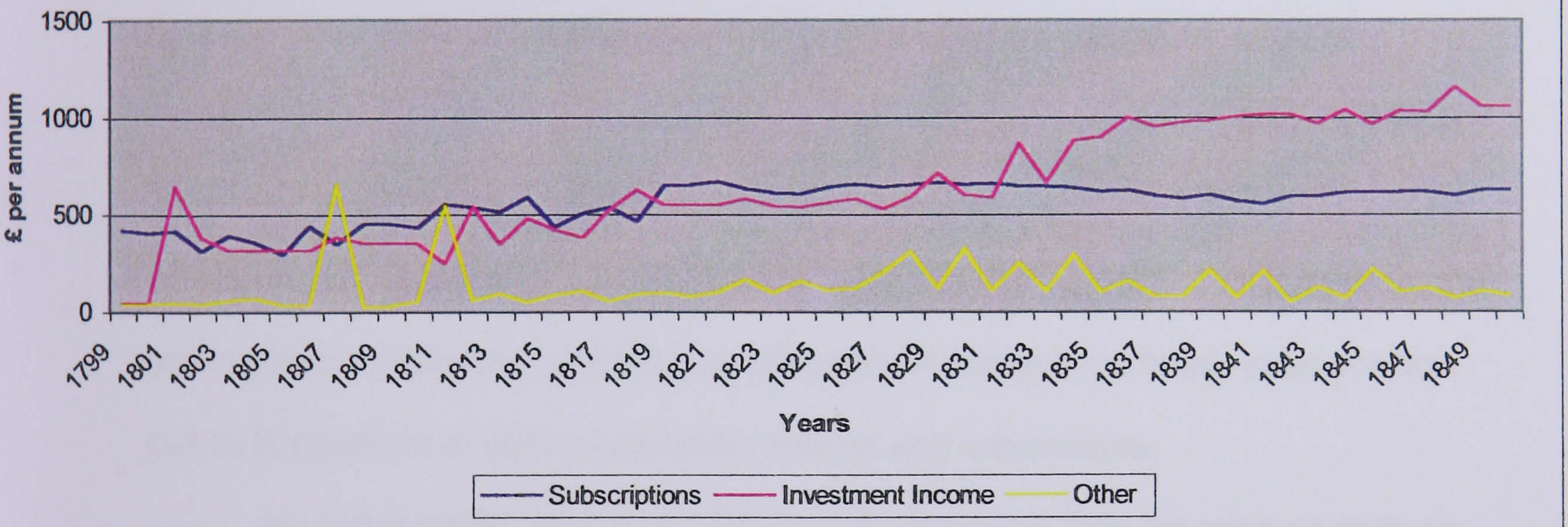
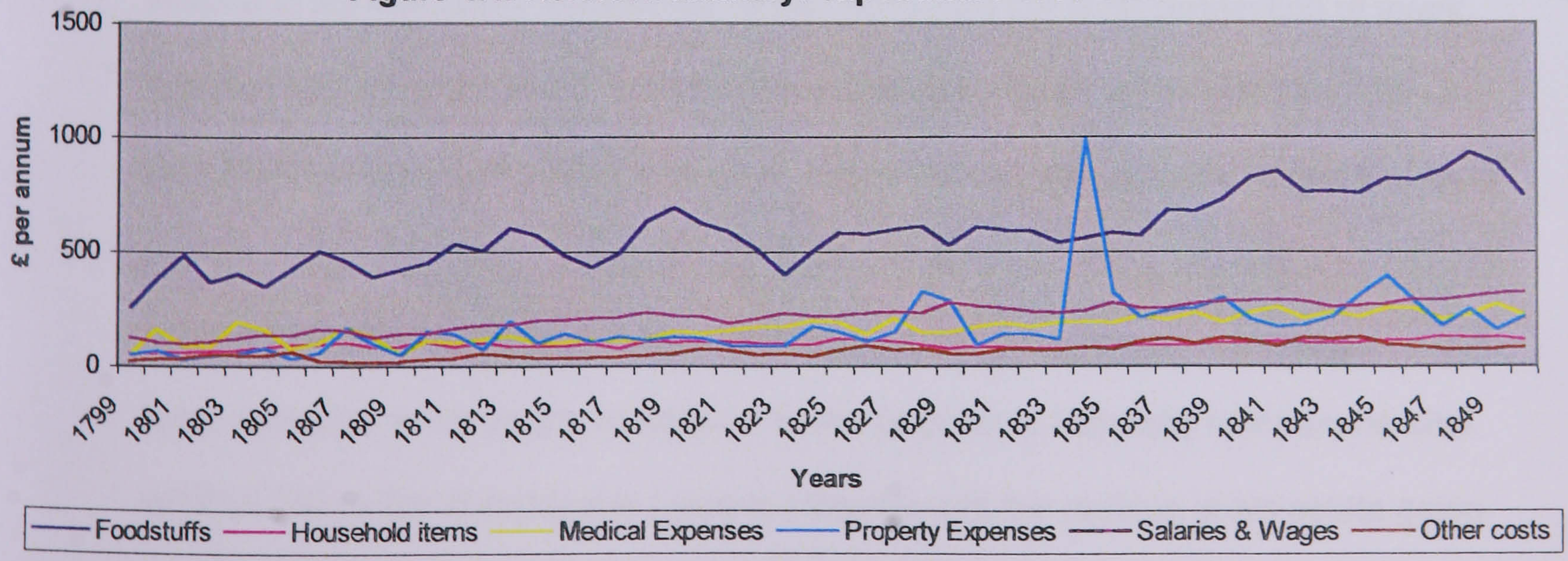


Figure 4.4: Hereford Infimary: expenditure 1799-1850



Both income and expenditure rose over the period and were almost equal in 1799 and 1850. In general the Infirmary managed to keep expenditure below income received although it did face periods when income was insufficient to meet outgoings. The records show that the Infirmary faced deficits throughout the 1780s and 1790s. In 1791 the governors agreed to the sale of £200 of investments to fund the deficit and three years later, in 1797, the Governors noted that subscriptions had declined to £460 from the £836 achieved in the first year of the Infirmary appeal.[43] In addition to reduced income during the 1790s the charity was also facing higher food prices and by 1800 the deficit was £307. These financial problems were not unique to Hereford as several provincial infirmaries are reported to have faced similar difficulties due to the depressed war time economy. [44] In the following year, 1801, the financial crisis at Hereford was significantly helped by the receipt of £600 of investment income most of which was two years interest accrued on a £5,000 legacy from Dr George Harris. Investment income stabilised at between £300 and £400 per annum for the next decade. While this improved the Infirmary's financial position, the organisation continued to experience difficulties in achieving a break-even position due to fluctuations in both subscription income and expenditure.

As noted earlier, Hereford Infirmary had benefited from legacies as early as 1785, and the bequest from George Harris confirmed the importance of this source of income to the institution. As with the earlier donations the local connection of many legatees can be established. Harris's father had been Dean of Hereford in 1729 and later Bishop of Llandaff based at Brecon. Harris himself was a doctor of law and legal advisor to three dioceses acting as chancellor for Durham, Hereford and Llandaff. He was an annual subscriber of three guineas to the Infirmary and had donated £20 in a lump sum prior to his death. In addition to the bequest to Hereford Infirmary he also left £15,000 to the Westminster Lying-in Hospital with the residue of his estate going

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[43] *Annual Report*, 1791 and Minutes of Governors' Meetings, 15 June 1797.
[44] Berry, 'Patronage', pp. 126-129.

to St George's Hospital, London.[45] The listing of donations above £20 to the Infirmary at Appendix 5 shows that from 1800 onwards the majority of gifts above this level were in fact bequests rather than gifts from living benefactors. The cumulative total of gifts and legacies of £20 or over left to the Infirmary up to 1850 was £33,006 of which £27,484 or 83 per cent came from legacies. Three bequests accounted for 62 per cent of the legacy income, the £5,000 from George Harris, £2,000 received from Henry Jones in 1818 and £10,000 received from John Morris in 1833. This situation is contrary to the experience of the London-based associated charities studied by Donna Andrew in the eighteenth century. Andrew argues that posthumous gifts went out of fashion and that although legacies did continue and charities actively solicited them, investment income made up only about 20 per cent of charitable income. [46] Figure 4.3 presents the Infirmary's sources of income over the period 1799-1850. In 1801-1802 investment income exceeded subscriptions due to the receipt of accrued income from Harris's legacy, but then fell back to just below the level of subscriptions. In 1818 investment income rose again on receipt of the legacy from Henry Jones and in the period to 1830 represented about 85 per cent of the value of annual subscriptions. Following the receipt of the legacy from John Morris in 1835, investment income exceeded that from subscriptions and by 1850, subscription income was only 59 per cent of the annual income from dividends and interest.

The relative importance of investment income at Hereford is due both to the high level of legacy income and the relatively low level of subscription income achieved by the charity. Subscription income in the first year of the appeal, 1775-1776, was £836 but this had fallen to £603 by 1785 and declined to as low as £295 in 1805. Income for subscriptions did not exceed £600 again until 1819 after which it stabilised at about this level. For most of the period levels of subscription income were insufficient to cover the ordinary expenses of the charity and it was only the

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[45] Renton, *Herefordshire's hospitals*, p. 26.
[46] Andrew, *Philanthropy,* p. 79.

growing levels of investment income after 1801 that enabled the Infirmary to remain solvent.

Comparison with other infirmaries suggests that subscription income at Hereford was low due both to the small number of subscribers and the low level of subscriptions. Table 4.7 provides comparative information on changes in the number of subscribers compared to the increase in population over the period 1765 to 1815 with the three provincial infirmaries in Amanda Berry's study.

Table 4.7: Change in number of subscribers and population for selected voluntary infirmaries.

Infirmary & number of beds	Subscribers 1765 (Hereford 1785)	Subscribers-1815	Increase (% increase)	Population 1811 (% increase c1750-1811)
Bristol 132 beds (1755)	466	1307	841 (180%)	76,433 (115%)
Devon & Exeter 160 beds (1773)	513	606	93 (18%)	18,896 (18%)
Northampton 60 beds (1775) 85 beds (1787)	225	441	216 (96%)	8,427 (64%)
Hereford 54 beds (1785)	249	246	(3) (-1%)	7, 306 (31%)

Source: Hereford Infirmary *Annual Report* 1785 and Berry 'Patronage', pp. 27-29.

Hereford is the only infirmary to show a decline in subscribers over the period. Berry notes that the increase in subscribers recorded in her sample equalled or exceeded the population growth in the city where the Infirmary was situated.[47] In contrast, the reduction in subscribers in Hereford occurred despite the fact that the population of Hereford City increased by at least 31 per cent. Hereford is most similar to Northampton in terms of population and the number of beds, but appears to have been not nearly so successful in attracting the support of subscribers.

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[47] Berry, 'Patronage', pp. 27-30.

At Hereford the minimum subscription levels were set at 1 guinea for a subscriber and 2 guineas for a governor. A small number of subscribers chose to donate at a higher level but the maximum level of subscription recorded is 10 guineas per annum. Although Exeter and Northampton also accepted subscriptions of 1 guinea per annum, the maximum subscriptions exceed those at Hereford, being 20 guineas at Exeter and 30 guineas at Northampton. The maximum subscription at Bristol was 15 guineas and the minimum was 2 guineas.[48] As noted earlier, around 50 per cent of Hereford subscribers chose to be governors subscribing at a level of 2 guineas or more. There is no record at Hereford of discussions about increases in the minimum subscription level or of encouraging a greater proportion of subscribers to increase their subscription level to 2 guineas. An additional problem experienced was the difficulty in collecting subscription income, and delays in paying promised subscriptions were a considerable issue until the 1820s. For example, of the £295 recorded as cash subscriptions in the year ending 1805, £48 related to arrears due for previous years and £245 to the current year. Total subscriptions pledged for the year were £417, so that only 59 per cent of subscriptions pledged had been paid.[49] Up to 1823, the accounts recorded the total of subscriptions in arrears and by the 1820s this was running in excess of £100 a year. In 1823 the format of the annual list of subscribers was amended to show the names of every individual subscriber in payment arrears. This public naming and shaming appears to have been successful and by 1824 arrears were down to £5 and remained below £30 for the rest of the period.

As shown in Appendix 6 and Figure 4.3, income from sources other than subscriptions or investment income made a minor contribution to overall income at the Infirmary. The principal exceptions to this were £612 raised in an appeal organised by the Bishop of Hereford in 1807 and the £330 proceeds from the sale of

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[48] *Ibid.* p. 69.
[49] *Annual Report,* 1805.

the old Infirmary building in 1811. Later in the period, some fundraising was linked to social events, in particular dinner parties; for example £5 6s 6d was raised from four dinner parties in 1820. In 1822, £2 11s 9d was raised from a 'Horsemanship performance', while other subscribers passed on monies collected as fines to the charity. The income raised from these activities reflects the merging of philanthropic and social activities that it is suggested were a factor in the popularity of these institutions with subscribers.[50] The cathedral clergy also participated in specific fundraising appeals from time to time. In 1806, Bishop Luxmore allowed a sermon to be preached in support of the Infirmary and a collection raised in all parish churches on a designated Sunday. [51] Although this did not become an annual event, it was repeated in 1826.[52]

How far did Hereford fit the classic model for a voluntary subscription hospital? In the early years the initial appeal attracted the support of the aristocracy and elite leaders in the county as well many of the minor gentry and the rural clergy. Despite this, purpose-built premises were not opened until almost ten years after the initial appeal. By the 1790s subscription income had fallen to less than half that achieved in its first year and the charity was facing significant financial problems. In the eighteenth century the Infirmary was reliant on subscription income but failed to attract sufficient support to maintain financial balance. The situation was transformed by increased levels of legacy income received during the nineteenth century and by 1850 investment income accounted for the majority of annual income. Although subscription income always remained an important source of income, the charity failed to attract the support of many potential subscribers in the neighbourhood, despite a low subscription level of 1 guinea.

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[50] Borsay, *Medicine and charity,* p. 81.
[51] Minutes of Governors' Meeting 17 and 26 June 1806.
[52] *Annual Report,* 1826.

4.2.2 Financial management of the Infirmary

This section examines evidence relating to the management of the Infirmary, to identify those governors who chose to become actively involved in its day to day running and the relationships between them. As noted in Table 4.6 above and discussed earlier, the number of subscribers who qualified as governors at Hereford Infirmary exceeded 100 throughout the period and represented between 40 to 55 per cent of all subscribers. Despite the large number of governors, records of attendance at meetings show that very few of these actually exercised their right to active managerial participation. The weekly board required five governors to attend but it appears that it was difficult to engage even this small number. Although the rules stated that there should be a general meeting of the governors at least four times a year, there were many occasions when this did not occur. [53] In 1799 the minutes record that 'House visitors are particularly requested to make one of their visits on a Thursday from the great necessity there is of making the attendance at the weekly board sufficiently numerous and respectable.' [54] In 1809, in an effort to encourage more involvement by governors, rule 20 was amended to change the date of the Annual General Meeting from an unspecified date in June or July to one of the mornings of the summer racing meeting. This normally coincided with the Summer Assizes in August and the annual commemorative service in the cathedral was also rescheduled for that week.[55] Problems in attracting subscribers and active governors persisted and in 1830 it was noted that even the current MPs for Leominster and Weobley did not subscribe to the Infirmary. The failure to gain the active support from such prominent county men indicates that support for the Infirmary was at a low ebb.[56] In 1836 the Anniversary sermon had to be postponed due to poor attendance

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[53] For example, the Minutes of Governors' meetings for 1794 record that meetings were adjourned on 16 Jan., 30 Jan., 13 Feb. and 21 March as no governors were present.
[54] Minutes of Governors' Meeting, 20 Jan. 1799.
[55] *Ibid.* 20 Dec. 1809.
[56] *Ibid.* 20 Aug. 1830.

as only fourteen ladies, eight gentlemen and the cathedral staff had turned up for the service in the cathedral. [57] This was a considerable snub as the Bishop normally preached the sermon. The problem of attracting active governors was not unique to Hereford; enthusiasm for administrative duties was frequently highest in the early years of an institution but became more difficult to maintain after that. [58] However, one reason for the lack of a broad-based support for the Infirmary at Hereford could have been the domination of management committees by members of Hereford corporation.

The rules provided for various honorary positions to be filled from amongst the governors. Joseph Perrin, a member of the city corporation, was appointed the first treasurer and George Terry and Reverend Morgan were appointed auditors. The two MPs elected for the county in 1774, Sir George Cornewall and Thomas Foley, were appointed to act as trustees for any funds held in private securities.[59] Biddulph and Cocks in London and Bright, Ames & Co of Bristol were appointed as bankers and correspondents to the Society authorised to receive subscriptions directly from subscribers. Both these banks were linked to personal subscribers to the Infirmary, the Biddulph family from Ledbury and Lowbridge Bright respectively. Joseph Perrin served as treasurer from 1775 and gave notice of his wish to resign this office in 1794. However, no one came forward to take his place and Perrin continued in post until his death in 1799.

The funding model for voluntary hospitals applied the commercial idea of the joint-stock company to a charitable purpose in which subscribers joined together to fund and manage an institution that would be an exemplary model of both civic virtue and financial good practice.[60] Strategies used to achieve this included linking financial sponsorship with engagement in the hospital's administrative structure and

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[57] *Ibid.* 28 July 1836.
[58] Borsay, *Medicine and charity,* pp. 26-31.
[59] *Hereford Journal,* 11 Aug. 1775.

close monitoring of income and expenditure. By linking financial sponsorship and managerial participation, the intention was to minimise the potential for fraud and maladministration, as subscribers would be keen to ensure that proper use was made of the funds they had contributed. Control was to be exercised by those who contributed most to the organisation and had gained the rights of a governor of the Infirmary.

The financial regime adopted was intended to ensure probity and those associated with the Infirmary were expressly forbidden from taking any 'fee, reward or gratuity of any kind' from 'any tradesman, patient, servant or stranger' on threat of expulsion. [61] Contracts for provisions were awarded on the basis of sealed tenders from potential suppliers by the weekly board which also reviewed all requests for payment with authorisation evidenced by the signature of the Chairman and two members of the board prior to payment by the treasurer or secretary.[62] The apothecary and matron were both given access to limited funds for household and drug expenses but had to submit these for weekly review by the management board.[63] Despite these precautions, the Infirmary was caught out in 1793 when Mr Blackfield, the apothecary, resigned and left owing a debt of £50 to the Infirmary. Future incumbents were required to give a surety of £100 to avoid anything similar happening in future.[64] The measures implemented in Hereford were all commonplace in eighteenth-century infirmaries, part of a concerted attempt to avoid any risk of embezzlement or allegation of corruption.[65] As noted above, the late 1790s were years of financial crisis for the charity and the governors had also taken on the building of a private asylum. [66] When Perrin tendered his resignation as treasurer in

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[60] A. Borsay, ' "Persons of honour and reputation": the voluntary hospital in an age of corruption', *Medical History,* 35 (1976), pp. 203-210.
[61] *Rules,* rule 26, pp. 8-9.
[62] *Ibid*, rules 14-15, pp. 5-6.
[63] *Ibid*, rule 68, p. 19.
[64] Minutes of Governors' Meetings, 7 Nov. 1793.
[65] Borsay, 'Persons of honour', pp. 286-289.
[66] The development of the lunacy charity is discussed in detail in Chapter 5.

1794, considerable additional work was in hand to update subscriber records and chase subscription arrears.[67] It could be argued that the charity had suffered from financial mismanagement, having failed to attract subscribers or even to collect monies efficiently from those who had pledged their support. It might have been expected that subscribers and governors would have been asking for a change of treasurer but instead it would appear that there was little interest and no momentum for change from the dwindling number of supporters.

Appendix 6 and Figure 4.2 shows that expenditure rose steadily between 1799 and 1850. Table 4.8 below sets out the proportions spent in each of six broad categories for 1785, 1800 and subsequent intervals of ten years. Foodstuffs were the main category of expenditure, accounting for between 41 and 48 per cent of the total in the selected years. Medical expenses represented 26 per cent of total expenditure in 1785 but later declined to 11 per cent of the total before rising slightly to 13 per cent. The proportion spent on salaries and wages increased over the period from 13 per cent in 1785 to a maximum of 21 per cent in 1830 before declining slightly to 18 per cent in 1850. Property expenses also increased over the period but were also much more variable, depending on repairs and extension work being carried out. In 1834, a new extension opened which increased the number of beds from 55 beds to 70 and also increased overall expenditure by some £300 a year.

Table 4.8: Hereford Infirmary: proportions of expenditure by category for selected years, (all shown as percentages).

	1785 %	1800 %	1810 %	1820 %	1830 %	1840 %	1850 %
Foodstuffs	41	48	46	48	48	47	44
Household items	9	8	11	9	7	6	7
Medical expenses	26	20	11	11	13	13	13
Property expenses	7	8	15	9	7	12	13
Salaries & wages	13	13	14	17	21	16	19
Other costs	4	3	3	6	4	6	4
Total Expenditure	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: HRO S60, Hereford General Infirmary, Annual Reports for selected years.

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[67] Minutes of Governors' Meetings, 30 Apr. 1794.

Appendix 6 also provides annual figures for these categories which are presented in Figure 4.4. While household items, medical expenses and salaries and wages increased steadily over the period, the cost recorded for foodstuffs fluctuated considerably. The price paid for bread illustrates the problems of controlling expenditure as between 1799 and 1801 the cost paid by the Infirmary more than trebled.[68] In 1800 the price of bread increased so considerably due to a poor harvest and import restrictions that a general proclamation was issued across the country to restrict bread consumption. Amanda Berry records examples of measures taken to restrict the consumption of bread by substitution with other foodstuffs; potatoes at Leeds and Northampton, rice in Norfolk and pease pottage in Nottingham. [69] There is no record of such measures being considered at Hereford.

Property expenditure included repairs and work on extending the Infirmary. The increase in spending in 1834 is due to the costs of the new extension, and property expenses are more stable after this date. The cost of salaries and wages rose steadily over the period from £86 in 1785 to £322 in 1850. The pattern of expenditure recorded at Hereford is slightly different from that at the three infirmaries in Amanda Berry's study. Although foodstuffs were the main expense items at all three hospitals in her study, medical supplies took second place, then domestic items, and then salaries and wages.[70] Whatever the exact proportions, medical costs were only a minority of the total costs of the infirmaries, the majority being spent on the provision of bed and board and the maintenance of buildings. Irvine Loudon argues that this perceived inefficiency of the infirmaries was one reason for the popularity of the charitable dispensary model.[71] In contrast to infirmaries,

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[68] Data from the *Annual Reports* has been used to estimate an average cost paid per bushel in each year. This rose from 7s 4d in 1799 to £1 0s 4d in 1801 before falling to 7s 9d in 1805.
[69] Berry, 'Patronage', p.141.
[70] *Ibid.* pp.137-139.
[71] Loudon, 'Origins and growth of the dispensary movement', pp. 338-340.

dispensaries provided care in people's homes or on an outpatient basis and saved many of these costs.

4.3 Medical services at the Infirmary

4.3.1 Medical personnel

In common with other voluntary infirmaries, medical services at Hereford were provided on an honorary basis and in 1776 three honorary physicians and two honorary surgeons were appointed. The medical personnel serving between 1775 and 1850 are listed at Appendix 7. The Infirmary rules included the requirement that those seeking an honorary appointment should have practised in Hereford for a minimum of two years and all of the appointments made in 1776 were of men with longstanding Herefordshire links. Three were members of the Cam family whose medical connections can be traced to the apprenticeship of a John Cam with Samuel Pye of Bristol in 1714 and who later took at least three apprentices in Hereford during the 1720s and 1730s.[72] John Cam was appointed as one of two honorary physicians and two other family members, Thomas and William Cam, were appointed honorary surgeons. Thomas Cam had three sons, all of whom became surgeons, and two of whom, Tom and Samuel, later acted as honorary surgeons at the Infirmary. The second physician to be appointed was Francis Campbell, a graduate from Glasgow University and the third surgeon appointed was Richard Hardwicke.[73]

In 1776, there was no real competition for the posts of honorary physician at the Infirmary as there were only four physicians practising in the county of which two were based outside Hereford. [74] These would have found it difficult to be able to fulfill the responsibilities of the honorary posts while maintaining their private practice and the two Hereford based physicians, John Cam and Francis Campbell, were duly

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[72] Wallis and Wallis, *Eighteenth-century medics.*
[73] *Hereford Journal,* 30 March 1776.

elected. Both were both members of the thirty-strong Hereford corporation and had significant reputation and influence within the city. Competition for the posts of surgeon was potentially greater due to the larger number of practitioners based in Hereford, but as noted, two of those selected were from the Cam family, suggesting that patronage played a significant part in the elections. It is clear, therefore, that the hospital appointments reinforced the existing professional and political elites in the city. As shown in Appendix 7, once appointed, the honorary appointees held the positions for a considerable period of time. From 1792, the Infirmary introduced the additional honorary posts of Physicians and Surgeons Extraordinary, which were filled by long standing honorary personnel in recognition of their contribution and service to the charity. These appointments also served to further support existing hierarchies.

Although the rules gave all governors the right to vote in the elections for honorary positions, in practice few chose to exercise this right. Medical practitioners who were associated with the corporation continued to dominate the honorary positions, elected by a very small number of governors. In 1794 there was a change of both surgeon and physician. Richard Hardwicke who had served from the inception of the charity had died and a meeting of only six governors agreed that an advertisement should be placed in the papers.[75] The six governors present at this meeting were Campbell, Cotes and Blount, Lacon Lambe, Joseph Perrin and John Nash. Francis Campbell was one of the two Physicians Extraordinary at the Infirmary, Blount was one of the serving honorary physicians while Thomas Cotes was a prospective candidate for the position of surgeon. Lacon Lambe was a member of Hereford corporation who served for a long period as town clerk and Joseph Perrin was also a member of the corporation. John Nash attended as he was the architect for the new charitable Hereford Asylum and was overseeing its

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[74] The number of medical practitioners in the county is discussed in Chapter 2.
[75] Minutes of Governors' Meetings, 30 April 1794.

construction. The minutes later record that Cotes was elected as surgeon and make no reference to any other candidate. At the same meeting it was noted that Thomas Cam, the other surgeon, had resigned and was to become Surgeon Extraordinary and that his son, Thomas Cam Junior, was elected to the other surgical post.[76] The dynastic domination of the Cam family over Infirmary positions was further consolidated in 1800, when Samuel Cam was elected as surgeon in place of his uncle, William, who had served since 1776.[77]

In 1817, John Griffiths, also a member of the corporation, was elected as the only candidate to replace Thomas Cotes as surgeon. When Thomas Blount resigned as Physician Extraordinary in 1820, John Bleek-Lye, a member of the corporation was appointed unanimously although the records show that Mainswete Walrond was thanked for his offer of services.[78] Walrond was eventually successful in being elected when Samuel Hughes resigned after 26 years to become Physician Extraordinary in 1825. On this occasion, Walrond was elected unanimously at a meeting where there were only six members in attendance, three of whom were members of the corporation. [79] When elections were held for a surgeon in 1837 on the resignation of John Griffiths, there were three candidates. One of these was Griffiths' son, John junior and the others were Francis Braithwaite and William Gilliland. The notes record that John Griffiths was elected unanimously as the other two candidates had withdrawn.[80]

The one occasion when a significant number of governors did chose to exercise their vote was in 1838 when Mainswete Walrond resigned leaving a vacancy for Infirmary Physician. There were three candidates for the post, William Gilliland, Superintendent at the Hereford Asylum, Charles Lingen and Dr Strong.

Lingen withdrew on the basis that he had not practised in Hereford for the requisite

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[76] *Ibid.* 16 May 1794.
[77] Renton, *Herefordshire's hospitals,* p. 29.
[78] Minutes of Governors' Meetings, 18 Aug. 1820.
[79] *Ibid.* 6 Oct. 1825.

time but the other two candidates stood for election. At the time, there was a Parliamentary Select Committee looking into conditions at the Hereford Asylum, and the candidature of Gilliland aroused considerable debate. The election started with alternate motions proposing a chairman. Referring to rules 1 and 6, it was moved that the Steward of Hereford races, when present, was entitled to take the chair. John Hopkins was proposed on this basis and following a division on the issue was appointed as chairman of the meeting. Hopkins was a visiting magistrate to the Asylum and one of those who was leading the campaign to refuse to renew the annual licence. Sixty-two governors attended to vote in person and thirty-six others voted by proxy. Two of the attendees claimed they had a double votes, John Gough as a governor and as Mayor of Hereford, presumably exercising a vote on behalf of the corporation, and John Griffiths as governor and as Honorary Surgeon at the Infirmary. These double votes were disallowed and Gilliland was elected by fifty-three votes to forty-five.[81] Two of the governors E. B. Clive, MP and Archdeacon Wetherall proposed an alteration to the rules to allow all governors to be entitled to vote by proxy in future. John Grififfiths, the surgeon resigned over the issue, despite a deputation of governors asking him to reconsider, and was replaced by Charles Lingen. [82] The election is exceptional in that it is the one occasion on which a significant number of governors chose to exercise their rights. The background to the election is discussed more fully in Chapter 5 where it is argued that the fundamental disagreement arose from a power struggle between the newly elected reformed city council and the county magistrates over the control of local lunacy policy.

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[80] Minutes of Governors' Meetings, 9 March 1837.
[81] *Ibid.* 19 Apr. 1838.
[82] *Ibid.* 27 Dec. 1838.

4.3.2 Patient care

Both honorary and paid medical staff were involved in providing medical care to patients. As noted earlier the honorary medical practitioners were involved in the admission process for patients recommended by subscribers but could also admit at other times in case of emergency.[83] At Hereford the original rules allowed them to recommend unlimited outpatients and two inpatients a year although this was reduced to three inpatients and ten outpatients a year in 1794.[84] Once patients were admitted, the medical practitioners were responsible for determining appropriate treatments including specifying diet and prescribing any drugs. The main responsibility for dispensing treatment to patients lay with a paid apothecary whose duties included visiting patients on a daily basis, dressing wounds, dispensing the prescriptions ordered by the physicians and being in attendance when the consultants visited. Although he dispensed drugs, the control of ordering and purchase of drugs was in the hands of the medical practitioners and the House Committee.[85] In cases of emergency, the Apothecary was authorised to take some independent action but in general was there to manage the patients under the direction of the honorary physicians and surgeons. The honorary practitioners were also allowed to take on trainees in a private capacity and were entitled to charge for instruction at the hospital. Each practitioner was limited to two pupils at any one time and the rules limited the duties they could undertake, for example they were not allowed to perform operations or prescribe although they could dress wounds.[86]

Unlike the honorary appointees, the apothecary was not allowed to undertake any private practice and the other main terms of his appointment were set out in the rules. For example, as he was responsible for providing the medical cover to the institution, he was required to be in by 10pm in the evenings and never to be absent

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[83] *Rules,* rule 32, p. 10.
[84] *Ibid.* rule 95, p. 24 and minutes of Governors' meeting 15 Aug.1794.
[85] *Ibid.* rules 55-61, pp. 16-17.
[86] *Ibid.* rule 94, p. 23.

for more than two hours at a time. The position of paid apothecary at the Infirmary does not appear to have been a very attractive one and as shown in Appendix 7, the first incumbents did not stay in post very long. Nevertheless, there is evidence that the Infirmary was able to attract some good quality men to the post. Richard Reece served as apothecary from 1795 to 1797 before continuing his career in London and acquiring the degree of MD from a Scottish University. He later established a reputation as a medical author and publisher and also became a subscriber to the Infirmary.[87] In 1805 Philip Tully was appointed and served as Apothecary for thirty-seven years until 1842.

As discussed in Chapter 2, changes in the training of medical practitioners in the first half of the nineteenth century meant that it was no longer possible to become a qualified practitioner solely through the apprenticeship system. Hospitals in London and a few major centres became increasingly dominant in the provision of medical education and this had an effect on provincial hospitals. At Hereford there were increasing problems in providing medical attendance to patients. In part this may have been due to the fact that the honorary practitioners could no longer attract sufficient apprentices to fulfill the services they had undertaken to provide at the Infirmary. In 1824 it was agreed that Philip Tully could take on an apprentice linked to his appointment at the Infirmary.[88] By 1836 the question of the provision of medical cover became more urgent as the number of beds at the Infirmary had been increased on completion of the extension funded by the legacy from John Morris. The solution found was to recruit further apprentices specifically to work at the Infirmary and three apprentices were taken on between 1839 and 1845. [89] Problems in providing sufficient medical support continued and, when Philip Tully resigned from the post of apothecary in 1842, his replacement was advertised for under the title of

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[87] Hutchinson, *Herefordshire Biographies,* pp. 91-93.
[88] Minutes of Governors' Meetings, 23 March 1824 and 7 Dec. 1824.
[89] *Annual Reports, 1839, 1841 and 1845.* Each of the three apprenticeships was for 3 years and attracted a premium of £150 that was recorded as miscellaneous income.

house surgeon and Mr Waudby was appointed. [90] In 1843 the Infirmary failed to attract any applicants for apprenticeship and instead appointed a dispenser via a London agent. [91] The difficulties in attracting people to the training posts continued, and in 1846 an increase in the house surgeon's salary was justified on the basis that he would be unable to attract any private pupils. The minutes record that 'changes in the practice of Medical Education tend to diminish the number of Pupils who seek instruction in country places or Hospitals.'[92]

Unfortunately no records survive detailing the treatments provided at Hereford, but evidence for the Norfolk and Norwich hospital suggests that the most common surgical procedures undertaken would have been lithotomy (the removal of bladder stones), operations for cataracts, trephining of the skull and the incision of abscesses.[93] In addition to these conditions, Joan Lane mentions amputations and treatments for ulcers, rheumatism and skin conditions being common ailments treated at Worcester.[94] In the early nineteenth century the range of treatments available at Hereford was extended to fitting trusses to treat hernias and undertaking inoculations.[95] Dealing with fractures and accidents were also part of the normal work of the surgeons. Two beds were designated for the treatment of accidents and two more for fracture cases and, as noted earlier, accident victims were treated without the need for a recommendation from a subscriber.[96] The bathing facilities could also be accessed by those who were not patients, at a charge of 1s for the cold-bath and 2s 6d for the hot-bath or sweating-chair. [97]

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[90] *Ibid*, 6. June 1842.
[91] Minutes of Governors' Meetings, 24 Aug. 1843 and 5 Oct. 1843.
[92] *Ibid*. 26 Aug. 1846.
[93] Cherry, 'Norfolk and Norwich', pp. 301-302.
[94] Lane, *Worcester Infirmary*, p. 2.
[95] Minutes of Governors' Meetings, 21 Sept. 1810 and 17 Aug. 1815.
[96] *Rules*, rule 51, p. 15.
[97] *Ibid*, rule 92, p. 23.

4.3.3 Patients treated

This section looks at the information available on the number of patients treated at the Infirmary and considers its contribution to the mixed economy for medical services. The Infirmary accepted both inpatients and outpatients for treatment and in common with similar institutions published details of the number seen and the outcomes achieved. The detailed data for the years available is presented in Appendix 8.

Table 4.9: Hereford Infirmary Inpatient Numbers, 1776-1850.

	1776-1788	1799-1810	1811-1820	1821-1830	1831-1840	1841-1850	Total
Inpatients treated							
Inpatients on 25 March		30	26	49	49	65	
Admitted in period	1,859	1,954	2,117	2,944	4,562	5,481	18,917
Total treated	**1,859**	**1,984**	**2,143**	**2,993**	**4,611**	**5,546**	**18,917**
Outcome of care							
Cured	992	1,201	925	1,021	1,485	2,357	7,981
Relieved	85	346	254	73	113	239	1,110
Discharged- misbehaviour	46	19	10	3	3	12	93
Discharged-own request	40	21	8	16	10	129	224
ImpropeInp	12	7	6	2	4	3	34
Incurable	16	22	5	3	0	9	55
Dead	86	46	63	105	239	237	776
Made outpatients	552	296	823	1,721	2,692	2,494	8,578
Inpatients on 25 March	30	26	49	49	65	66	66
Total treated	**1,859**	**1,984**	**2,448**	**2,519**	**2,615**	**2,725**	**18,917**
Death rate %	5%	2%	3%	4%	5%	4%	4%
% cured or relieved	59%	79%	56%	37%	35%	47%	48%
% made outpatients	30%	15%	39%	58%	59%	46%	46%
Average inpatients admitted per year	155	177	212	295	456	548	300

Source: Appendix 8.

The annual report for 1788 published cumulative figures for the 12 years the charity had been operating to that date. Thereafter the annual data for the years 1799 to 1850 is recorded. Tables 4.9 and 4.10 present a summary of the information grouped into six periods of 10-12 years covering the period 1776-1850.

The average number of inpatients admitted, shown in Table 4.9, demonstrates a rising trend over the period, from 155 for the period 1776-1788 to 548 for the period 1841-1850. The annual figures given in Appendix 8 are plotted in Figure 4.5 and show that the general trend was an increase in inpatients admitted and that these more than quadrupled over the period, increasing from 129 in 1799 to 585 in 1850. The increase in the number of inpatients admitted was slow at the start of the period, reaching 200 for the first time in 1817, but then rose more rapidly to exceed 300 for the first time in 1827 and 400 in 1834, the year that fifteen additional beds were added. By 1838 inpatient admissions exceeded 500, reaching 590 in 1840 and remaining between 500-600 for the next decade.

Table 4.10 provides similar summary information for outpatients with the annual figures shown in Figure 4.5. In contrast to the pattern for inpatients, the number of outpatients admitted each year shows more fluctuations over the period to 1850. The number of outpatients admitted rose faster than inpatients from 149 in 1799 to 496 in 1825. The following two years saw a marked reduction but then recovered to rise steadily and reach a peak of 798 in 1835. After this the numbers dropped steeply to 512 admissions in 1838 before beginning to rise again to reach 585 in 1850. The number of outpatients admitted in a year normally exceeded the number of inpatients admitted. The ratio of outpatients to inpatients was 1.4 : 1 in both 1799 and 1850 but varied considerably over the period, peaking at 2.3 : 1 in 1833-1834. The marked fall in outpatient numbers between 1835 and 1838 is associated with the opening of the new Hereford dispensary in 1835. However the trends in patient numbers are also influenced significantly by changes made to the presentation of figures relating to the recorded outcome of treatment.

HEREFORD INFIRMARY PATIENT NUMBERS 1799-1850

Figure 4.5: Patients admitted to Hereford Infirmary 1799-1850

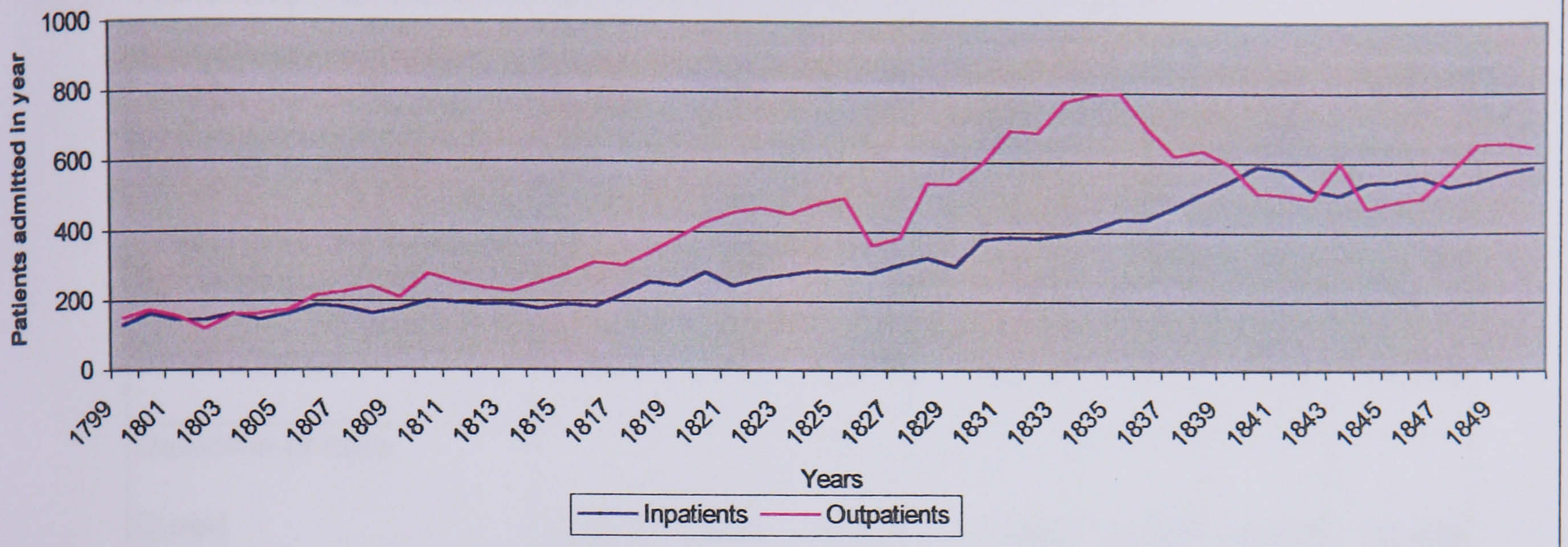

Figure 4.6: Hereford Infirmary: inpatient outcomes 1799-1850

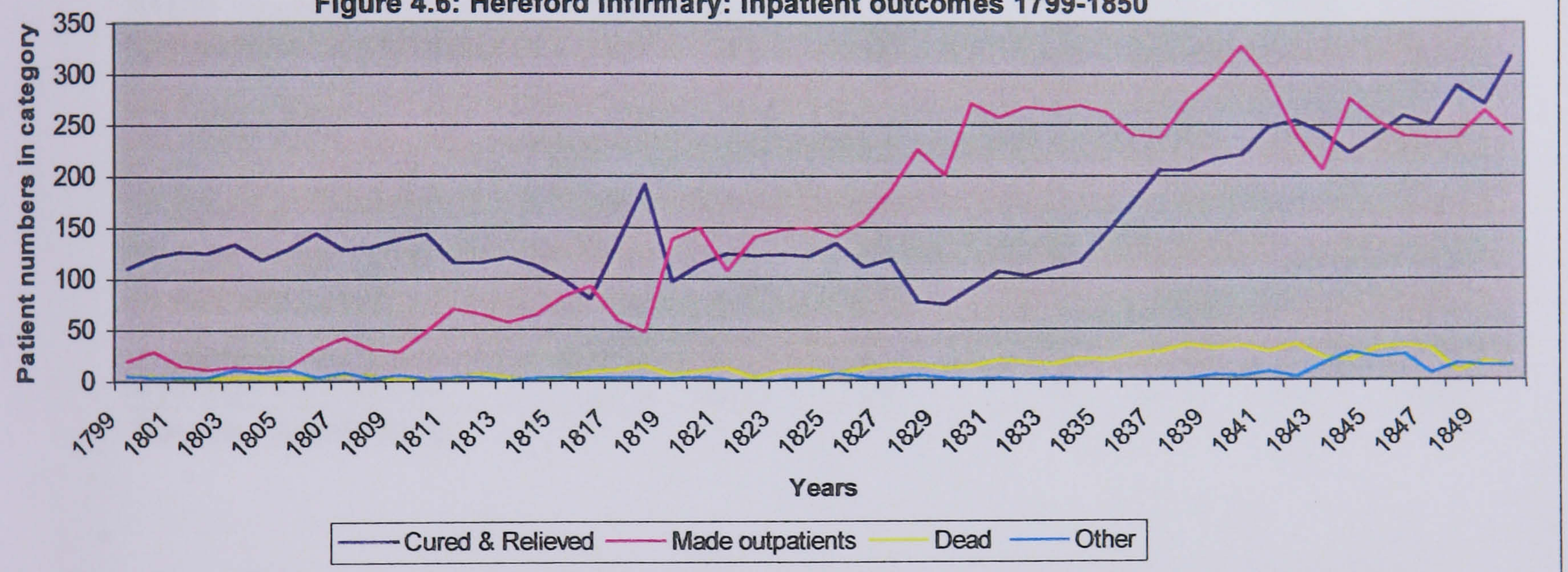

Figure 4.7: Hereford Infirmary: outpatient outcomes 1799-1850

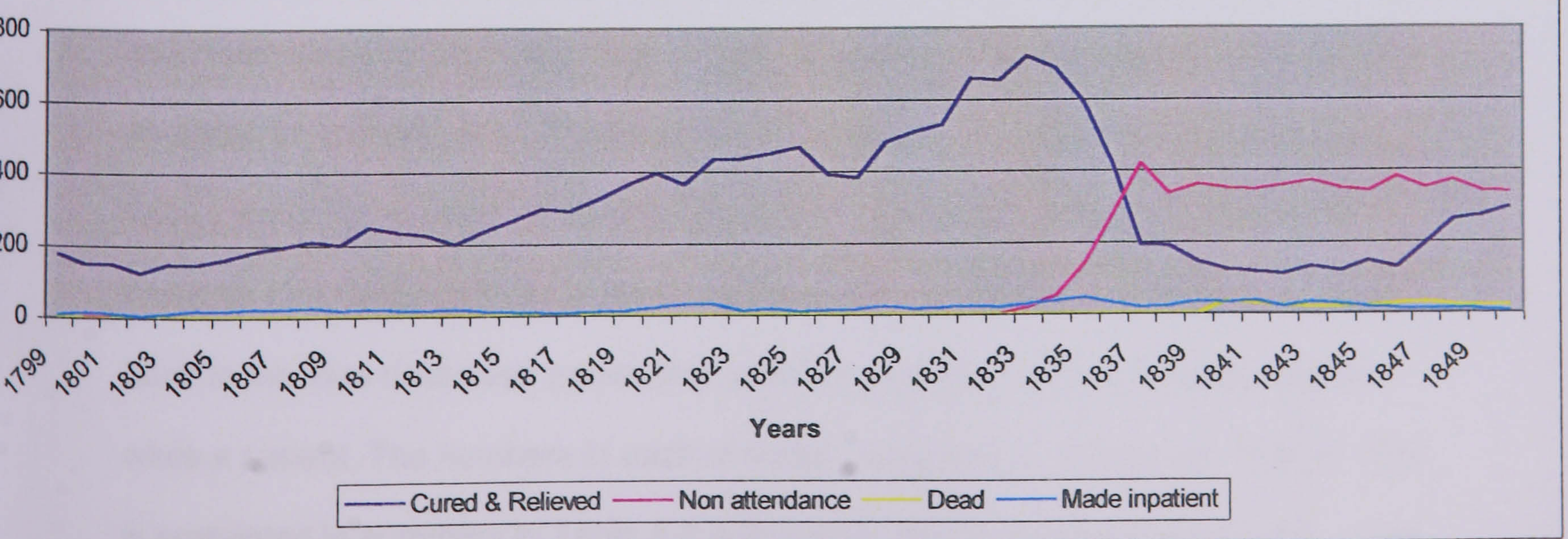

Table 4.10: Hereford Infirmary Outpatient Numbers 1776-1850.

	1776-1788	1799-1810	1811-1820	1821-1830	1831-1840	1841-1850	Total
Outpatients treated							
Outpatients at 25 March		66	36	78	215	378	50
Admitted in period	3,249	2,250	2,994	4,760	6,802	5,567	25,638
Total treated	**3,249**	**2,316**	**3,030**	**4,838**	**7,017**	**5,945**	**25,688**
Outcome of care							
Cured	2,071	1,848	1,919	3,006	3,166	1,418	13,428
Relieved	140	236	905	1,439	1,206	350	4,276
Non-attendance	684	6	0	0	1,950	3,538	6,178
Dead	112	0	0	0	33	221	366
Made inpatient	176	190	128	178	284	173	1,129
Outpatients at 25 March	66	36	78	215	378	245	245
Total treated	**3,249**	**2,316**	**3,030**	**4,838**	**7,017**	**5,945**	**25,622**
% cured or relieved	69%	91%	96%	96%	48%	31%	70%
% made inpatients	6%	8%	4%	4%	4%	3%	4%
% non attenders	21%	0%	0%	0%	0%	62%	24%
% dead	4%	0%	0%	0%	4%	4%	1%
Average admissions	271	204	299	476	680	557	407

Source : Appendix 8.

The number of inpatients treated each year was calculated as the total of new admissions in year, plus those who had been inpatients at the start of the year, less those in the hospital on the last day of the reporting year, 25 March. The outcome of treatment was also presented, the majority of patients being recorded as discharged, as cured or relieved, or as discharged into outpatient care. Other categories used were died or having been discharged for misbehavior, at the patient's request or because they were deemed to be incurable or improper. This last category relates back to the idea discussed earlier that patients must behave in a suitable manner while a patient. The numbers in each of these categories for the period 1799 to 1850 is presented in summary in Table 4.9 with annual figures plotted in Figure 4.6. At the start of the period the majority of inpatients were recorded as cured or relieved.

From 1806 an increasing number were recorded as discharged from inpatient care by being transferred to outpatients and from 1823 more patients were in this category than recorded as cured or relieved.

The number of outpatients recorded as treated in a year were those transferred from inpatient care plus those referred directly as outpatients by subscribers. Adjustments were also made for those 'on the books' at the start and end of the reporting year. At the start of the period, the categories used to record the outcome of care for outpatients were cured or relieved, died, or made an inpatient. In 1833 a new category was introduced to record outpatients who had not attended. The numbers in each of these categories for the period 1799 to 1850 are plotted in Figure 4.7. Prior to 1833, the figures printed in the annual reports presented a picture of overwhelming success in the treatment of outpatients, with over 700 patients being treated of whom almost 100 per cent were recorded as having been either cured or relieved. In contrast, in 1837, although 629 patient cases were closed in the year, 420 of these were marked as not having attended.

While it is difficult to fully understand what lies behind these changes in presentation, they do show how figures could be manipulated for publicity purposes. The practice of transferring many inpatients to outpatients, had the effect of boosting the number of recorded outpatients although many had not been referred directly by a subscriber and it would appear that many never actually attended as an outpatient. This strategy may have been employed to continue to demonstrate an increase in outpatient numbers even when subscriber numbers were low or to try to demonstrate that the Infirmary was expanding its outpatient care. The category of non-attendance of outpatients was first recorded in 1833 and in 1837, 420 outpatients were recorded in this category. This period coincided with the planning and opening of Hereford Dispensary, which provided outpatient and home care. The figures may show that outpatients preferred to go to the Dispensary for treatment and therefore did not take

up their right of treatment at the Infirmary, but could also be an indication of competition between the two charities.

The *Hereford Times* report of the proceedings at the ninth Annual Meeting of the Hereford Dispensary included a summary of patients treated since 1835. [98] This information is summarised in Table 4.11. By 1844, the Dispensary was reporting that it had treated 884 patients in comparison to the 861 reported for the Infirmary.[99] The Dispensary charity was a subscription charity and appears at first to have required patients to be recommended by a subscriber, as at the Infirmary. However, from 1838, casual patients who applied without a recommendation were also treated, and from 1841 this category exceeded the recommended patients. The Annual Report for 1844 discussed this point, saying that although only two subscribers did not exercise their rights of recommendation in the year the demand for services had been so great that the charity had had no option but to treat casual patients as well. The result of this was that the charity had run up a deficit for the year and therefore urged supporters to find additional subscribers from among their friends and acquaintances.[100]

Table 4.11: Patients treated at Hereford Dispensary from 1836 to 1844.

	New patients Recommended	Casual patients	Total Patients treated
1836	178	0	178
1837	226	0	226
1838	346	135	481
1839	332	152	484
1840	200	189	389
1841	206	210	416
1842	244	371	615
1843	233	553	786
1844	241	643	884
Total	2,206	2,253	4,459

Source: *Hereford Times,* 13 July 1844.

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[98] *Hereford Times,* 13 July 1844. Report of the Hereford Dispensary Annual meeting.
[99] Appendix 10.
[100] *Hereford Times,* 13 July 1844. Report of the Hereford Dispensary Annual meeting.

In addition to the proportion of patients recorded as cured or relieved, there was also considerable interest in the numbers recorded as dying at the Infirmary. The death rate among inpatients was 4 per cent in 1799 but then declined and did not reach this level again until 1812. After 1816 the death rate increased to a level of 5 or 6 per cent in most years, reaching a top level of 7 per cent in 1838 and 1842. The published outcomes at Hereford compare reasonably with those published for other infirmaries. For the eighteenth century, Joan Lane computed death rates of between 3.3 and 7.5 per cent at Worcester Infirmary for selected years between 1747 and 1798, finding these higher than at other provincial infirmaries. Using comparative data for eleven provincial hospitals drawn from the 1779 *Medical register* she found the highest death rate of 5.8 per cent at Worcester and lowest of 1.2 per cent at York. The rate she reports for Hereford is calculated at 2.9 per cent, the fourth lowest of the eleven infirmaries recorded.[101] Steven Cherry has calculated the death rate at the Norfolk and Norwich Hospital between 1772 and 1870 as normally being between 4 and 5 per cent, rising to between 5 and 6 per cent in the decades 1820-1830, 1860-1870 and 1870-1880.[102]

The numbers treated prior to 1785 were constrained by the low number of beds available in the temporary premises. The new building opened with 55 beds in 1783 and increased to 70 in 1834 and to 80 in 1844. The average number of patients treated each year from 1799-1810 was 180, an average of 3.3 patients for each of the 55 beds. This ratio remained relatively stable in the following decade but rose to 5.4 patients in the decade to 1830. Between 1830 and 1850 the average was between 6.6 and 6.9 patients treated per bed. It should be recalled that the rules had laid down a maximum stay of 2 months per patient.

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[101] Lane, *Worcester Infirmary*, pp. 39-40.
[102] Cherry, 'Norfolk and Norwich', p. 299.

Table 4.12: Hereford General Infirmary: Bed numbers and inpatients treated from 1799-1850.

	1799-1810	1811-1820	1821-1830	1831-1840	1841-1850
Average inpatients per year	180	214	299	461	555
Number of beds (maximum in period)	55	55	55	70	80
Inpatients per bed per annum	3.3	3.9	5.4	6.6	6.9

Source: Appendix 8.

It was important for the infirmaries to demonstrate efficiency and success in terms of patient care. The official figures reported in the *Annual Reports* showed an upward trend in both inpatient and outpatient numbers for the majority of the period. From 1835 the numbers of outpatients seen at the Infirmary decreased, due to the opening of the Hereford Dispensary which also provided free care to patients. Closer analysis of the figures show that changes in medical practice or in the conventions for reporting the number of patients altered over the period. While it is not possible to reach a definite conclusion, these changes provided an opportunity to inflate the number of outpatients recorded as being treated by the Infirmary. The information available on the throughput of patients suggests that patients either stayed a considerable number of months in the Infirmary or that the Infirmary was not always full. Thus although the figures presented in the *Annual Reports* showed increasing patient numbers over the period, more detailed analysis suggests that the Infirmary was less successful in increasing the delivery of patient care than the summary numbers suggest.

4.4 The rewards of philanthropy

Sections 4.1 to 4.3 have provided a detailed examination of the workings of the Infirmary. In this section attention is focussed on the interaction of the Infirmary with local society. Three topics are considered, the public justification for the charity, the association of the initial appeal with the parliamentary election campaign of 1774 and the public representation of the charity as expressed through the physical structure of the Infirmary building.

4.4.1 Public justification for the Infirmary

Thomas Talbot wrote three addresses calling for the foundation of a 'Publick Infirmary' in or near the city of Hereford between 1763 and 1774.[103] The first address was entitled 'A proposal for erecting an Infirmary at Hereford,' and called on 'inhabitants of the county' to take advantage of the end of the Seven Years' War in 1763 to use their energies, 'humanity, compassion and Christian charity' to establish a public infirmary. Talbot was explicit that the institution he had in mind would operate as others did elsewhere and would be funded by subscription and provide free medical services to the poor. The main justification put forward for an Infirmary was the fact that there was no other method through which the poor could access reliable medical help and thus chronic illness or an accident could result in pauperism for an individual or an entire family. Voluntary Infirmaries filled this gap in the welfare system. The possible religious benefits were also emphasised as religious teaching could be encouraged by clergymen attending to provide comfort and instruction to patients.

Talbot's second address was again directed at the inhabitants of the county but was subtitled 'To excite them to be liberal benefactors to their intended Infirmary'. This second address was more direct in stressing what Talbot saw as the duty of the rich to help the poor. 'They deserve some degree of compassion from the great and

wealthy; who can scarce manifest their gratitude to providence, in a more natural way, for the blessings they are distinguished with themselves, that by sometimes making their more indigent neighbours share with them in the effects of that plenty, which God has given them'.[104] The benefits of the charity are justified in terms of the tributary relationship discussed in Chapter 3.[105] The two estates of poverty and wealth are inevitable but to maintain the stability of society the rich have a duty of stewardship towards the poor. The rich had God to thank for their good fortune and had a Christian duty to help those less fortunate than themselves. The poor were in any case the source of the wealth that the rich enjoyed and charity was required in order to maintain a growing and healthy population.

> The poor of any nation are a very valuable part of it, and absolutely necessary to make riches themselves of any real use to the possessors of them. Without their labour our lands will lie uncultivated, and all our fruitful fields become as barren and desolate as the sandy desart. Our flocks and herds will diminish, without their care, and the various sources of our plenty soon fail, and leave us destitute and wretched. The temples of our God, the palaces of our nobles, the stately dwellings of the rich, all our public edifices, which proclaim the wealth and grandeur of the kingdom, will sink under their own ruins, and never can be restored, unless the hands of the industrious poor be employed in these important and necessary services.[106]

This extract illustrates that the two estates of rich and poor were accepted as a part of the established order of things, but also that this arrangement relied upon the powerful to fulfill certain responsibilities in return for enjoying the rights of

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[103] Talbot, *Three addresses.*
[104] *Ibid*, p. 7.
[105] Borsay, *Medicine and charity,* pp. 183-189. This is discussed more fully in Chapter 3.

possession. Anne Borsay has warned against assuming a simple linear movement between the tributary and proprietary discourses and this seems to be true in this case.[107] The arguments put forward inTalbot's tracts show a reliance on justifications from the tributary discourse in the emphasis given to the responsibilities of the rich and the recognition that the wealth of the nation depends on the health of the population.

The third address is directed not at all the inhabitants but more specifically at the 'Nobility, Gentry and Clergy'. Emphasis is given to the increase in poverty levels over the previous sixteen to twenty years due to the increase in the cost of food and other essentials exceeding that of the rise in wages. Talbot argues that the poor now have difficulty in meeting the necessities of life and have no opportunity to save to cover emergencies. A charitable Infirmary would solve both the problem of access to medical care in parishes with no resident surgeon and provide a centre where medical skills could be developed through experience of more and more varied cases. Possible objections to the charity are also discussed within the tract, in particular the possible claim that the Infirmary might encourage the poor to be improvident. The language and arguments used in this third address give much more emphasis to economic ideas and are redolent of the proprietary discourse. It is argued that many of the poor were in straightened circumstances through no fault of their own. 'An Infirmary is not a nursery of idleness, nor a harbour for pride; it gives no shelter to the lazy, nor encouragement to the vicious.' The charity would meet a real and tangible need as illnesses and wounds were visible and could be verified and the subscribers themselves would ensure that any patients recommended really required medical attention. However, the importance of leadership in any appeal was recognised and the address ends with an open challenge to the nobility to come

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[106] Talbot, *Three addresses.* p. 8.
[107] Borsay, *Medicine and charity,* pp. 181-186.

forward to start the appeal; 'If it fails, it must be for want of a Patron among the Noble and Opulent. [108]

The ideas put forward in these three addresses were representative of the publicly stated motivations behind many charitable enterprises in the eighteenth century. Charitable enterprise had extended into many areas, including health and education and was becoming accepted as a necessary part of welfare systems required to fill gaps left by the Poor Law system. The infirmaries supported the social order in that they emphasised the ability of the rich to be benevolent and the dependence of the poor on charity while at the same time providing some level of practical assistance through personal ties of patronage or loyalty. They were a public symbol of Christian duty voluntarily entered into by the generous donors and subscribers. Talbot's arguments in favour of an Infirmary were not original but rather a reiteration of those that Allured Clark had used in gaining support for the Winchester Infirmary in 1736; a summary of ideas that had been in circulation for forty years. Yet, this time, after eleven years of apathy, Talbot's proposals were taken up; the address was published in the *Hereford Journal* and a sufficient number of people willing to make a public commitment and donations came forward to start the subscription.[109] It would appear that the catalyst for this change of heart was not due to any sudden rise in charitable fervor in the county but rather to the contested parliamentary election of October 1774.

4. 4.2 Political interests

> Dear Sir, I received a letter late last night, which informed me, that you behaved gloriously at the Mayor of Hereford's on Monday last, for which I greatly esteem you. I by no means could sleep on my Bed, but am risen about One to tell you so, and that I would give five

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[108] *Ibid*, p. 18.
[109] *Hereford Journal*, 20 Oct. 1774.

> hundred pounds to gain a Day for inserting your Speech into Pugh's journal. ... If I can be of the least service to you by coming to Town now, I insist on receiving your commission.[110]

These were the grateful words written by Thomas Talbot to the Honorable Thomas Harley one of three candidates fighting for the two County Hereford parliamentary seats in 1774. Harley had made a large fortune as a London merchant and government contractor providing the pay and clothing to the British army in America and was an Alderman of the City of London. He became Lord Mayor in 1761 at the age of thirty-seven and served as MP for London from 1761-1774 when he decided to contest the Herefordshire seat.[111] Talbot's enthusiastic endorsement of Harley's actions was due to the latter's support for Talbot's third proposal for a General Infirmary and refers to a speech Harley had made at the feast held to inaugurate the new mayor of the City, the physician Thomas Cam. This feast took place on 3 October, just nine days before polling was to start. In the following weeks, the appeal was enthusiastically taken up with Harley promising £100, his two opponents in the election each committing £200 and Talbot himself pledging the £500 mentioned in the letter. Pugh's newspaper, the *Hereford Journal*, played a crucial part in the appeal reporting the news of the speech and the appeal's progress.[112]

The other two candidates in the election, Thomas Foley and Sir George Cornewall Bart, were also members of eminent Herefordshire families. All three families had a history of parliamentary representation in Herefordshire, and the Harleys and Foleys had also shared the representation of Droitwich between them from 1758. Thomas Harley was the third son of Edward Harley, third Lord Oxford and the family owned land in the north of the county close to the Shropshire border. Thomas's father and brother both represented County Herefordshire prior to taking

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[110] HRO, F37/240, Letter from Thomas Talbot to Thomas Harley, Oct. 1774.
[111] Namier and Brooke, *History of Parliament, Vol.2*. pp. 586-587.

their seats in the Upper House. Both had served with Velters Cornewall from Moccas, father-in-law of the 1774 candidate, who held his seat for forty-six years from 1722 to 1768. On Cornewall's death in 1768, the two Thomas Foleys, father and son, contested and won the County Herefordshire seats and were the sitting MPs at the time of the 1774 election.[113]

In addition to their estate at Stoke Edith in east Herefordshire the Foleys also had family ties with Worcestershire and held at least one of two seats at Droitwich throughout the eighteenth century. In 1754, Thomas Foley senior was elected there together with Robert Harley, the uncle of Thomas. In 1768, Thomas Foley won at both Droitwich and Herefordshire but stepped aside at Droitwich, allowing Edward Foley to take his place. Robert Harley continued as an MP in Droitwich until his death in March 1774, when replaced by Andrew Foley. His uncle's death may well have been the catalyst that prompted Thomas Harley to give up his London seat and seek election in Herefordshire in order to maintain family influence in the area. In 1774, Thomas Foley junior stood for Droitwich and only Thomas Foley senior contested the Herefordshire election, leaving the field at Hereford open to Thomas Harley. It is likely that this was part of an agreement between the two families to attempt to retain control of both seats.

The third candidate to stand was Sir George Cornewall, son-in-law of Velters Cornewall who had been an immensely popular local figure, particularly over his opposition to the cider tax in 1763. In 1771, Catherine, his only daughter and heir, married Sir George Amyand who assumed the name and arms of Cornewall and was encouraged to contest the 1774 election. It is clear from the above that throughout the eighteenth century political influence in Herefordshire reflected a continual rebalancing between three powerful families. Changes in the county's representatives in the House of Commons were frequently occasioned either by the

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[112] *Hereford Journal,* 6 Oct. 1774.

death of sitting members or their elevation to the House of Lords. The county franchise was extensive, estimated to approach 4,000 in total with voters having the right to two votes each. In consequence, the outcome of a contested election was never easy to predict.[114] In 1774, each of the candidates had a clear geographical power base but needed to gain support from across the county in order to be successful.

Competition for votes was fierce and the proposal for an Infirmary must have seemed an excellent way of raising the profile of a candidate, demonstrating a commitment to the county and generating goodwill among the voters without fear of allegations of corruption. The clergy were a key group among the electorate and given that a clergyman was the first promoter of the Infirmary and the support of the Bishop for the scheme, any candidate supporting the Infirmary could hope to curry favour with that group. Thomas Harley's brother, John, was Archdeacon of Hereford at the time and would have exercised some influence with the cathedral clergy at least. The election campaign lasted approximately six weeks from early September to polling on the three days between 12-14 October. The progress of the campaign can be traced from correspondence in the *Hereford Journal.* The formal campaign began with an open meeting held in the Shire Hall on the 9 September at which four possible candidates were proposed. Of the two sitting MPs, Thomas Foley senior accepted the nomination but his son declined in order to stand at Droitwich. Thomas Harley was proposed by his brother, the Archdeacon, but was also supported by the Foley interest. Two other candidates were also proposed, Sir George Cornewall and James Walwyn, although at the meeting Walwyn declined to stand and publicly supported Cornewall.[115]

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[113] Much of the biographical detail for the candidates is drawn from relevant sections in Namier and Brooke, *History of Parliament.*
[114] F. O'Gorman, *Voters, patrons and parties: the unreformed electoral system of Hanoverian England* (London, 1989) and Namier and Brooke, *History of Parliament,* p. 303.
[115] *Hereford Journal,* 22 Sept. 1774.

The support for Foley and Harley at the meeting was clearly very strong and this, and perhaps other pressure applied, caused Cornewall to decide to stand down the following day. He communicated this to Thomas Harley saying he had come to his decision in the interests of 'preserving the peace of the county'. However, within a few days he was persuaded to change his mind again by those who opposed the alliance between the Foleys and Harleys. This series of events lead to a lively correspondence in the *Hereford Journal,* with the Foley/Harley camp accused of collusion while Cornewall, in return, was castigated for changing his mind, 'thereby degrading the character of a gentleman.'[116] Over the following weeks, allegations of bribery and intimidation were also made against both Foley and Harley as it was reported that tradesmen in Bromyard had been threatened with loss of business and non renewal of licenses to trade. The opponents of Foley and Harley exhorted voters to defend the independence of the House of Commons and vote for the honest Cornewall as one who would act as an independent MP and remain clear of party association. The Foley and Harley camps were sufficiently worried by the combined effect of these smears and allegations of collusion to be forced to refute some of them publicly. Thomas Foley placed a statement in the *Hereford Journal* saying that he was not associated with either candidate while Harley published a letter denying claims that he had voted in favour of the cider tax during the last parliament. [117] All of the candidates continued to try to raise their profile locally, for example both Harley and Cornewall were at the anniversary dinner for the charity school on 6 October.[118]

When viewed against this background, it can be argued that the timing of the re-launch of the Infirmary appeal after eleven years coincided with the need for Harley to build a broad base of support among the electorate and to take steps to improve his local reputation. As part of his duties in the City of London, Harley had served as President of the City of London Hospital from 1758 to 1767 and continued

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[116] *Ibid.* 29 Sept. 1774.
[117] *Ibid.* 6 Oct. 1774.

this work as President at St. Bartholomew's from 1767 to his death in 1804. St Bartholomew's dated back to 1123 and its constitution provided for formal links with both the crown and the City of London.[119] Harley's London experience meant that he was familiar with the hospital movement and aware of the subtle social and political bonds of patronage and philanthropy between such institutions and the communities they served. By associating himself with the Infirmary appeal he was able to raise his profile, demonstrate a commitment to the general public good in the county and attempt to generate goodwill among the voters without fear of allegations of corruption.

It is noteworthy that despite his endorsement of the Infirmary appeal, the *Hereford Journal* did not report that Harley or any others attending the mayor's feast had pledged any money. When the poll closed the day following the *Hereford Journal* article, neither Harley's candidature nor the Infirmary appeal was secure. The outcome of the poll saw the election of Foley and Cornewall with 2,450 and 1,971 votes respectively against Harley's 1,631. The poll book for the election records that Thomas Talbot voted for Harley and Foley.[120] Although Harley's strategy failed in the short term, the family maintained both their political interests and their support for the Infirmary and both these enterprises were ultimately successful. The edition of the *Hereford Journal* that reported the election results also published an anonymous letter suggesting that Thomas Foley would soon be elevated to the House of Lords and a further election held.[121] This did indeed occur although not until 1776. In the autumn of 1775, the hospital subscription received a new boost with the news that Thomas Harley's elder brother, the Earl of Oxford, was to donate a plot of land as the site for a permanent Infirmary. Although the subscription fund was still felt to be too

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[118] *Ibid.* 13 Oct. 1774.

[119] J. Andrews, A. Briggs, R. Porter, P. Tucker and K. Waddington, *The history of Bethlem* (London, 1997), especially ch. 12, pp. 156-177. The City of London were closely associated with the management of St. Bartholomew's, Bethlem and the Bridewell.

[120] *An alphabetical list of the Poll* (Hereford, 1774), HRO, BC 79/Z6/3.

low to commence any building work, this donation guaranteed the future of the Infirmary appeal. Thomas Harley had further renewed his links with his home county by purchasing the Berrington estate, near Leominster, as a home for his family and from 1775 was engaged in laying out the grounds with the help of Lancelot 'Capability' Brown. The publicity surrounding these activities would also have helped to raise the local profile of the family. The following year, Lord Foley's elevation to the peerage forced another election in which Harley was successful against James Walwyn, a candidate with the open support of both the Cornewall's and the Foley's. Thomas Harley sat as one of the MPs for County Hereford until his death in 1804.

Adrian Wilson has identified a link between the establishment of voluntary infirmaries and contested parliamentary elections.[122] Taking as a starting point the thesis put forward by Roy Porter that infirmaries were designed to transcend party and religious differences, Wilson explores the question of whether the institutions were an expression of pre-existing local social cohesion or whether they were a force in fostering social cohesion.[123] One of Wilson's most striking findings is that in eight counties, one third of all the counties acquiring infirmaries before 1800, the election prior to the hospital foundation date was contested and that this followed two previous uncontested elections. Wilson suggests two possible hypotheses to explain the statistical association he has uncovered. The first, termed the eirenic hypothesis, suggests that local elites, mindful of the possible unsettling effects a contested election might have on the peace of the countryside, supported the development of a voluntary Infirmary as a way of smoothing party differences and restoring political harmony. Promoters of the infirmaries could seek to take advantage of this mood by launching an appeal hoping to generate a high level of support from rival candidates. His second hypothesis, termed 'the antagonistic hypothesis', posits that hospitals

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[121] *Hereford Journal,* 20 Oct. 1774.
[122] A. Wilson, 'Conflict, consensus and charity'.
[123] Porter, 'Gift relation'.

might provide a focal point for particular political interests which served to strengthen political alliances.

The evidence from Herefordshire confirms that there was indeed a relationship between a contested parliamentary election and an Infirmary appeal and that elements of both the eirenic and antagonistic theory came into play. There is a clear association between the date of foundation of the Infirmary and the contested election and it was the contest itself that ensured that all the candidates publicly promoted the Infirmary. The timing of the launch of the subscription, literally a few days prior to the start of polling suggest that this was a well-orchestrated and well thought out attempt to use publicity and the influence of the local media in some last minute electioneering. The Infirmary was a tangible symbol suitable for a public relations exercise aimed at generating publicity and goodwill to boost Harley's profile with the local community in a contest against two strong candidates. However, much of its power as a public relations exercise lie in the impression given of altruistic enterprise for the common good. It appeared an unselfish act of philanthropy while serving Harley's individual interests. Among the other individual interests served were those of Thomas Cam, physician and mayor. As discussed earlier in this chapter, Cam became one of the first physicians at the Infirmary and the Infirmary management soon came to be dominated by members of Hereford corporation.

4.4.3 A tangible symbol of philanthropy : the new Infirmary building

The first priority of those leading the Infirmary campaign was to establish a service and this was achieved by using rented premises for the temporary Infirmary that opened in July 1776. Meanwhile, the governors pursued their plans for a permanent, purpose-built Infirmary and were actively looking for a site for the new building by August 1775. By October they were considering a specification although they had not yet identified a site and had insufficient funds to finance a new building. The invitation to tender that was placed in the *Hereford Journal* included details of the facilities that

the new building should have. A few weeks later, further publicity gave the following additional guidance to prospective bidders-

> That it is the opinion of this Committee that a liberal allowance of room should be made for at least fourscore patients in chambers of different sizes, that the Committee are likewise of the opinion that a plain edifice, recommended by convenience and simplicity, will be most agreeable to the subscribers, and that they will wish to avoid, as much as may be, all useless and expensive ornament.[124]

In November 1775 the problem of a site was resolved when Lord Oxford donated a suitable site on the River Wye just outside the city perimeter and close to the old castle grounds. The land was vested in Hereford corporation for the use of the charity. [125] No further progress with the building was made until the autumn of the 1776, when William Symonds was invited to prepare an estimate for the completion of the plans submitted by him up to a maximum cost of £4,000.[126] These new plans were approved in January 1777.[127] Later that month, confidence in the generosity of patrons was high enough for the possibility of expanding the design to include some provision for lunatics to be mooted and a separate subscription was started to raise the additional money required.[128] This confidence was short lived and it soon became apparent that there would be insufficient funds to finance the Infirmary scheme let alone to extend the scheme. In June 1777, the committee felt that prudence dictated that all plans for a purpose built Infirmary should be put on hold until capital funds reached £6,000.[129]

By October 1779, the medical personnel were arguing for the need for extended premises but despite this a committee was not appointed to look into the

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[124] *Hereford Journal*, 15 Nov. 1775.
[125] Minutes of Governors' Meetings, 27 March 1776.
[126] *Ibid.* 10 Oct. 1776.
[127] *Ibid.* 16 Jan 1777.
[128] *Ibid.* 25 Jan 1777.
[129] *Ibid.* 27June1777.

detail of executing William Symonds' plan until the following July.[130] This exercise included a review of Leicester Infirmary and resulted in the abandonment of Symonds proposals in favour of an alternate plan submitted by William Parker, a local architect who was involved in the restoration of the cathedral and was the surveyor to Hereford Improvement Commission.[131] These plans were put into action and on 27 February Thomas Talbot laid the foundation stone for the new building.[132] The new Infirmary was a three storey brick building with a central pediment with two single storey wings. Figures 4.8 and 4.9 provide views of the Infirmary and Figure 4.10 a plan of the front elevation and the ground floor. The wards were on the top two floors of the main building and provided accommodation for fifty-five patients in thirteen wards. The accommodation on the ground floor included a surgery and rooms for the physicians, apothecary and matron, as well as a room for dressings and a mortuary. The largest room was the committee room for the use of the governors. There was a kitchen and dining room and separate rooms for hot and cold baths. Outbuildings included a laundry, brew house and accommodation for a porter. The final cost, excluding fittings and furniture but including building the embankment on the river's edge, was £5,110.[133]

The hospital site occupies a prominent position on the banks of the Wye, close to the main thoroughfare into town leading from the south of the City. It is within walking distance of the cathedral and is adjacent to the public gardens laid out on the site of the old castle at the end of the eighteenth century. The river-bank opposite also later became a public recreation area. The Infirmary was undoubtedly one of the most prestigious buildings in Hereford, and its image was reproduced in many nineteenth century guidebooks to the town. Several wards in the Infirmary were

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[130] *Ibid.* 4 July 1780.
[131] Whitehead, 'Architectural history', in Aylmer and Tiller, *Hereford Cathedral,* p. 258-260.
[132] Minutes of Governors' Meetings, 1 March 1781.
[133] Renton, *Herefordshire's hospitals,* p. 23.

Figure 4.8: View of Hereford General Infirmary, 1827.
Source: W. J. Rees, *The Hereford guide*, 1827.

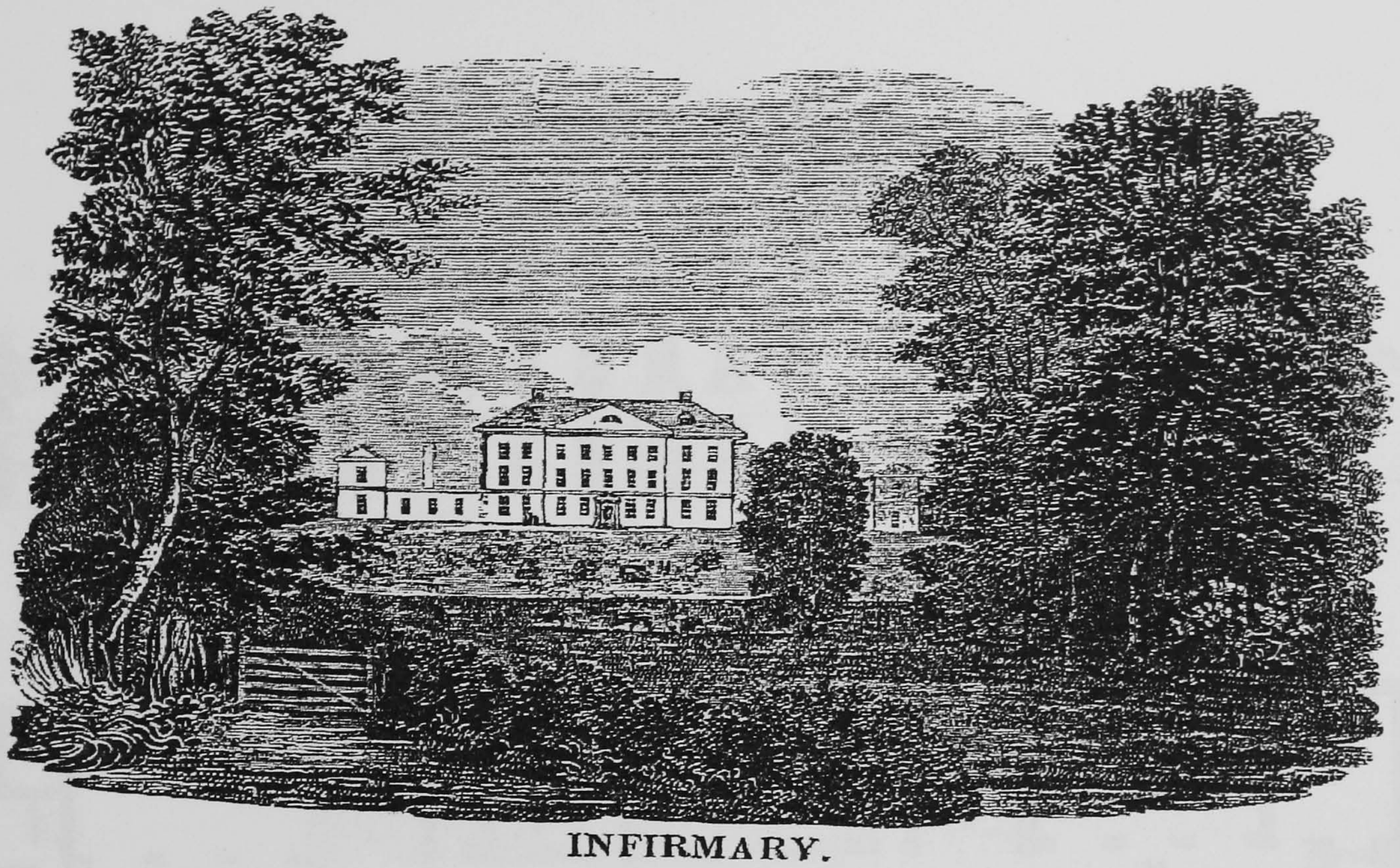


Figure 4.9: Hereford Infirmary from the palace gardens, 1796
Source: I. Price, 1796.

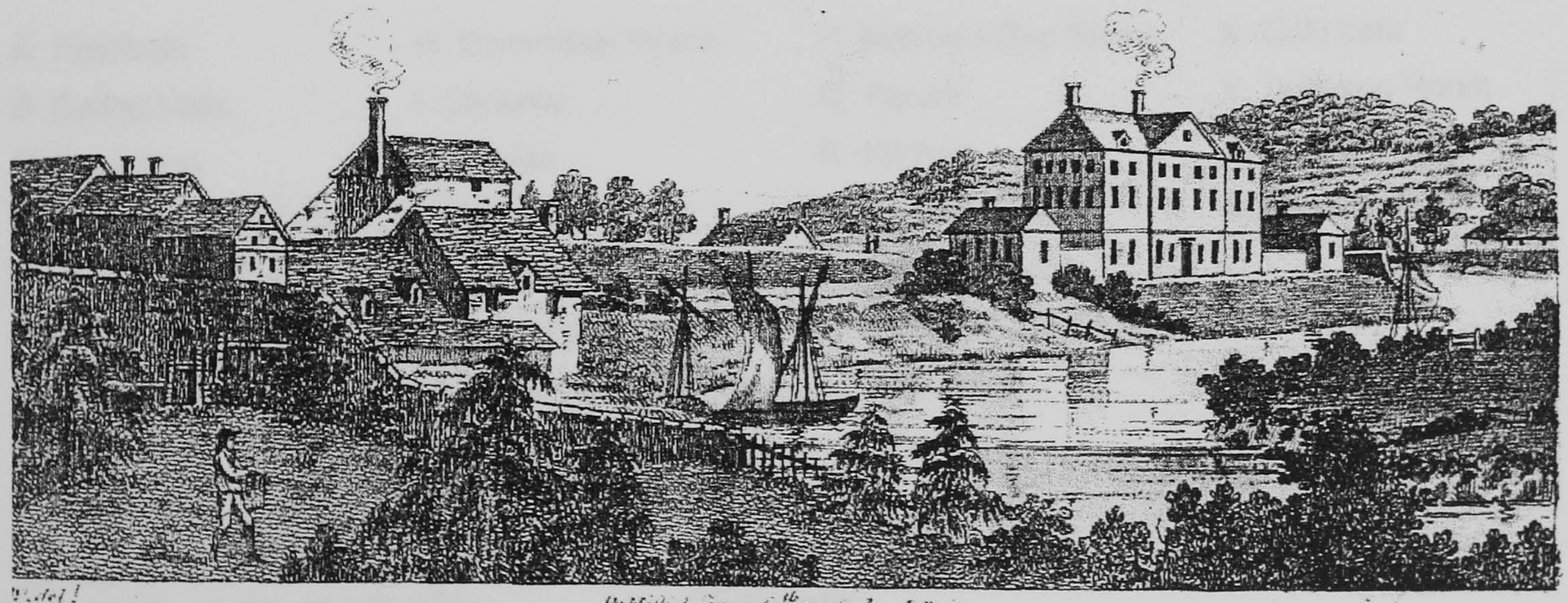
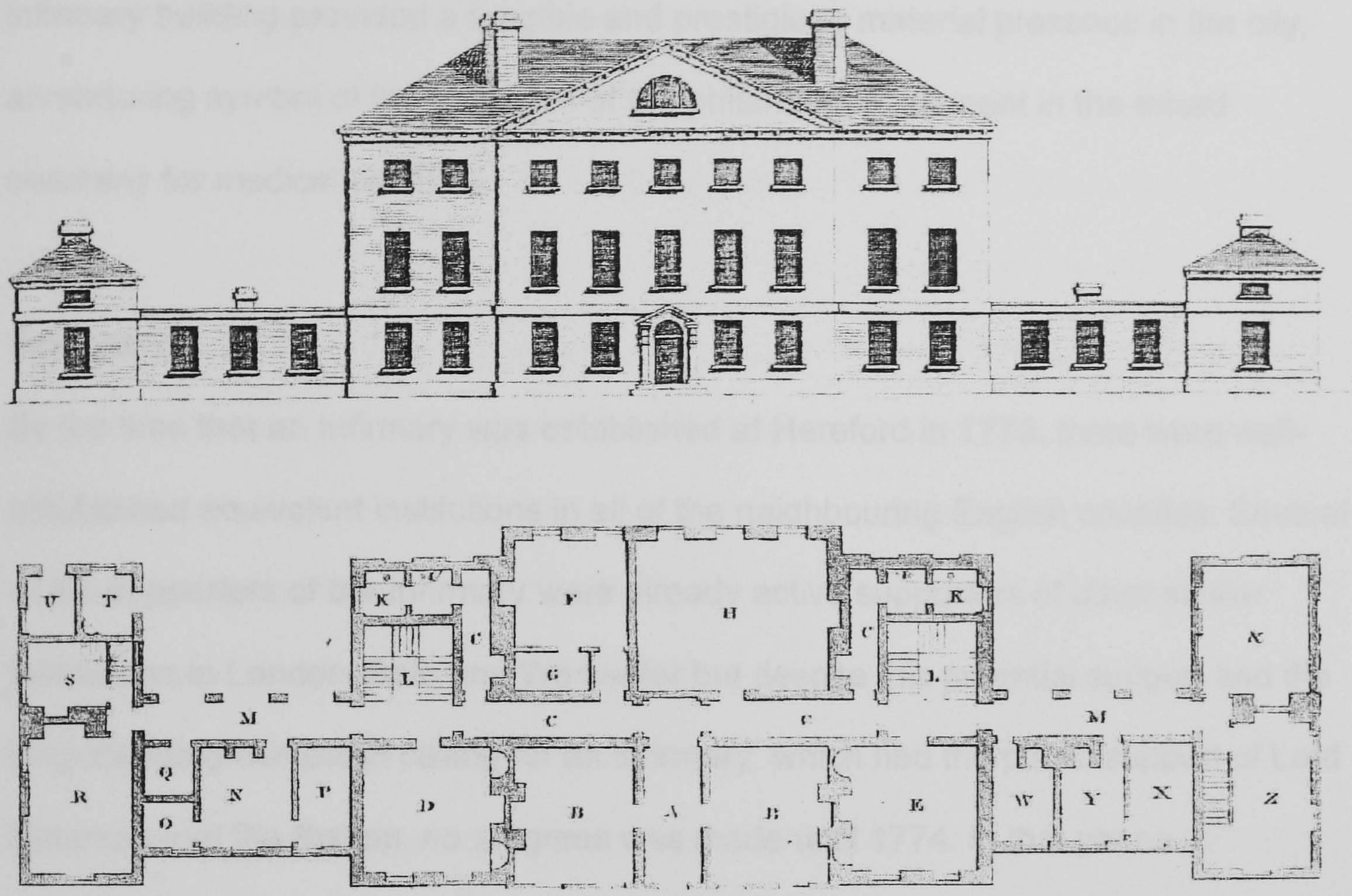


Figure 4.10: Plan of Hereford General Infirmary, 1785.
Source: *Annual Report*, 1785.



Key

A Vestibule
B Eating Halls
C Passages
D Apothecary's Room
E Physician's Room
F Surgery
G Closet to the Surgery
H Committee Room
I Cisterns
K Privies
L Stairs
M Covered Ways
N Matron's Room
O Matron's Store Room
P Matron's Bed Room
Q Pantry
R Kitchen
S Scullery
T Porter's Room
U Room for the Dead
W Hot Bath
X Cold bath
Y Dressing Room
Z Wash House
& Brew House

Six wards on the principal floor for	27 patients
Five wards on the attic floor for	28 patients
Total	55 patients

named after the initial substantial donors, in particular Oxford and Talbot wards. Other wards were named after later major donors including Morris.[134] The governors erected a monument to the memory of Thomas Talbot in the cathedral in 1830. The Infirmary building provided a tangible and prestigious material presence in the city, an enduring symbol of the presence of the philanthropic element in the mixed economy for medical services.

Summary

By the time that an Infirmary was established at Hereford in 1775, there were well-established equivalent institutions in all of the neighbouring English counties. Several of the supporters of the Infirmary were already active supporters of other similar institutions in London, Bath and Worcester but despite this potential support and the long-standing campaign calling for an Infirmary, which had the public support of Lord Bateman and the Bishop, no progress was made until 1774. In that year a parliamentary election provided a catalyst for the members of the nobility and gentry to provide the publicity and the initial pledges of support to successfully start an appeal. The appeal was launched at the inauguration of the new mayor, Thomas Cam, one of the most eminent medical practitioners in the town. His interest in the scheme was undoubtedly professional as he took up one of the prestigious honorary roles and his family served the charity for several generations but also reflects the interest of Hereford corporation in the scheme. The corporation had become increasingly concerned with the need to modernise the city and had worked to achieve the passage of the Hereford Paving and Lighting Act. This Act, which was passed in 1774 allowed both for improvements to the infrastructure and to some of the city's ancient charitable endowments. In order to achieve these aims they

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[134] The only original donors to be commemorated in the new hospital building that opened in 2002 are the Harley family. The outpatient department is called the Oxford Suite.

needed to foster support among the gentry and townspeople and to generate funding from a variety of sources. A self-financing Infirmary based on the voluntary model was a valuable contribution to these plans.

The individuals who contributed to the initial appeal and those who provided ongoing support can be identified from contemporary newspaper reports and the surviving *Annual Reports* of the institution. The majority of the initial donations came from members of the aristocracy and gentry with close links to the county. Although few in number, the support of the aristocracy continued to be important both for financial reasons and for the legitimacy and status confirmed on the charity by their public support. Subscription records indicate that the gentry and clergy provided the backbone of on-going support for the institution. The Bishop and high-ranking diocesan and cathedral clergy were important supporters in addition to the mass of the rural clergy. Towards the end of the eighteenth century, subscription income declined from the levels achieved in the early years of the charity and the Infirmary was in difficult financial straits for a number of years before financial security was assured through investment income earned from a number of large legacies. Thereafter, investment income became crucial to the continued solvency of the Infirmary, eventually making up approximately half of annual income.

Although built as a county Infirmary, members of the unreformed Hereford corporation exercised significant influence over the running of the institution throughout the period, both as honorary medics and as individual governors active in the management committees of the organisation. In this way the Infirmary was securely integrated into the existing power structures of the city. Both the timing of the hospital appeal and the management the charity demonstrate the dynamic interrelationship between personal motive, political interest and philanthropic activity.

Chapter 5

Medical services for the insane

The century between 1750 and 1850 saw a radical change in the arrangements for the care and confinement of the insane.[1] At the start of the period there were only three institutions providing specialist care in England, at Bethlem hospital and some specialist wards at Guy's Hospital in London and at Bethel Hospital in Norwich. The majority of insane people were maintained in the community, either living with their own families or supported by other individual arrangements, with Poor Law authorities funding care for paupers. It was only the minority of those classified as insane, the 'furiously mad' who were very disruptive or considered a public danger, who were contained in institutions, mainly in gaols. In 1774 legislation introduced a system of licensing and inspection by the local public authorities for all madhouses caring for more than one patient and this model for public regulation remained in force until replaced by a national system of central inspection by specialist Lunacy Commissioners in 1845.

During the eighteenth century private and charitable madhouses developed to meet the increasing demand for services for the insane. Following the enabling legislation of 1808 the first public asylums were established. In the first half of the nineteenth century a mixed economy operated for asylum care with increasing numbers of private, charitable and public asylums being established.[2] In 1845, legislation was passed making it obligatory for counties to provide a public asylum for insane paupers within three years, and by the end of 1847 thirty-six out of fifty-two counties had built asylums, with the others following

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[1] The standard text is Scull, *Most solitary of afflictions.* See also R. Porter, *Mind forg'd manacles: a history of madness in England from the Restoration to the Regency* (London, 1987).
[2] Parry-Jones, *Trade in lunacy* and Smith, *Cure, comfort and safe custody.*

in the next few years.[3] The numbers of both acutely and chronically ill patients in these institutions grew rapidly from the 1850s as the public institution model grew to dominate the arrangements for the care of the insane in England.

Historians have provided a variety of explanations for the development of this institutional response to managing lunacy. In the 1950s and 1960s, the benevolent and progressive nature of the changes was emphasised, in particular the success of the lunacy reform movement and the developing medical specialism of psychiatry in establishing humane curative institutions. The seeds of the welfare state were identified in the early nineteenth-century reforms.[4] In his polemical work, *Madness and civilisation,* Michel Foucault provided a more critical reading of the effects of the Enlightenment and the development of 'moral management '. In particular he drew attention to the repressive role of the state and the medical profession in classifying the insane as a deviant population and effecting their subsequent confinement. [5] Although the detail of much of Foucault's analysis has since been refuted, it has stimulated a rich seam of historical debate and enquiry that has examined the specific English experience in more detail and has developed his underlying thesis in a number of areas. For example, the identification of the insane as a distinct social group and their incarceration in asylums has been associated with the development of the modern European state. Andrew Scull argued that the key driver for change was social dislocation arising from increased commercialisation and the development of a consumer culture from the eighteenth century which linked the whole nation in a new kind of market economy.[6] Underlying economic changes strained the resources of families and communities and promoted the need for a national

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[3] Scull, *Most solitary of afflictions,* p. 267.
[4] K. Jones, *Asylums and after: a revised history of the mental health services: from the early eighteenth century to the 1990s* (London, 1993).
[5] M. Foucault, *Madness and civilisation: a history of insanity in the Age of Reason* (London, 1971).
[6] Scull, *Most solitary of afflictions,* pp. 26-34.

solution to manage the problem of a group of people who were unable to maintain themselves and were perceived as posing a significant threat to bourgeois society. Some of the conclusions of Scull's revisionist national model have since been challenged by more detailed studies of particular aspects of policy, time frames or geographic areas.[7] Of particular interest to this study is work investigating the influence of Poor Law Guardians and local elites over lunacy provision that has emphasised the validity of considering these changes within a broader administrative and legal framework.[8] County asylums were costly to build and to run, and local lunacy policy was developed through a process of negotiation, especially in the period before 1845 when public asylums were one of several institutional models to be considered. Lunacy reform at the local level in the nineteenth century is best understood within the context of the administrative structures and legal framework of the New Poor Law and of local political arrangements.[9] This chapter discusses the development of local policy and provision for lunatics in Herefordshire within this context.

The earliest evidence of interest in establishing a specialist institution for lunatics in the county is found in minutes of a meeting of the governors of the General Infirmary held in 1777.[10] Although a subscription appeal was launched in that year it was not immediately successful and sufficient funds for a purpose built asylum were not collected until 1792. The asylum opened in 1799 and operated under the management of the Infirmary governors for two years after which it was leased to two doctors to be run as a private madhouse. Two other private asylums also operated in the county, one from the 1820s to 1831 and a

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[7] J. Melling, 'Accommodating madness: new research in the social history of insanity and institutions', in J. Melling and B. Forsythe (eds), *Insanity, institutions and society, 1800-1914* (London, 1999) provides a useful summary.
[8] B. Forsythe, J. Melling and R. Adair, 'The New Poor Law, and the county pauper lunatic asylum', *Social History of Medicine*, 9 (1996), pp. 335-355.
[9] Bartlett, *The Poor Law of lunacy.*
[10] *Hereford Journal,* 27 Jan. 1774.

successor from 1833. The first public asylum for Hereford paupers opened in 1851 as part of a joint venture with neighbouring Welsh counties and a public asylum within the county borders opened in 1871. There was therefore no specialist institutional care within the county until the very end of the eighteenth century and with the exception of two years, this was provided by private madhouses until 1851.

Although many madhouses were private businesses, a number of public authorities had statutory or voluntary responsibilities concerning the insane, which meant they had some jurisdiction over asylums. From 1774, County magistrates had responsibility for licensing and inspecting private madhouses and for signing admission and discharge papers for individual lunatics. From 1808 county magistrates also had the option of promoting a public asylum and from 1845 this became an obligation. Poor Law guardians under the Old and New Poor Laws had responsibility for the financial support of pauper lunatics and the governors of the General Infirmary continued to have an interest in the private asylum at least as landlords. Hereford corporation also had an interest in the specialist accommodation provided within the city. All of these groups had a role that affected how the asylum was run or who was admitted to it, and the local model adopted required their endorsement and support. It is argued here that the model established in Hereford at the start of the nineteenth century was a pragmatic solution that suited the interests of all these parties. The private asylum model that operated from 1801 came under threat in the 1830s as a result of the introduction of the New Poor Law and the Municipal Reform Act but ultimately survived until the 1845 legislation made provision of a public asylum obligatory.

Section 5.1 explores the origins of the private asylum in Hereford and the way in which it operated up to 1834. A relatively underdeveloped area within the historiography of madness is the relationship between philanthropy and lunacy, particularly in the nineteenth century when the main focus of interest has been

the increase in the role of the central state. Prior to the enabling legislation of 1808, voluntary asylums were the only alternative to private madhouses, and the perceived abuses of the private madhouse system were one of the main drivers for their introduction.[11] The evidence from Herefordshire shows that the distinction between a private and voluntary asylum was not necessarily straightforward and that pragmatism and agreement between power brokers influenced the model adopted in a locality. A comparison of Hereford Asylum and Hereford Infirmary as philanthropic ventures provides an opportunity to explore contemporary views as to what constituted appropriate spheres of philanthropic activity. It is argued that the private madhouse in Hereford successfully operated within a system of collaboration between magistrates, the Infirmary and the city corporation; and that this meant that the model of a public asylum was not seriously considered until the 1830s. Section 5.2 discusses the care provided to the insane in the county during the first half of the nineteenth century, drawing on evidence from returns compiled by parishes and the county magistrates and surviving records of the asylums.

From 1834, changes arising from the introduction of the New Poor Law and the Municipal Reform Act meant that new groups with a financial, legal or administrative interest in lunacy provision emerged. In 1836 tensions arose between the asylum keeper, the County magistrates, the New Poor Law guardians and the newly elected Hereford council over standards of care at the private asylum and jurisdiction over licensing. This led to a public dispute that resulted in a House of Commons Select Committee Enquiry. The outcome endorsed the private asylum model by the prevailing powers and no public asylum was developed until after the 1845 legislation made this compulsory.

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[11] Smith, *Cure, comfort and safe custody*, pp. 12-20and A. Digby, *Madness, morality and medicine: a study of the York Retreat, 1796-1914* (Cambridge, 1985).

Section 5.3 provides a detailed exploration of these events, the issues raised and the underlying reasons behind the dispute. Section 5.4 discusses the action taken to establish public asylum provision after 1845.

Source materials used in compiling this chapter include the minutes and *Annual Reports* of Hereford General Infirmary and minutes of the New Poor Law Unions. Quarter Sessions records used include papers relating to lunacy returns, the licensing and inspection of private madhouses and discussions relating to the establishment of a public asylum. Papers relating to the private asylum in Hereford include a register of cases for the period 1817 to 1834 and records of the Joint Counties' Asylum at Abergavenny include *Annual Reports,* an admission register and case summaries for many of those transferred to the asylum in 1851. In addition, the minutes of the Parliamentary Select Committee Enquiry into the management of Hereford Asylum provide a valuable source for consideration of conditions there and the limitations of the regulatory mechanisms in place. Information reported in the local newspapers has also been drawn upon.

5.1 The establishment of Hereford Asylum

In 1714, vagrancy legislation had distinguished between lunatics and 'rogues, vagabonds, sturdy beggars and vagrants', and had empowered justices of the peace to authorise the apprehension and confinement of those deemed to be 'furiously mad'. No guidance on the type of suitable accommodation to be provided was given and it was not until 1763 that legislation sought to regulate this in any way. In that year, following increased public concern over abuses in private madhouses, a Select Committee was established to examine alleged shortcomings at the large private madhouses in London. However, the impetus for reform was in its infancy and it was ten years before the Act for Regulating Private Madhouses was passed in 1774.

This Act established the important principle that private institutions run for profit were subject to some regulation by the public authorities. A system of compulsory licensing and inspection was introduced for all private houses taking in more than one lunatic. Outside London, justices of the peace were responsible for considering applications for licences and appointing a committee of visiting magistrates at Quarter Sessions. The visitors were to attend each asylum on a regular basis to ensure that the patients were cared for in humane conditions and that no one was wrongfully detained. In addition, every application for the admission of a patient to an asylum required authorisation by a medical professional and a magistrate or Poor Law guardian. In practice, the powers of the commissioners to enforce standards were limited. A madhouse keeper who refused to admit the visiting magistrates might forfeit his licence, but provided he allowed them access they had no basis for the refusal of a licence.[12] Despite its acknowledged limitations, the Act remained the only statute dealing with lunacy provision until the County Asylums Act of 1808.

By the beginning of the nineteenth century there were sixteen licensed private madhouses in the London metropolitan area and twenty-two in the provinces.[13] The majority of the provincial houses were relatively small, taking between six and twenty-five patients.[14] Voluntary asylums began to be established from the middle of the eighteenth century some of them developed by infirmary charities that expanded their activities to caring for the insane. The first charitable asylum to open was St Luke's Hospital in London in 1751, and the first provincial voluntary asylum was the Newcastle Lunatic Hospital that opened in 1765. By the end of the eighteenth century there were seven voluntary asylums

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[12] *Jones*, p. 45.
[13] Parry-Jones, *Trade in lunacy*, p. 30.
[14] *Ibid.* p. 41. The information is estimated from the available data for 1819.

providing an alternative to the private madhouses, one of which was in Hereford.[15]

As discussed in Chapter 4, a sustained effort to establish a voluntary infirmary in Hereford did not occur until 1774. By this time the model of providing a voluntary asylum in addition to an infirmary was becoming better established and the governors of the General Infirmary first discussed the possibility of facilities for the insane in 1777.[16] The timing of the infirmary appeal coincided with Thomas Harley's efforts to be elected MP for County Herefordshire between 1774 and 1776 and the proposal to extend the infirmary charity to include a lunatic asylum may have been a further attempt to raise his profile by association with the venture. The site donated by Harley's brother for a purpose built infirmary on the edge of the city was sufficiently large to enable an asylum to be provided on the same plot. Harley had also gained direct experience of institutional asylums while serving as Alderman for the City of London and had been a member of the 1763 Select Committee.[17] He also served as President of St Bartholomew's Hospital for many years and would have been well aware of the strong political links between the City of London and the four London hospitals, which included Bethlem.

The proposal for an asylum in Hereford was publicly justified on the basis that 'the security and cure of Lunatics in private families is almost impracticable' but that private madhouses did not offer a suitable alternative due to various abuses put down to the 'ignorance and venality of the keepers'.[18] However, the appeal did not prove popular and insufficient support was forthcoming to make any real progress. In fact, sufficient funds had not yet been raised to finance the new Infirmary building although some beds had been opened in temporary

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[15] Smith, *Cure, comfort and safe custody*, p. 15.
[16] *Hereford Journal,* 27 Jan. 1777.
[17] Jones, *Asylums and after*, p. 34.
[18] HRO, S60, Hereford Infirmary, Governors' minutes, 18 Oct. 1777.

accommodation and it is likely that the governors realised they needed to give priority to the Infirmary appeal. In 1788, four years after the new building opened, the Governors re-launched the appeal for a scheme 'to Rescue Objects of Insanity from the Custody of ignorant, cruel and rapacious Pretenders'.[19] It was emphasised that the finances of the Asylum and Infirmary would be kept separate in order to protect the financial position of the Infirmary, which had been running small annual deficits for much of the 1780s. Although £500 had been raised for the asylum, it was estimated that a further £300 was needed to pay for accommodation for twelve to fourteen patients.

The steward at the Annual General Meeting in 1788 was Charles, Duke of Norfolk (then Earl of Surrey), who had a personal interest in lunacy. Following the death of his first wife in childbirth in 1768, Norfolk had married Frances Scudamore, only child and heir of Charles Fitzroy Scudamore of Holme Lacey in Herefordshire. In 1771, shortly after their marriage, Frances was declared insane and was cared for at home until her death in 1820.[20] Although they are not recorded as financial supporters to the asylum charity, both Norfolk and Scudamore were among the principal subscribers to the General Infirmary and William Blount, the institution's honorary physician, cared for the Duchess. The appeal records include an anonymous donation to the asylum fund of £100 that may well have come from one of them. 1788 was also the year of the first of George III's attacks of madness, which increased public awareness of the problems of lunacy and may have prompted support for a specialist asylum.[21]

In 1792, the promise of a legacy of £200 meant that the asylum building could finally proceed and in 1793 a building committee was appointed which invited William Parker, the architect of the General Infirmary, to draw up plans.

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[19] Hereford General Infirmary *Annual Report*, 1788. I am grateful to Charles Renton for making available a copy of the report for this year.
[20] HL, 091.02, marriage settlement and deed of separation of Charles Howard and Frances Fitzroy Scudamore.

Anthony Keck, who had designed Worcester Infirmary, and John Nash, who was working on the new Hereford Gaol and several country houses in the county reviewed the proposals and advised that Parker's scheme was too expensive.[22] Nash offered to produce some alternatives, which were accepted. The building services were tendered for separately and in April 1794 a contract was agreed with a local builder, Mr Knight. By 1795 the scheme was running into difficulties with the committee concerned that Knight's work was not up to standard. They had also fallen out with John Nash, and, when Knight went bankrupt, they handled the ensuing arbitration case themselves, eventually settling in 1796 for £1,268 of the original contract sum of £1,297. Nash was paid £63 for the plans although he claimed an additional £21 was due.[23]

Ongoing financial problems at the Infirmary during the 1790s and the lack of sufficient committed supporters for the asylum charity led the Governors to conclude that they could not run the Asylum as a subscription hospital as had originally been intended. Instead they agreed to lease it to the honorary physicians at the General Infirmary for them to run as a private madhouse. However, some of the Infirmary subscribers objected to this on the grounds that it was not in accordance with the charitable intentions of the Infirmary and the proposal was revoked.[24] Eventually a compromise was reached under which the Infirmary governors managed the asylum with day to day supervision provided by an experienced madhouse keeper. In common with other voluntary asylums, a charge was levied to cover the cost of care. This contrasted with the approach in

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[21] I. Macalpine and R. Hunter, *George III and the mad-business* (London, 1969).
[22] Nash's work in the county included the Cornewall family's estate at Moccas Court with Anthony Keck and the Scudamore's estate at Kentchurch Court.
[23] HRO, S60, Hereford Infirmary, Governors' minutes, March- Apr. 1798.
[24] HRO, A95/J/38. Papers of J. S. L. Pateshall.

charitable infirmaries where treatment was provided free. [25] The asylum opened with twenty beds on 6 June 1799. [26]

The rules of the asylum set out the principles to be followed in caring for patients in addition to the procedure for admission, discharge and payment.[27] The Infirmary's honorary medical staff had responsibility for the medical treatment of patients but their day to day management was delegated to a matron and keeper. Care had been taken in recruiting to this key appointment and David Davies had been appointed as keeper on the recommendation of John Haslam from Bethlem Asylum. Male and female patients were accommodated separately, and convalescent patients kept separate from ' the unhappy sufferers under more violent degrees of insanity'. Rules 18 and 19 stated that

> All patients be treated with all the tenderness and indulgence compatible with the steady and effectual government of them; and that the Keeper and Matron be strictly enjoined never to employ any unnecessary severity. That no violent means be employed in administering Medicines to the patients; but if any one be pertinaciously refractory, the Physician shall be informed of it, that he may give the necessary directions concerning the method to be pursued with such Patient.[28]

Physicians were to visit patients at least twice a week and were required to maintain case notes showing details of age, sex, occupation, lifestyle and hereditary constitution. These rules demonstrate a commitment to humane treatment and show some awareness of best practice including the limited use of methods of restraint and the importance of a curative regime. There were only six other specialist institutions in the country and Haslam was an acknowledged

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[25] Smith, *Cure, comfort and safe custody,* p. 17.
[26] Renton, *Herefordshire's hospitals,* p. 184.
[27] *Rules for the Government of the Lunatic Asylum in Hereford* (1799).
[28] *Ibid.* rules 18 and 19, p. 7.

authority through his appointment at Bethlem and his many publications.[29] How far the asylum was able to fulfil these aspirations is unclear, as with only twenty beds it is unlikely that it would have been possible to follow the degree of classification of patients set out in the rules.

The rules were drawn up to ensure compliance with the provisions of the Act of 1774. No patient was to be admitted without an order or declaration of insanity and where possible the Infirmary physician examined patients prior to admission. Where this was impractical due to the distance of the patient's home from Hereford, the local surgeon was required to sign a declaration in a specified format. On admission, patients were examined for any bruises or sores and were allocated to the care of a physician who would sign to demonstrate acceptance of responsibility. Patients were only to be discharged on the recommendation of the physicians and a record of the patient's mental state on leaving the asylum was to be noted in the discharge records. The rules also stated that no pregnant women or incurables were to be admitted.[30]

The minimum charge per week was 16s with no differentiation in price for pauper or private patients.[31] This was unusual as many asylums charged private patients a higher rate to subsidise the cost for paupers and the insane poor.[32] In Gloucester, in 1794, it was estimated that parishes could afford a maximum of 8s a week for pauper patients and forty years later the county justices in Hereford were suggesting a weekly cost of 5s a week for paupers at the proposed county

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[29] For a discussion of Haslam's career, see A. Scull, C. MacKenzie and N. Hervey, *Masters of bedlam: the transformation of the mad-doctoring trade* (Princeton, 1996). pp. 10-47.

[30] E. Showalter, *The female malady: women, madness and English culture, 1830-1980* (London, 1987) discusses contemporary views of female insanity relating to gender differences for a later period. Pregnant women were also excluded from the Infirmary, but in the context of care for lunatics it was probably due to the belief that pregnancy and female sexuality could stimulate mental illness.

[31] *Rules of the Lunatic Asylum,* p.14.

[32] Smith, *Cure, comfort and safe custody,* p. 17. For example, charges at Manchester ranged from 4s to one guinea a week in the 1770s.

asylum.[33] Once a patient had been approved as a suitable case for admission, a bond was completed setting out who would accept financial responsibility for the cost of care. In addition to providing surety of £100, the bond confirmed the weekly charge and the bondsman's responsibility for clothing, burial expenses and any extra costs incurred in treating any physical illness. The asylum failed to attract sufficient patients under these terms and between October 1799 and February 1800 the committee considered whether or not to lower the fees. In 1801 they finally decided that the charitable model was not viable and agreed to let the asylum on a peppercorn rent of one guinea per annum to William Blount and Thomas Cotes for them to run as a private madhouse.[34] The Infirmary governors continued to be involved in the asylum as landlord but took no further part in the day to day operation of the institution.

A detailed cashbook covering the period 1791 to 1799 survives which provides details of the £1,726 donated to build the asylum.[35] Donations were not collected as they were pledged and the cashbook shows that only £91 was held by the charity in 1791, with the majority of donors paying the amounts pledged between 1793 and 1799, when the asylum building was in progress. For example, Dr Campbell, honorary physician at the Infirmary, did not pay over the twenty guineas he had originally pledged in 1777 until October 1794. In total £1,613 was available from donations and legacies and an additional £116 in interest. One of the largest gifts, a legacy of £150 from the estate of Elizabeth Smith, was given on an interest only basis and this made up the majority of the balance of £210 left over after building and fitting out the asylum.

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[33] A. Bailey, 'An account of the founding of the first Gloucestershire County Asylum, now Horton Road Hospital, Gloucester, 1792-1823', *Bristol and Gloucestershire Archaeological Society Transactions,* 40 (1971), pp.178-191, p. 179 and HRO Q/AL/192, Report of the Committee to Quarter Sessions, June 1839.

[34] HRO S60, Hereford General Infirmary, Governors' minutes, 18 April 1801.

[35] *Ibid.* The cash book is in the same volume as minutes for 1791-1799.

Table 5.1 provides a summary of the major donors. Six of the 112 donors donated in excess of £100, totalling £950 or 60 per cent of the total collected. Four of these were legacies and one gift was anonymous. A further fifteen donors gave over £20, which in total amounted to £328 or 20 per cent of the total. These people were entitled to become governors of the Asylum as were all governors of the General Infirmary. Ninety-one people gave smaller donations totalling £335. It was therefore the gifts of the six major donors that enabled planning to proceed. Of the five largest donors to the Asylum, three also supported the General Infirmary but there is no record of Miss Cam or Mr Seward supporting that charity. Only eighteen of the donors listed were governors of the General Infirmary.

Table 5.1: Summary of donors to Hereford Asylum building fund

Donors	**Amount £**	**No of subscribers**
Miss Cam	200	
Mrs Smith, Hinton	150	
John Freeman, Letton	250	
Rev Grand, Dirham, Gloucester	150	
Abraham Seward, Sarum	100	
Anonymous	100	
Total over £100	**950**	**6**
Others over £20	328	**15**
Others	335	**91**
Total	1,613	**112**

Source: Asylum cashbook, HRO S60, Hereford General Infirmary Governors' Minutes, 1791-1799.

The difficulty in raising money and the relatively small amounts collected make the fact that an asylum was opened in Hereford prior to 1799 all the more remarkable. The success of the project was due to the efforts of a few dedicated people working over a number of years to bring the project to fruition. These

included Joseph Perrin, a lawyer and member of Hereford corporation who was treasurer of the Infirmary and acted as treasurer to the Asylum until his death in 1799. Perrin was also a member of the committee that established the first workhouse in the city in 1785. Strong support also came from the medical professionals working at the Infirmary and all three honorary physicians, Symonds, Campbell and Blount, gave money to the appeal. These three clearly had a personal interest in the success of the project and in the end Blount was provided with a purpose built asylum from which to run a private madhouse for profit.

The difficulties faced in Hereford in establishing a voluntary asylum were also being experienced elsewhere. Although plans had been explored in several areas, few charitable asylums were actually established and in operation prior to 1800.[36] In neighbouring Gloucestershire, for example, the idea of an asylum was first promoted as an extension to the Infirmary in 1792 and a subscription fund was opened in September 1793.[37] By July 1794, the appeal had raised over £4,000 and a scheme and plans were under active consideration. The eventual plan approved was to provide accommodation for three classes of patients; private patients, paupers, and a third class to be supported by contributions from subscribers. Despite the extensive planning and a sizeable fund, the planned building did not go ahead, perhaps due to the emerging debate about the need for the provision of public asylums. An influential local figure was Sir George Onesipherous Paul who had a particular interest in criminal lunacy and was influential in the national campaign for prison reform.[38]

Paul was one of the key witnesses to be called to the 1807 Select Committee that was established 'to inquire into the State of Criminal and Pauper

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[36] Smith, *Cure, comfort and safe custody*, pp. 12-20.
[37] Bailey, 'First Gloucestershire County Asylum'.
[38] Smith, *Cure, comfort and safe custody*, pp. 20-22.

Lunatics in England and the laws relating thereto'.[39] At this time, the law allowed for vagrants to be confined in workhouses but it was widely accepted that this was inappropriate and the Committee recommended that each county set up an asylum to provide specialist provision for both pauper and criminal lunatics. These county asylums were to be financed from the county rate under the management of a committee of governors nominated by the local justices. These proposals were encapsulated in the County Asylums Act of 1808 that empowered counties to raise a rate for the purpose of establishing an asylum. Public concerns about abuses in lunacy provision continued which eventually led to a further Select Committee in 1815. This investigated some of the best known asylums in the country, including Bethlem, the new county asylum in Nottingham, several large private madhouses in London and the subscription asylum at York.[40] Earlier concerns about the treatment offered had led local Quakers to establish a private asylum, the York Retreat, in 1792. In 1808 there were allegations of fraudulent management practices in addition to poor patient care and further claims of ill treatment led to an inquiry into the York voluntary asylum in 1813.[41] At Bethlem the focus of much of the evidence was on the treatment of individual lunatics, including issues of inappropriate confinement and the use of chains and other forms of restraint. The case of William Norris, highlighted by Edward Wakefield, drew particular public attention. [42] Despite the publicity given to a wide range of substantial shortcomings in lunacy provision, legislation passed in 1815 and 1819 did little more than refine the provisions of earlier legislation. [43]

In 1827 another Select Committee examined provision for pauper lunatics in metropolitan boroughs where evidence of poor conditions at Warburton's large

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[39] *Ibid.*
[40] Jones, *Asylums and after*, pp. 67-74.
[41] Digby, *Madness, morality and medicine*, pp. 178-182.
[42] Scull, *Most solitary of afflictions*, pp. 93-95.

private madhouses activated the campaign for the construction of the Middlesex County Asylum at Hanwell. In 1828, some of these concerns were addressed in two Acts relating to Private Madhouses and County Asylums which introduced a stricter regulatory framework to be enforced by the justices of the peace in the provinces and the metropolitan commissioners in the metropolitan area. Each asylum was to be visited four times a year and an annual return of admissions, discharges and deaths was required by the Secretary of State. Additional returns required included the number of curable patients, analysis by gender, the number of patients judged incurable and the number under restraint. Pauper patients were only to be admitted on the authority of two justices or the parish overseer. In the provinces the regulatory visits were to be carried out by two justices and a medical visitor. [44]

The provisions of the 1808 Act were aimed at providing suitable accommodation for pauper lunatics and allowed a county rate to be levied to fund the building of the asylum. The costs of treatment for paupers were to fall on their parish of settlement. The first county asylum opened in Nottingham in 1811 and by 1837, fifteen had been established. A variety of models were adopted and some projects brought to fruition had been in gestation for several years. The new county asylums ran into a number of problems with some finding it difficult to attract patients due to the fact that weekly charges exceeded those in workhouses, while others became hopelessly overcrowded within a few years.[45] The 1808 Act established the principle of public provision for the mentally ill for the first time but public asylums did not dominate the market in the period to 1845. The majority of provision was still in private madhouses, at home or in the various boarding out arrangements set up by individual parishes. Indeed it has been argued that the 1830s were the 'heyday of the private mad house', as the

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[43] *Ibid.* pp. 122-125.
[44] *Ibid.* pp. 122-132.

belief in the benefits of institutional care over domestic arrangements became accepted and demand for institutional care could not be satisfied by public asylums. By 1845 it is estimated that there were some 97 private provincial madhouses, fifteen county asylums and an additional five counties with some sort of voluntary provision. [46]

5.2 Care of the Insane in Herefordshire

Within Herefordshire, institutional provision for the insane remained in private hands until the opening of the Joint Counties' Asylum at Abergavenny in 1851. Hereford Asylum remained the only asylum in Hereford City but two other private mad houses operated in the south of the county, at Whitchurch and at Peterstow. Under the Act of 1823, all counties were required to submit a return of lunatics by parish to the home office. The earliest records for the county are for 1828-1829 and relate to individuals resident in Herefordshire.[47] These records appear to be incomplete as several parishes are noted as not having returned the necessary information. Nevertheless they provide an indication of the numbers classified as insane and of the range of provision for them.

The return for 1829 identified 118 insane persons, of which 50 were classified as lunatics and 68 as idiots. A summary of the information is presented in Table 5.2. [48] Lunacy was assumed to be a state that could commence at any time in life and allowed the possibility of a cure and of lucid intervals. In contrast, idiocy was defined as a permanent state, very often starting at birth or very shortly afterwards.

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[45] Smith, *Cure, comfort and safe custody*, pp. 27-35 and p. 52.
[46] Parry-Jones, *Trade in lunacy,* p. 282 and Smith, *Cure, comfort and safe custody*, p. 52.
[47] HRO, Q/AL/26-29, Lunacy returns for Herefordshire 1829.
[48] *Ibid.*

Table 5.2: Summary information from the 1829 lunacy returns for Herefordshire

	Male	Female	Total
Lunatics	15	35	50
Idiots	34	34	68
Total	49	69	118
Of which Dangerous	9	8	17
Confined in asylums	4	9	13

Source: HRO, Q/AL/26-29, Lunacy returns for Herefordshire 1829.

The description 'dangerous' implied a patient was either a danger to themselves through self-harm or suicide or a danger to others. Of the thirteen people confined in institutions, nine were in lunatic asylums; six in the Hereford Asylum and one each in the private Droitwich asylum, the new County Asylum in Gloucester and the private Hoxton Asylum in London. Of the four not held in asylums, one was in Hereford Gaol and three in workhouses. The cost per week of this provision ranged from 1s to 12s 6d, with an average of 5s a week.

A more detailed return of 1836 showed that almost all those confined in institutions came from the group defined as lunatics, while idiots were recorded as not confined. [49] All the eleven lunatics classified as dangerous were confined with nine in asylums and two elsewhere. Nine of the 24 not considered dangerous were also confined, five in asylums and four in workhouses. Only six idiots were confined, of which three were in a workhouse and three in private houses. All the others, some of whom were supported by outdoor relief from their parishes, were living in domestic settings.

A separate return was made by each licensed madhouse in the county.[50] In 1829 there were two licensed madhouses, the Hereford Asylum catering for a maximum of 23 patients and Simon Exton's establishment at Peterchurch, which was licensed for six patients. The information for Hereford Asylum is summarised

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[49] HRO, Q/AL/96, Lunacy returns for 1836.

in Table 5.3. Fourteen of the 25 patients cared for in the year came from Herefordshire, with nine from Wales and two from Shropshire. Eleven of the inmates were paupers funded by their parishes and the other fourteen were private patients.[51]

Table 5.3: Patients treated at Hereford Asylum in 1829.

County	Male	Female	Total	Parish	Private
Herefordshire	6	8	**14**	9	5
Wales	7	2	**9**	1	8
Other	1	1	**2**	1	1
Total	**14**	**11**	**25**	**11**	**14**

Source: Quarter Session returns, HRO Q/AL/31

Of the five patients at Simon Exton's house in Peterchurch, all were from Herefordshire parishes and only one was a private patient. The evidence from these returns illustrates that institutional care for those classified as insane was, in general, limited to those considered dangerous, most of whom were confined in the local, private madhouses. These institutions did not only provide care for Herefordshire paupers but derived a large proportion of their trade from private patients, many of whom came from Wales.

Although subject to the same legislative framework as England, very little institutional care for the insane was available in Wales prior to the mid-nineteenth century. Only a handful of private madhouses operated and one small county asylum opened in Haverfordwest in 1824. [52] Sir Andrew Halliday, who visited North Wales in 1829 to collect evidence on the prevalence of insanity, reported that no one was confined in an asylum. The majority of the insane were cared for

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[50] HRO Q/AL/31, Lunacy returns for 1829.
[51] *Ibid.*
[52] P. Michael, *Care and treatment of the mentally ill in North Wales, 1800-2000* (Cardiff, 2003), pp. 2-3.

at home by their relatives or through individual arrangements agreed by parishes. If the Welsh wished to place relatives in an asylum they were forced to send them to England and the asylums in Herefordshire were well placed to attract those from South and Mid Wales.

Although Hereford Asylum became a private business in 1801, the governors of the Infirmary retained an interest as landlord. Improvements were funded as additional legacies and donations allowed and in 1803 a washhouse, beer-house and cellar were built. By 1817 the general state of the building was poor and there was particular concern about the roof, walls and ventilation. A full survey was carried out and repairs financed by the doctors. It may have been the burden of these additional costs that prompted them to leave the asylum as later that year the lease was transferred from Thomas Cotes to William Symonds and John Scudamore Lechmere Pateshall. [53]

The lease transfer formed part of a more comprehensive business agreement between the three parties. Under the terms of the agreement, Symonds and Pateshall agreed to provide Thomas Cotes with an annuity of £150 per annum for the term of his natural life in return for his interest in the Lunatic Asylum and his practice as surgeon and man-midwife. In return Thomas Cotes agreed not to practise as a man-midwife in the City of Hereford or within a six-mile radius or to open an asylum within the County. Specific exceptions were recorded allowing Cotes to continue to care for the widow and children of William Meacham and the Duchess of Norfolk.[54] An amendment to the agreement the following year allowed Cotes to practice as man-midwife within the city provided that half of his earnings there were given to Symonds and Pateshall. [55]

There is no evidence that William Symonds involved himself in the detailed management of the asylum, which was left in the hands of Pateshall who

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[53] HRO S60, Hereford General Infirmary, Governors' minutes, 15 Oct. 1817.
[54] HRO, A95/J/1, Papers of John Pateshall.

ran it from 1817 until his death in 1834. In addition to his work at the Asylum, Pateshall also ran a surgical practice in Hereford City with his partner, John Gilliland. Pateshall's asylum ledger covering the period 1817 to 1834 has survived. This records details of the name, age, sex, marital status and home village or parish for all patients. Information relating to the care provided are limited to dates of admission, readmission, discharge, where the patient was discharged to, and the state of the patient's health when discharged. Supplementary comments were sometimes added referring to any damage caused by the patient, any escape attempts or other details it was felt that it was worthwhile to record. The most complete information relates to payment and provides a record of the amount to be charged per week, the person responsible for payment, any problems in payment and the amounts outstanding.[56]

Pateshall's asylum ledger provides details of 223 patients admitted over a period of 17 years from 1817 to 1834. Five patients were in the asylum when Pateshall took over from Thomas Cotes. On average twelve patients a year were admitted with the highest number in any one year being nineteen and the lowest six. Of the total admitted, 55 per cent of patients were from Herefordshire parishes, 25 per cent from Wales and 3 per cent from the surrounding English counties. The parish of origin of the remaining 17 per cent of patients is not recorded. The majority of Herefordshire patients were paupers while the majority of those from Wales or unknown parishes were private patients.

A wide variety of patients were treated at the Asylum, with some patients chronically incapacitated while others were treated for a relatively brief period. 127 patients (56 per cent) were in the asylum for over one year or were readmitted on more than one occasion. Just over one third of all patients, 79, were in for a period of three months or less. For some patients, the asylum was

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[55] HRO, A95/J/4, Papers of John Pateshall.
[56] HRO, A95/J/34 and A95/J/35, Hereford Asylum ledger.

their only home. Susan Elpen (or Essex), from Goodrich entered the asylum on 6 June 1806 when it was still under the management of Drs Blount and Cotes and died in the asylum some 28 years later in November 1834. As she was a pauper patient, Goodrich parish paid for her care which was at first priced at 12s per week but was later reduced to £15 a year. For others, even chronic illness was managed at home with shorter lengths of stay in the asylum. Elizabeth Danials, also of Goodrich, was admitted to the Asylum in April 1820 and remained there for over a year until May 1821 when she went home to her husband, Thomas. Thereafter, she was readmitted to the asylum on a number of occasions, a three month period in 1824, six months in 1828, ten weeks in 1829, sixteen weeks in 1832 and two months in 1833. The lunacy returns for 1836 record that at that time she was classified as a 'dangerous lunatic' and was detained as an inpatient in Llangarren Asylum.[57]

John Parry was one of several patients admitted from the prison system, coming to the asylum from Brecon Gaol in February 1820 where he remained until 1829.[58] Benjamin Beamen was taken to the Asylum from the City Gaol in April 1827 and remained there for two months. The notes record that he 'did not appear at any time during his stay in the Asylum (to be) deranged', and he was discharged home. John Jackson was more troublesome; admitted under warrant in August 1829, he managed to secure the assistance of others in the asylum and broke out through a window in the passage. Four months later he was returned to the asylum but escaped again a few weeks later taking Charles Cooper, one of the other patients, with him. Nothing else is recorded of Jackson, but Cooper was back in the asylum within a week. A year later he escaped again, this time with Matthew Bach, who had been brought to the asylum from Hereford Gaol. Both patients were brought back to the asylum, although Bach made

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[57] HRO, Q/AL 168, Register of patients 1836 to 1845 at Llangarren Asylum.
[58] HRO, A95/J/34 and A95/J/35, Hereford Asylum ledger.

another escape attempt in 1832. Joseph Symonds was admitted to the asylum in 1832 from the City Gaol and stayed at the asylum a few weeks until sent back to his home parish in London. [59]

Some patients were transferred to or from other asylums. Mr Grosvenor was admitted as a private patient in November 1819 but escaped home after three months, returning to the asylum for a further period in the summer of 1820. He returned home again but was later taken to Bethlem by two of Pateshall's keepers. Andrew Stephens was admitted to the asylum in April 1821and died in St Luke's, London in November of that year. In 1821, Mary Berry, a servant of Lord Somers from Eastnor Castle, near Ledbury, was also transferred from Hereford to St Luke's, as was Miss Collins, from Chepstow, in 1827. Reverend William Evans came to Hereford from Dr Fox's asylum at Brislington, near Bristol.

The gender of patients is noted for almost all entries and indicates that 128 (58 per cent) of the patients were male and 91 (41per cent) female. This contrasts with evidence for the latter part of the nineteenth century, which suggests that a greater number of women were confined in insane asylums.[60] It may well be that the demographic profile of the population confined in asylums altered as the number of chronically ill paupers in asylums grew after 1850.[61] The information discussed above has shown that it was mainly troublesome patients who were confined, the minority of the insane who were considered to be dangerous. The majority of the insane were not confined in institutions at all but were supported at home. The fact that most patients were men may have been due to the greater difficulties in managing them outside an institutional setting. In addition, all those transferred from the prison system to Hereford Asylum in the period were men.

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[59] *Ibid.*
[60] Showalter, *The female malady.*
[61] Scull, *Most solitary of afflictions,* pp. 334-338.

There were two other private asylums in Herefordshire in this period, both in the south of the country between Ross-on-Wye and Monmouth. Simon Exton's small asylum at Peterchurch, which provided accommodation for six inmates, received a reasonable report from visiting magistrates in 1829.

> The house contains 6 rooms with a bed in each on the first floor, well aired and commodious; a convenient sitting room on the ground floor of sufficient dimensions for convalescents, well adapted for the purpose, a yard into which the building opens for occasional exercise of the convalescents and a garden surrounded by a high wall for such patients as require air and exercise attended by proper keepers. [62]

Two years later, the visiting magistrates were less complimentary, criticising the house for its 'great want of a system and cleanliness', the inappropriate use of restraint, and the lack of attention to the comfort and health of the patients.[63] The house was not licensed after 1831. In 1833, another private madhouse opened at Whitchurch, near Ross-on-Wye. The asylum was run by the owner Samuel Millard MD and opened with accommodation for seven female patients but soon expanded to take ten patients of either sex. By 1836 it was licensed for 20 patients and the following year was extended again to take 35 patients, to include 20 paupers. In 1845 patient numbers increased to 50 and reached a peak at 60 in 1853. In common with Hereford Asylum, Whitchurch provided accommodation for a number of patients from Wales. [64]

Despite the enabling legislation passed in 1808, there is no evidence of interest in establishing a county asylum in Herefordshire before 1836. The private asylum in Hereford City retained administrative and therapeutic links with the Infirmary as Cotes and Blount were honorary medical practitioners at the

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[62] HRO, Q/AL 189, Report of visiting magistrates to Quarter Sessions.
[63] *Ibid.*

Infirmary and the visiting medical practitioner was another of their colleagues. Their replacement, John Pateshall, came from an established local gentry family and was also a member of Hereford corporation. The charitable asylum had proved not to be financially viable and had posed a potential financial risk to the Infirmary charity. Although the finances of the Infirmary were on a better footing by 1817, problems in balancing the books persisted and the financial security of the charity remained a concern.

As discussed in Chapter Four, reasons put forward to explain the notable increase in philanthropic activity in the eighteenth century emphasise the potential social and cultural benefits that could flow to supporters in addition to more altruistic motives.[65] A subscriber to the General Infirmary could expect to be able to exercise their right to recommend a patient for treatment each year. This was much less likely to be the case for a subscriber to a specialist insane institution as the lower number of sufferers in the population and the more chronic nature of much mental illness meant that fewer new patients were admitted each year. The central returns for the period indicate that the asylums in the county were able to meet the demand from parishes for places for pauper lunatics as it was only infrequently that Herefordshire patients were sent to institutions outside the county. New cases of insanity in the county were probably below twenty cases a year of which a considerable number were paupers chargeable to Poor Law authorities. The number of patients from 'the deserving poor' who might benefit from treatment at a charitable asylum would have been very low.

Another important justification for charitable or public asylums was the perception that private madhouses offered poor care and facilities. At Hereford this risk was dealt with by granting the lease on the Asylum to medical professionals of high status in the community. The financial outlay required to

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[64] HRO, Q/AL 177 and 179, Returns for the Whitchurch Asylum, 1836-1845.
[65] Porter, 'Gift relation', pp. 8-20 and Owen, *Philanthropy.*

provide purpose built premises was provided from charitable sources, ensuring a good level of physical comfort for the patients and a financial subsidy to the medical practitioners who took over its management and gained the opportunity to set themselves up in a developing medical specialism. The regulatory framework for annual licensing and inspection provided a safety net to ensure that the Asylum operated within acceptable limits. The city corporation and justices had an opportunity to influence aspects of the care of lunatics through these mechanisms and did not therefore need the closer managerial supervision offered by a charitable institution.

On Pateshall's death in November 1834 the remaining interest in the lease passed to his partner, John Gilliland.[66] Later in the year John Gilliland's brother, William, joined his brother in Hereford. William became resident superintendent of the Asylum although the lease and licence continued to be held in John's name. The transfer of the Asylum in 1834 coincided with the introduction of the New Poor Law that introduced fundamental changes to the administration of pauper lunacy, shifting power from the county justices to the New Poor Law Unions. In addition, the Municipal Reform Act of 1835 changed the dominant political influence on the city council. As discussed in the next section, these two factors meant that Gilliland would have to operate the Hereford Asylum in a very different environment to the pre 1834 era.

5.3 The campaign for a public asylum

Although the New Poor Law was passed in 1834 it was not implemented in Herefordshire until 1836. Hereford Union held its inaugural meeting on 9 May at which it appointed 14 ex officio and 50 elected guardians. One of the ex officio guardians was John Hopkins, a magistrate for the county and a member of the visiting committee for Hereford Asylum. Another was John Gough, mayor of the

new city council. The dominant political party in Hereford had altered in 1836 with the election of a majority of Reform party candidates in the first elections following the Municipal Reform Act of 1835. Only four of the old Tory councillors were elected to the new council, but among these was John Bleek-Lye, honorary physician at the Infirmary and the newly appointed medical practitioner on the Hereford Asylum visiting committee.

It has been argued that the introduction of the New Poor Law shifted influence over poor relief, including that given to pauper lunatics, from the local gentry and magistrates towards the elected Union officials and the appointed Poor Law officers. Although magistrates continued to be involved in the New Poor Law Unions this was on an ex officio basis, where they were in a minority compared to the group of elected officials. The new arrangements employed and supervised paid Relieving Officers to undertake the functions of assessing and directing support to the poor that had previously been carried out by networks of gentry, clergy and voluntary officers, thereby eroding their influence. Although the justices retained formal authority for the insane, in practice they became increasingly reliant on the Poor Law system for the administration of lunacy cases.[67] The main focus of the New Poor Law was control over relief to the able-bodied poor and no change was made to the existing legislation regarding lunacy. This meant that provincial magistrates continued to control many processes relating to the insane through their established roles of licensing and inspecting houses and signing admission and discharge documents. However, financial responsibility for paupers passed to the New Poor Law Unions who were also responsible for providing institutional care to the non-able bodied poor in workhouses.

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[66] HRO, S60, Hereford Infirmary, Governors' minutes, 14 May 1834.

In 1836 and 1837 several new appointments were made to the visiting committee appointed to inspect Hereford Asylum by the county magistrates. Among these were the Dean of St Asaph, John Hopkins, John Barneby and Tomkins Dew. John Bleek-Lye replaced Thomas Symonds as visiting physician. Soon after their appointment the visitors identified that some of the administrative provisions of the Act of Parliament were not being fully complied with; for instance the required medical journal or weekly statement giving details of patients were not regularly maintained. William Gilliland rectified these administrative shortcomings as they were pointed out, but over the next two years the visitors' book records concerns over the physical limitations of the buildings and over the nature of the care provided to patients. [68]

The Asylum building was by this time almost forty years old and suffering from overcrowding and poor ventilation. Just under half of the patients were privately paid for while the rest were paupers. It was considered to be good practice that private and pauper patients should be kept in separate accommodation, but this was not always possible at Hereford due to the cramped conditions. It was also good practice to segregate the sexes and to ensure that convalescent patients could be cared for separately from violent or noisy patients. Although this principle was accepted, it could not always be assured due to the limited space available.

Although there were four sitting rooms, two for men and two for women, one of the women's rooms was called the 'drying room' and on occasion was used for drying clothes. From time to time male and female patients were both in the same room and sometimes noisy and deranged patients were put in a day room with the quieter patients. There was an 'airing yard' for each sex but on one

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[67] Forsythe, Melling and Adair, 'The New Poor Law, and the county pauper lunatic asylum' *Social History of Medicine,* 9 (1996), pp. 335-355 and Bartlett, *Poor Law of lunacy,* pp. 20-22 and 32-51.

occasion, a visitor had found the female patients were kept indoors because washing was hanging in the yard. Patients sometimes ate outside although there were no tables set up. Other concerns related more specifically to the care provided to patients, in particular the low number of staff employed, the adequacy of supervision and the continued use of mechanisms for restraint of patients and treatments such as the cold bath. In 1837 the visiting magistrates seriously considered whether the licence should be renewed and only did so after reducing the licensed numbers by six to thirty-six and noting various improvements that were required. [69]

By this time the magistrates had decided to investigate the possibility of establishing a county asylum. In part this was due to their concern over conditions at Hereford Asylum but it was also opportune as the New Poor Law Unions were considering plans for new workhouses. One of the decisions they had to make was whether or not to provide specialist accommodation for pauper lunatics in their plans. In November 1836 the magistrates wrote to each of the Unions seeking their support for a public asylum. Hereford Union requested clarification as to whether the proposed asylum was intended to provide accommodation for pauper lunatics and when this was confirmed the Union supported the proposal and established a sub-committee to communicate with the county magistrates, nominating John Hopkins as one of their representatives.[70] In the meantime pauper lunatics from the Union continued to be placed in Hereford Asylum.

The following year, in May 1838, concerns over the management of the Asylum were brought to a head when Mary Jenkins presented a petition to John Barneby, chairman of the visiting magistrates, alleging that her husband, a private patient, had been ill-treated. His physical health had deteriorated rapidly after his

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[68] HRO, Q/AL, 100-102 and 156. Quarter Session minutes.
[69] HRO, Q/AL, 120-122 and 156, Quarter Session minutes.

admission and in particular he had developed various sores that seemed to have been neglected. His wife had decided to take him out of the asylum and care for him at home where he died some six weeks later. John Barneby ordered an internal enquiry that agreed that the patient had been either mistreated or neglected and concluded that this was due to the fact that William Gilliland did not personally attend to the patients but left this to a few poorly trained members of staff.

Between May and October 1838, the visitors recorded their concerns in the official visitors' book and on 13 October they drew up a special report to be presented to the justices at Quarter Sessions which recommended that the licence application be refused. Their reasons for refusal included concerns about deficiencies in the building and the care of the patients. In particular, despite the fact that the number of patients had been decreased, the buildings were still considered to be too small to enable sufficient segregation of patients to promote their care. Their report concluded:

> Compared with other institutions, the Hereford Lunatic asylum is not in that state, either as relates to ventilation, to classification, to employment, to moral treatment, to recreation, and religious consolation of convalescents, which, according to the improved system of managing the insane, they would wish to prevail. [71]

They were also concerned about the treatment of patients; in particular the unjustified use of the cold bath treatment, which was applied 'not for the purpose of cure, but for that of correction'. The report also noted their objection to the continued use of forms of restraint, including gloves, belt, waistcoat, manacles and fetters. There was evidence that a lack of supervision had led to

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[70] HRO, K42/215, Nov. 1836, Hereford Union minutes.
[71] HRO, Q/AL 156, Quarter Session minutes, 13 Oct. 1838.

fighting and bruising of patients particularly when they were outside in the airing ground. On one occasion the visitors had arrived at the Asylum to find that a fifteen-year old girl had been left in charge.

The special report was presented to the county magistrates at the Quarter Sessions held on the 15 October who decided to refuse to renew John Gilliland's licence. [72] Gilliland responded to this by applying to the Hereford city magistrates for a licence at their sessions to be held ten days later on the 25 October.

Although the county magistrates had been granting the licence in the recent past, the Asylum lay within the liberties of the city of Hereford, so that it could be argued that the city was in fact the proper licensing authority. On hearing that the licence was to be refused, Gilliland gave an application to Jonathan Elliott Gough, Mayor of Hereford, asking him to give it to the clerk of the city sessions. [73]

The application and its refusal were clearly a matter of considerable consequence for Hereford Poor Law Union. The new workhouse had recently opened and although this provided accommodation for 200 inmates, no provision had been made for specialist wards for lunatics. Despite their initial support for the idea of a public asylum, the Union had recently reached agreement with Gilliland to house all their pauper lunatics at Hereford Asylum. This agreement had been reached after extensive negotiations with both Shrewsbury Asylum and Gilliland that were mainly concerned with reducing the cost to a minimum. Gilliland had agreed to take the Union's paupers at 9s a week, the only extra being clothing. Hopkins had opposed the decision, favouring placing the pauper lunatics in Shrewsbury Asylum. [74]

Following the refusal of the asylum licence, Hopkins attempted to press the case of those agitating for reform. On the 17 October he presented a motion to Hereford Union proposing that the clerk write to the Shrewsbury Asylum to

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[72] HRO, Q/AL 84. Quarter Session minutes.
[73] *Report from the Select Committee on the Hereford Asylum*, p.151.

organise the immediate transfer of the pauper lunatics.[75] This attempt to force the issue to a conclusion was delayed as the Shrewsbury Asylum was unable to accommodate all the Hereford paupers. In the meantime, Gough and a number of the other city magistrates visited Hereford Asylum themselves. They found conditions there acceptable and at the next Union meeting on 23 October put forward an amendment calling for Hopkins' motion to be reconsidered should the licence be granted by the City Sessions to be held the next day. [76]

On the 24 October, the recorder, Joseph Smith, arrived in Hereford for the Quarter Sessions on the following day. Soon after his arrival, the clerk of the County Court came to see him at the request of John Barneby, to advise him of the refusal of the licence application and the consequent application by Gilliland to the City Sessions. None of the visiting magistrates was available to make a formal report in court the following day and the clerk was not empowered to do so. Joseph Smith's opinion was that without a formal objection in court, he would have no grounds to refuse the licence and he therefore decided to visit the asylum himself and asked Jonathan Gough to accompany him. During his visit, Smith read the latest visitors' reports including the special report issued some two weeks earlier, toured the premises and spoke to Dr Gilliland and to some of the patients. He saw nothing that he considered gave him grounds to refuse the licence so that when there was no formal objection to the application in court, he renewed it for a further year. [77] On the 7 November, the Hereford Union overturned their previous decision to remove the paupers from Hereford Asylum.[78]

The county magistrates responded to this by petitioning the House of Commons for an investigation and a Select Committee was established which sat

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[74] HRO, K42/2, 15 July to Sept. 1838, Hereford Union minutes.
[75] HRO, K42/215, 17 Oct. 1838, Hereford Union minutes.
[76] HRO, K42/215, 23 Oct. 1838, Hereford Union Minutes.
[77] *Select Committee on Hereford Asylum,* pp. 96-101.

between March and June 1839. The committee first focussed its attention on the authority of the city sessions to consider a licence that had already been overturned in the County Court and examined two areas in relation to this issue. The first was the extent of the evidence Smith could reasonably have amassed in his one visit to Hereford Asylum and whether this should have outweighed the opinion of justices appointed under an Act of Parliament. The second was the validity of the processing of the application by the city sessions, as, under the terms of the Act, any application had to be submitted to the clerk of the court at least fourteen clear working days before the court session that was to consider the application. The Recorder admitted he had not specifically checked the details of the application and notice as he felt the issue at stake was not this formal point but the fitness of Dr Gilliland to run the asylum. Smith's examination by the Select Committee was acrimonious in tone, with Smith objecting to his treatment and the process followed by John Barneby in drawing up the petition calling for an enquiry. In particular he challenged the Select Committee's right to dispute the decisions of another court of law. [79]

Although the Select Committee called many witnesses and examined the details of the justices' concerns, it did not finally recommend the closure of the asylum, but limited its recommendations to commenting on the formal provisions of the licensing process:-

> That provision be made by law to compel the person intending to apply for a licence of a house for the reception of insane persons, to insert a public notice in some newspaper usually circulated in the county to which the said house shall be situate, fourteen clear days at least previous to the holding of the Quarter Sessions at which the application is intended to be

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[78] HRO, K42/215, 7 Nov. 1838, Hereford Union Minutes.
[79] *Select Committee on Hereford Asylum,* pp. 127-129.

made, in addition to the notice which is now given to the clerk of the peace. [80]

The committee did not find that Dr Gilliland ran the asylum to unacceptably low standards. This indicates that many of the points raised by the justices were issues, which, while deemed unacceptable by the reformers, were still accepted by many as meeting the standards of the day. The evidence presented to the Committee provides an insight into the day to day running of a private madhouse, the welfare issues that were being debated and the development and operation of the regulatory framework that was in operation.

The nineteenth century saw a developing consensus of what constituted good practice in the treatment and management of the insane. Good practice centred on the theory of moral management and the principle of non-restraint. Samuel Tuke has been credited with a pivotal role through his work at the York Retreat, and the publication of the *Description of the Retreat* in 1813. His approach favoured influencing behaviour patterns through occupation, organised pursuits and religious participation rather than depending on medical and physical methods. To be effective moral management required a holistic treatment regime to operate within an asylum and this depended in large part on well-trained staff.[81] The evidence brought before the committee sought to demonstrate the shortcomings of the regime at Hereford. Two of the areas examined in detail were the amount of medical supervision and the types of treatment employed.

William Gilliland, the medical superintendent, was the only trained medical professional working in the asylum. Prior to joining his brother in Hereford, Gilliland had practised in Northern Ireland where he had cared for some lunatic patients on a private basis and had visited the Londonderry Asylum, but

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[80] *Ibid.* p. v.
[81] Smith, *Cure, comfort and safe custody*, Chapter 4.

otherwise had not specialised in the care of the insane. Hereford Asylum was licensed for sixteen female patients who were looked after by the housekeeper and two assistants who also had to fulfil other duties. For a maximum of 20 male patients, Gilliland employed one full time male keeper who received some help from the groom when his other duties allowed. [82]The regular keeper contracted smallpox in 1837, after which a number of temporary keepers wee employed who were sometimes left in charge for a whole day despite having very little previous experience. To the reformers, the duty of a keeper was more than one of restraining the patients from violence. In the ideal model of moral therapy they should be involved in treating patients through an active therapeutic regime. In practice the role of keeper was less elevated, involving domestic duties in addition to a custodial element. Len Smith has noted that the ratio of keepers to patients in 1840 ranged from 1:30 in Norfolk to 1:15 at Maidstone. [83] The ratio at Hereford lay between these and in addition treatment was under the supervision of a trained medical professional.

Whatever the comparative situation, members of the visiting committee were of the opinion that the number and calibre of the staff resulted in inadequate supervision. This was most apparent when the patients were outside. On fine days the male keeper sometimes worked in the garden leaving the patients unsupervised in the yard and the Select Committee minutes noted several instances of fighting among the patients while unsupervised. [84]They were also concerned about the activities offered to the patients and specifically asked Jane Phelps, the housekeeper, about the curative regime in operation. Under oath, she admitted that despite having day to day responsibility for the care of the female patients, she was unaware of any detailed regimen. [85] Some of the women were

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[82] *Select Committee on Hereford Asylum,* pp. 44-45.
[83] Smith, *Cure, comfort and safe custody*, p.133.
[84] *Select Committee on Hereford Asylum,* p. iv.
[85] *Ibid.* pp. 108-116.

provided with sewing and the private patients had access to a piano, the prayer book and any other books Dr Gilliland provided. Some of the male patients worked with the horses under the supervision of the groom and some in the garden.The detail of the questioning in the Select Committee indicates that they considered this to fall short of best practice. [86]

In what way do you attempt to cure them when they come in and afterwards? - I do not understand anything of curing them.

Have you a discipline of any sort by which you attempt to restore them to reason? - I find kindness do as well as anything else.

What are Dr. Gilliland's directions to you, as to putting them to work or encouraging them to work, or treating them in such a manner, except by kindness, as will restore them to reason? - I really do not know.

Have you any plan for restoring the female patients to reason? - Medicine I believe the doctor gives them.

Nothing but medicine? - I do not know; the doctor has said the cold bath is a good thing for them.

Besides the cold bath, have you any other treatment by which you hope to restore them to reason; by employment for instance? - Some of them.

What are the directions that have been given to you by your masters as to the mode of curing the female patients who are put under your care? – I do not know anything that can be done on my part to cure them, except to behave kindly to them.

You have a general direction to behave kindly to them, but no

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[86] *Ibid.* pp. 110-111.

directions as to employing them? - Employing them in sewing or anything they liked to do whatever they were most willing and chose to do.

Is that the direction given to you? -Yes.

What is the direction given to you? - To treat them kindly, and to let them do the work they choose, what they like best. [87]

While the Select Committee might endorse the emphasis on kindness and gentleness in Jane Phelp's responses, her evidence made it clear that the ideal of the therapeutic regime was not practised in Hereford. The reference to the cold bath was taken up by the committee in an effort to probe the distinction between punitive and curative methods in use. Several of the visitors had become acquainted with Phillip Charles, a pauper patient, and concluded that he was not insane and should not be committed. They had first taken this up with Gilliland and had finally written to the committing magistrate who agreed that Charles should be released. Charles had also complained that although a convalescent, he was forced to spend time with more disturbed patients, and that he had been subjected to the cold bath as a result of a dispute over a clean shirt. The Committee asked William Walters, one of the keepers, about the use of the cold bath.

Were they put in for the sake of washing them, or for punishment? – For punishment.

Will you state what they had done, so as to cause them to be put in there for punishment? – When they have fought, or something of that sort, or ripped their clothes, their bedclothes at night.

How long were they kept in the bath? – They were not kept in long; only just put in; one dip.

Their clothes were taken off? – Yes

Did they ever resist being put in the bath? Yes- sometimes.

Were their hands chained? – No, fastened by a number of straps.

Were their hands fastened when put in? Yes

Were they put over head, dipped entirely? Yes, they were put in over their head.

Were their feet strapped as well as hands? No

Were they stripped quite naked? Yes.

To put the patients in the bath was it necessary to take hold of their legs, and another of their arms and shoulders? Yes, one had hold of their legs.

Was that the general way you put them in the bath? Yes, some of them were so strong that we could not put them in.

How long did you keep their bodies in the water, except the head? – Not three minutes; only to give them one dip and out again.

Did they go face downwards or upwards? Upwards. [88]

When Dr Gilliland was questioned on whether the use of the cold bath was punishment or cure, he explained that he had applied the bath as a cure to Philip Charles but had waited for the excuse of the dispute over a shirt before using it. He believed that 'unless you can associate it in the mind of the patient with an idea of punishment, that it will (not) have the desired effect.' [89] The issue of dominance by a keeper over the patient was a point of contemporary debate. In the late eighteenth century, Francis Willis had promoted the importance of gaining psychological dominance over an insane person in order to cure them,

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[87] *Ibid.* pp. 110-111.
[88] *Ibid.* pp. 53-54.

citing the success of this method in his treatment of George III. The need for proper control within an asylum was also recognised as a pragmatic necessity and the distinction between punishment and cure was not always clear cut. The use of the cold 'bath of surprise' is a good example of this. [90] The important point is that there was a wide range of practice in operation across the country and Gilliland's methods were not outside the range of acceptability.

The use of physical restraint was another example of an issue on which there was a considerable range of views. Elizabeth Lewis was seen by the visitors on several occasions, often confined in a room with no window. On one occasion she was seen in bare feet, chained by a manacle round the ankle and in a strait- waistcoat.[91] Although the county visitors objected to this use of restraint, it was acceptable to the city visitors appointed after the granting of the licence in October 1838. A minute of their visit of 6 November 1838 records 'The woman, Elizabeth Lewis, confined in irons (properly so) from the violent state of her mind'. She was in irons again when they visited on 10th December. On 1 January they recorded: 'Elizabeth Lewis is under restraint, but is more quiet than we have before seen her.' The minute of 7 February notes; ' Elizabeth Lewis is confined'.[92]

The provisions of the Act of Parliament depended on the local magistrates to decide whether or not to license private madhouses, and on the visitors appointed by the local magistrates to attempt to regulate the institutions licensed. The evidence presented at Hereford illustrates the shortcomings of these arrangements. Jonathan Gough was asked what he considered the purpose of visitors to an asylum to be and replied, as follows. 'I conceive that the object is to see that the patients are properly taken care of, and to inquire if they have any complaint to make; that they are kept clean, and that the house is properly

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[89] *Ibid.* p. 163.
[90] Smith, *Cure, comfort and safe custody*, pp. 202-205.
[91] *Report from Select Committee on Hereford Asylum,* p. 76.
[92] HRO, Q/AL 136, Quarter Sessions minutes,1.Jan. 1839.

ventilated'. The Committee then asked whether he thought that the appointment of visitors was based on 'the suspicion that the superintendents may not do their duty by their patients', to which Gough agreed. [93]

The regulatory legislation in place gave lay members of the visiting committee the responsibility to form an opinion of matters relating to appropriate care. As noted above, Tomkyns Dew, one of the visitors, was cross-examined by Dr Gilliland and confirmed that before being appointed visitor to the Hereford Asylum, he had never been in an asylum before. However, he did not perceive that this prevented him from forming an opinion on matters, as illustrated in the following exchange.

> Do you conceive yourself a judge as to the necessary classification to be adopted in an asylum? – I cannot say whether I am a particular judge; only common sense tells me that persons who are insane in one way, and persons who are insane in another, ought not to be kept together.
>
> How many classes ought to be in one house, according to your idea of classification? – There ought to be three or four, at least.
>
> But you have never been a visitor of any asylum previous to this? – Never. [94]

John Hopkins, another visitor, had attempted to establish some standards of comparison through reading about other asylums. He noted that

> I had taken the trouble to buy Sir William Ellis's book, which I had read carefully through, when I was appointed visitor; and the hints I got from that, as to treatment, I thought very useful.

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[93] *Report from Select Committee on Hereford Asylum* p. 107.
[94] *Ibid.* p. 89.

Sir William Ellis was the person who was superintendent of the Hanwell Lunatic Asylum? – Yes.

You perused his book, and from the perusal of that book you tried to form an opinion as to the proper mode of conducting a house of that sort? – Yes, I did. [95]

Hopkins had been concerned about the lack of emphasis on cure at the asylum, the fact that there was no religious consolation made available to inmates and that there was no employment for the inmates. He had specifically raised a point on suitable forms of restraint with Dr Gilliland and had met with a derisive response. '...as to the nature of confinement with twines instead of chain, Dr Gilliland merely laughed at me, and said it was ridiculous'. [96] Another visitor, the Dean of St Asaph reported that he had visited both Bethlem and Hanwell, and had been concerned that divine service was not performed on a regular basis at Hereford. He also referred to the asylum at Shrewsbury in his evidence, making the point that in all these asylums the accommodation and number of attendants were far superior to those at Hereford. While national standards of what comprised appropriate accommodation and treatment had moved on, the conditions at Hereford had remained those of the late eighteenth century. When asked by the committee why the justices had agreed to renew the licence in 1837 but not in 1838 he commented 'I think some of us had obtained more information with regard to lunatic asylums altogether.' [97]

One possible source of expertise for the lay visitors to call on was the medical visitor but this was shown to be of limited use at Hereford. John Bleek-Lye, the medical visitor, was honorary physician at the Infirmary and it is noteworthy that in 1838 Gilliland had been appointed to the other honorary post. Under examination, Bleek-Lye noted that he had only ever once discussed the

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[95] *Ibid.* p. 90.
[96] *Ibid.*

medical condition of a patient with Gilliland and his evidence to the committee suggests that professional solidarity was an important consideration. When asked to describe his duties as medical visitor, he responded:

> The duty I consider I had was to accompany the visiting magistrates whenever they summoned me to attend, and to see whether any were placed under restraint who ought not to be so placed, and to inquire into the condition of the house, whether it was well ventilated, and whether they were properly taken care of, and whether they had sufficient food...
>
> I thought that the medical physician had nothing to do with the medical treatment where the superintendent of the asylum is a medical man; I believe that falls immediately under his own management. [98]

Clearly, the task of visiting magistrate was a difficult one, with each visitor left to define acceptable standards for themselves. Few of the visiting magistrates had any previous experience of asylums and those that had, had developed this through a personal interest. Some had visited other asylums and some had read about the subject. The expertise available locally would depend on the interest of the persons appointed as visitors. With no articulated standards or objective measures available, opinions naturally varied between individuals and between committees. Thus the visitors appointed by the City Sessions appeared to find nothing to object to in the standards at Hereford Asylum although the visiting committee had a number of concerns. The evidence from the Select Committee report reveals the problem of using lay visitors to determine appropriate

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[97] *Ibid.* pp. 118-119.
[98] *Ibid.* pp. 27-28.

standards. A central plank of the reform movement had been the call for a national inspectorate and this was introduced in 1845. [99]

Despite their defeat in achieving the closure of the Hereford Asylum, the county magistrates continued with their campaign for a public asylum. The Select Committee's report was published on the 27 June 1839 and two days later the county magistrates held a public meeting in the Shire Hall in Hereford to present their formal report calling for the establishment of a public asylum for the county. The report was the result of the work first put in train in 1836 and it emphasised the economic rather than the therapeutic case for a public asylum. [100] The average cost of care for those in an asylum was quoted as 10s 8d per week, or £807 6s per annum. Assuming an average cost of 5s a week in a county asylum, the cost for 30 patients was calculated at £390 per annum which, it was argued, would be sufficient to cover the cost of interest on capital of £10,000 at 4 per cent. In addition, it was expected that further savings would be achieved by the 'more rapid cure of those who under the present system are kept only in safety, with little effort at their restoration'. The indications are that it was not intended that all lunatics should be cared for in an asylum, only those currently in specialist institutional care.

Information collected at the request of the Poor Law Commissioners had indicated that there were 166 paupers of unsound mind in Herefordshire out of a population of 111,000; an average of 1.5 per 1,000 population compared to the average for England of 1 in 1,000. Sixty-one of the 166 were classified as lunatics with the remaining 105 categorised as idiots. Twenty-nine of the 61 lunatics were confined in asylums, 20 in Hereford, three in Droitwich, one in Staffordshire, one in Gloucester and four in Whitchurch. The remainder were under 'no remedial treatment', being cared for at home or in the workhouse. Only two of the 29

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[99] Scull, *Most solitary of afflictions,* pp. 155-165.
[100] HRO Q/AL/192. Quarter Session minutes, 29 June 1839.

confined lunatics were therefore in public asylums, those at Staffordshire and Gloucester, with the remaining 27 in private madhouses.[101] The committee also noted that the magistrates at Shrewsbury were considering building a county asylum and had invited neighbouring counties to consider joining with them. However, as Shrewsbury was 53 miles from Hereford, the committee also recommended investigating a joint arrangement with Gloucester, which was only 31 miles away. These proposals were circulated to the Unions to seek their support and the committee was instructed to pursue discussions with the justices in Shrewsbury and Gloucester.

Opposition to the proposed county asylum was unanimous among the Herefordshire Poor Law Unions. There was much concern over the projected capital cost that was deemed unnecessary as the asylums within the county provided adequately for those that needed specialist attention. The idea of an asylum outside the county was considered a retrograde step. In addition to the distance that relatives or friends would have to travel it was noted that there would be a detrimental effect on the city's medical profession. Hereford Union's response noted that the care provided in the private madhouses had been vindicated through the recent Select Committee report. The Union also raised questions about the probity of financial transactions from county funds alluding to outstanding monies due to holders of Shire Hall Bonds used to finance the building of the Shire Hall from the county rate. [102]

In addition to the Unions, there was also vociferous opposition to the proposals from the ratepayers who all objected to the capital cost that would have to be financed through increased rates. A correspondent from Welsh Newton commented that there were 'only 29 dangerous lunatics in June 1839 as shown by the committee's report and these can be accommodated in the private houses

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[101] *Ibid.*
[102] HRO, Q/AL 196 and 197 and *Hereford Times,* 19 Oct. 1839.

at Hereford and Whitchurch'. [103] The objections from the Union and the ratepayers were sufficiently strong to curb any further progress in establishing a public asylum for Herefordshire until this was made compulsory by the 1845 Act.

What was not articulated in these responses was the struggle for control and influence over lunacy provision between the Poor Law Unions and the county magistrates. The events of 1836-1839 show that although the magistrates retained the formal responsibility for developing a public asylum they were unable to put this into practice in the face of opposition from the Poor Law Unions and the city council. The county magistrates at first sought to influence the placement of pauper lunatics in Hereford Asylum by influencing the policy decisions made by the Unions. When the elected guardians overturned their proposals they shifted their strategy to use their powers as the licensing authority to close the private asylum in the city based on allegations of poor quality of care.

The county magistrates' case emphasised the poor therapeutic environment and the expected benefits of a public asylum over a private madhouse but this issue was of minor interest to the Poor Law Unions. They had the financial responsibility for all insane paupers. In their view, only a minority of these needed accommodating in specialist asylums. The initial support shown by the Poor Law unions for a public asylum in 1836 lessened by 1838. A public asylum would reduce their influence over both the care and the cost of the pauper insane.

The close political links between the Hereford Poor Law Union and the reformed Hereford city council provided an opportunity to challenge the authority of the county magistrates over the licensing of Hereford Asylum. The city authorities were happy to take this up in a test case of its jurisdiction. The establishment of separate City Sessions had been jeopardised in 1838 when the

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[103] HRO, Q/AL 196.

county magistrates had refused to collaborate over improvements needed to the City Gaol and this had crystallised antagonism between the city and county authorities.[104] The county had also raised a rate for the building of a new Shire Hall that had resulted in expenditure significantly above initial estimates and allegations of financial mismanagement.[105] The ratepayers and the city council were not keen to authorise them to start on another large capital project.

The dispute over the licensing of Hereford Asylum had undoubtedly generated considerable debate in the town. In 1838, in the midst of the enquiry by the visiting magistrates into conditions at the asylum, William Gilliland had been elected an honorary physician to the General Infirmary in the most contested election ever held for such a post. [106] It would appear that a portion of the medical profession were not happy to see a fellow professional publicly disgraced and that many governors of the Infirmary were prepared to put their political interests before the wellbeing of patients. The issue of the city's reputation was probably also important. Despite the conclusions of the Select Committee, the affair generated unwelcome publicity for Hereford.[107] The roots of this struggle are, therefore, to be found not only in concerns over the appropriate care available for pauper lunatics but also in influence over policy-making and the distribution of resources. The early years after the passage of the New Poor Law were transitional years in the development of national and local policy. In the new political climate after 1836, the new Unions and the city council were keen to establish their independence from the county magistrates. The issue of a public

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[104] *Hereford Times,* 14 May 1836, 28 May 1836 and 4 June 1836.
[105] *Ibid.* 7 July 1839 and 19 Oct. 1839.
[106] HRO S60, Hereford Infirmary, Governors' minutes, 5 May 1838.
[107] The local newspapers collaborated with the town council and magistrates to restrict any bad publicity and neither the *Hereford Journal* nor *Hereford Times* reported the dispute between the sessions or the findings of the Select Committee in any detail, alluding only to the 'financial and other business of the county'. *Hereford Times,* 20 Oct. 1838.

asylum for the county provided an opportunity for these tensions to be worked through.

5.4 Public asylum achieved

The County Asylums Act of 1845 made it compulsory for all counties to establish a public asylum for pauper lunatics within three years. By 1846 the Herefordshire justices were exploring their earlier idea of a joint venture with neighbouring counties and finally concluded an agreement with Hereford City and the three Welsh counties of Monmouthshire, Breconshire and Radnorshire in September 1847. [108] Under the terms of the agreement a new asylum would be built on the outskirts of Abergavenny with the costs shared in proportion to population. Together Hereford and Herefordshire contributed 35 per cent of the total capital cost and were able to nominate 33 per cent of the total number of visitors who were to comprise the management board. A twenty-acre site was purchased on the outskirts of Abergavenny and Thomas Fulljames was appointed as architect. He had been responsible for substantial improvements to Gloucester Asylum and for the design of the County Asylum that had recently opened in Denbigh, North Wales.[109] The design was approved by the Commissioners in Lunacy to provide accommodation for 200 patients, 40 more than the 160 estimated to be confined in institutions at that time. By the time the first patients were admitted in December 1851, the design had already been adjusted to provide fourteen more beds than originally planned. [110] By 1857 the available accommodation was proving inadequate, and, although 125 more beds were added in 1861 some patients had to be placed in other asylums.[111] As an alternative to further expansion at Abergavenny, it was proposed that Monmouth and Brecon should

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[108] GwRO D 3202.24, Register of Copy Documents. Sept. 1837.
[109] Michael, *Mentally ill in North Wales*, p. 44.
[110] GwRO, D 910.7, *First Annual Report of the Joint Lunatic Asylum for the Counties of Monmouth, Hereford, Brecon, Radnor and the City of Hereford.*

buy out the other members who would make alternative provision. The agreement was dissolved on 2 December 1870 with Hereford agreeing to provide a separate asylum within the county borders. [112] In 1871 St Mary's opened at Burghill with accommodation for 400 patients, more than ten times the number in Hereford Asylum in 1839.

From 1854 onwards, the statistical tables for the Joint Counties Asylum show the numbers of pauper lunatics chargeable to each Union, distinguishing between those living both inside and outside the asylum.[113] At the end of 1854, a total of 198 insane persons were being supported by Hereford city and Herefordshire of which 80 (40 per cent) were confined in the asylum and 118 (60 per cent) were maintained outside. The report of 1839 had identified a total of 166 lunatics of which 29 (17 per cent) were in an asylum. The total increase in the reported number of insane persons over the fifteen-year period was 32, an increase of 19 per cent, but the increase in the number confined in asylums was 51 or an increase of 175 per cent.[114] The reasons for this can be explored through an examination of the patient registers and case notes for the first years of the asylum's operation. The first *Annual Report*, completed for the period to 31 December 1852, recorded that of the 207 patients admitted in the first year of operation, 62 patients were chargeable to Hereford or Herefordshire.[115] Summary information from the admissions register for the period December 1851 to mid January 1853 showed 78 admissions from Herefordshire Unions, 16 higher than the figure given for Herefordshire in the Annual Report. [116] Some of this discrepancy related to five patients admitted in January 1853. The remaining

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[111] GwRO, D 910.9. *Statement in favour of dissolution of the present union.*
[112] GwRO D 3202.24, Joint Counties Asylum, Register of copy documents.
[113] *Joint Counties Asylum, Statistical tables of lunatics and idiots 1864*, Newport Library.
[114] This may be understated as this analysis only counts patients from the eight poor law unions predominantly in Herefordshire. Patients from Herefordshire parishes in other Unions have been excluded.
[115] *Statistical tables of lunatics and idiots 1864*,

difference is not easy to reconcile but arises from the fact that a Poor Law Union was made up of parishes from more than one county.[117] The admissions register provides brief demographic details of the patients admitted, recording their name, age, sex, place of origin and responsible union, together with a diagnosis, brief observations and date of discharge or death.

For 54 of these patients, these details are supplemented with case notes from the first case-note book of the asylum, the only case records to survive from this period.[118] At the time of admission, the book recorded brief notes of the history of each patient's illness and the results of the physical examination carried out. After this, further notes were made as considered necessary, recording any accidents, incidents, illnesses or instances of noteworthy behaviour. In general a minimum of one annual comment was made, often reminiscent of a school report, such as 'No change in mental or bodily health'. As the page allocated to a patient was completed, the patient records were continued in further casebooks. Unfortunately these have not survived, so the available records for each patient cover a longer time period if details were brief. Considered together, these records provide a register of the pauper patients from Herefordshire confined in 1851, a brief overview of their case histories and an indication of their treatment up to that date. As most of the patients suffered from chronic illness this cohort includes a significant proportion of the individuals thought to need treatment in an asylum in the middle decades of the nineteenth century. The books also reveal the classifications used for mental disorders and provide an indication of what were considered noteworthy symptoms.

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[116] GwRO D3202.30/1, Joint Counties Asylum, admission registers 1851-1859.
[117] Thus, some parishes in Dore Union were in Monmouthshire rather than Herefordshire and some Herefordshire parishes were in Welsh Unions. For the purpose of the summary analyses presented here, no attempt has been made to reconcile these differences.
[118] GwRO, D757.43. Joint Counties Asylum Case book, 1850-c.1860.

Appendix 9 shows that fifty-two of the patients, 67 per cent of the total, were admitted from another asylum. A single patient was admitted directly from Hereford Gaol and four patients from workhouses. Nineteen of the patients, 24 per cent of the total, were admitted either from home or an unspecified place. The majority of patients were therefore transferred from one specialist institution for the insane to another; the difference being that for most patients this was the first time that they had been treated in a public asylum. However, in addition to this group, the opening of the public asylum meant that an additional group of patients, previously living in the community or in other institutions, were confined in an asylum for the first time. [119]

Twenty-one of the patients were transferred from the Hereford Asylum, of which nine were chargeable to the Hereford Union, four from Ross and single numbers from the other Unions. Seventeen of the patients were previously at Whitchurch, of which eight were from Ledbury Union, three from Ross, three from Hereford, and two from the Dore Union. The majority of patients from the middle and south of the county were held in asylums in Herefordshire, normally the one closest to the parish. Nevertheless, despite having an asylum in the city, Hereford Union maintained one patient at Shrewsbury and one at Gloucester public asylums, and Ledbury sent one to Droitwich private asylum.

A different pattern emerges for the Unions in the north of the county, for whom the asylum of choice appears to have been an out of county institution. Leominster Union had seven patients transferred from asylums, one from Hereford, four from Birmingham and two from Shrewsbury. Three patients chargeable to the County of Hereford had previously been placed in Droitwich private asylum and Bromyard Union had one patient at Droitwich and one in Bristol. Only Kington Union had no patients held in asylums prior to 1851, and

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[119] *Ibid.*

only transferred three to Abergavenny in the first year. Kington, situated on the north west border of Herefordshire was the most geographically remote area of the county and this may have been a factor in the decisions made about patient care. The reasons for particular choices are not clear but the pattern of provision demonstrates that prior to 1851 Poor Law Unions had considerable choice as to where they placed pauper lunatics. A number of specialist asylums were used and in some cases Unions were prepared to lodge patients as far away as Birmingham or Bristol.

Summary

This chapter has examined the factors that affected the provision of institutional care for the insane in Herefordshire. It has demonstrated that in the period prior to 1845, the model adopted reflected the influence of several groups, the county magistrates, the Infirmary governors, members of Hereford corporation and the reformed council, magistrates and the New Poor Law Unions. Hereford Asylum was an integral part of the welfare provision that developed in Hereford City at the end of the late eighteenth century as several new institutions were built, including the Infirmary. Both philanthropic and public funding were necessary to enable these new institutions to be established. The building appeal for an asylum was associated with the General Infirmary charity but the funding for patients was to be provided by private individuals or the Poor Law authorities. When the charitable model proved difficult to operate, the asylum was leased to medical professionals to be run as a private madhouse. However the philanthropic influence was maintained through continuing links with the Infirmary charity, which funded further capital developments to the Asylum. By granting the lease to medical professionals who held honorary posts at the Infirmary, and through the operation of a visiting committee, an informal regulatory mechanism was instituted which satisfied the initial charitable motivations of local supporters. The

introduction of the New Poor Law and municipal reform in the 1830s disrupted these relationships. Proposals by the lunacy reform movement centred on the provision of a public asylum and asserted the primary role of the county magistrates in leading local policy. The local impetus for reform was led by a few of the local justices but they were unable to gain local support for the national reform programme. The New Poor Law Unions, Hereford council and the county ratepayers were united in opposition and were able to ensure that the local solution continued in place until 1851. The roots of their objections lay in their opposition to the administrative and political changes that underlay the lunacy reform programme. The public asylums were managed through the county magistrates although funding continued to come from the Poor Law Unions and the county ratepayers, and they were determined to withstand a loss of influence and control over this aspect of medical services for as long as they could.

Chapter 6

Public Health and the cholera epidemic of 1831-1832

The Public Health Act of 1848 created a Central Board of Health and included provision for the establishment of local boards with powers over drains, water supplies, burial grounds, refuse disposal, gas works and housing. Before the Act could be implemented locally, a preliminary enquiry into sanitary conditions had to be carried out and the support of a minimum of 10 per cent of those rated for poor relief obtained. The provisions of the Act were enabling rather than compulsory, and the Central Board was only able to force a local authority to establish a board of health where the general death rate exceeded 23 per thousand.[1] It was not until the 1866 Sanitary Act that public health legislation introduced significant compulsory duties on local authorities. Prior to the 1848 Act, decisions about public health measures were under local control. Responsibility for water, sanitation and the management of 'nuisances' rested with individual local improvement societies, established under individual acts of Parliament. An exception occurred in 1831-32 when central policy developed to deal with the cholera epidemic made it compulsory to establish local boards of health.

From the 1960s historians began to study disease from a social history perspective. It was argued that the differential impact of morbidity and mortality on various sectors of the population provided an opportunity to analyse class structure within a society. The dynamic impact that epidemic disease had on social and political relations and the influence of epidemics on the development

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[1] Wohl, *Endangered lives*, p.149.

of public health measures were also highlighted.[2] In the 1970s, three studies by R. J. Morris, Margaret Pelling and Michael Durey developed this approach in relation to cholera in Britain in the nineteenth century.[3] These studies are drawn on in the later discussion.

The strategies for prevention and management of cholera developed by central government reflected both contemporary medical theory and political structures and ideology.[4] At the time of the 1832 epidemic, the only central medical bodies were the Vaccination Board and the Commission in Lunacy, and the only relevant legislation was the Quarantine Act of 1825, based on older plague regulations.[5] National policies to deal with the new disease were developed within 'the parameters of custom, tradition and political continuity', which meant in practice that considerable powers were delegated by central government to local elites.[6] Implementation of central policy was hindered by the complexity of the local government structure with 15,000 parishes, 200 borough councils and many improvement authorities all having some responsibility in this field.[7] In the absence of a pre-existing enforcement structure, new local boards of health were established which were given the freedom to implement central directives within the constraints of local priorities.

During the nineteenth century, Britain was hit by four cholera epidemics, in 1831-1832, 1848-1849, 1853-1854 and in 1866-1867. It is estimated that 32,000 people died in the first epidemic, 62,000 in the second, 20,000 in the third

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[2] R. E. McGrew, 'The first cholera epidemic and social history', *Bulletin of the History of Medicine*, 34 (1960), pp. 61-73 and A. Briggs, 'Cholera and society in the nineteenth century', *Past & Present,* 19 (1961), pp. 76-96.
[3] Morris, *Cholera 1832*, Pelling, *Cholera,* and Durey, *Return of the plague*.
[4] Porter, *Health, civilisation and the state*, p. 91.
[5] Durey, *Return of the plague,* p. 9.
[6] *Ibid.* p. 77.
[7] *Ibid.* p. 78.

and 14,000 in the last.[8] During the first two epidemics, there was considerable debate about the cause of the disease and the measures needed to control it. It was not until 1849 that the work of John Snow clarified that the disease was spread through the water supply, and not until 1883 that Koch identified the cholera bacillus as the disease agent.[9] Cholera's impact on mortality in Britain was minimal in comparison to the effect of other epidemic diseases, such as typhoid, typhus, scarlet fever, smallpox and measles.[10] However, its indiscriminate impact, sudden onset and high mortality rate, all heightened the psychological and social impact of the disease.[11] The influence of cholera on public health reform has been a matter of debate. The orthodox view stresses the catalytic impact the disease had on the reform programme of the sanitarians. In contrast, Margaret Pelling and others have emphasised the continuing importance of the eighteenth-century view of fever in the policy deliberations of the reformers.[12] Political factors were also relevant to cholera's impact. The first outbreak affected Europe at a time of considerable political upheaval and in Britain it coincided with the passage of the Reform Act of 1832. The years between the first two epidemics saw the implementation of the New Poor Law by the first Reform Parliament. John Pickstone has argued that the political philosophy of the day supported Chadwick's sanitary approach, focussing attention and political action on the independent causes of disease, such as water and sanitation, rather than a debilitated and impoverished population.[13]

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[8] Wohl, *Endangered Lives,* p.118.
[9] *Ibid.* pp.124-125. Snow's theories were not widely accepted until 1854 when he demonstrated that contaminated water supplied by the Southwark and Vauxhall water company was the source of many cholera deaths.
[10] *Ibid.* p. 4.
[11] *Ibid*, p.118.
[12] Pelling, *Cholera,* p. 4.
[13] J. V. Pickstone, 'Dearth, dirt and fever epidemics: rewriting the history of British public health', 1750-1850', in T. Ranger and P. Slack (eds), *Epidemics and ideas:*

These political approaches were endorsed by the development of a revisionist view of fever itself, which 'stressed that fever was primarily a localised disturbance rather than a general disease of the whole constitution'.[14]

From the late 1830s, concerns about the poor health of the population, particularly in rapidly expanding urban areas, resulted in growing pressure for increased state intervention in public health matters. At the beginning of the nineteenth century approximately 20 per cent of the population of England and Wales lived in towns of over 5,000 residents. By 1851 this figure had risen to 54 per cent.[15] Pressure for public health legislation was spearheaded by the sanitarians, among them Edwin Chadwick, who believed that dirt and decomposing matter was a prime cause of epidemic disease. In 1839 a report commissioned by Chadwick at the Poor Law Board to investigate the links between poverty and illness, confirmed that disease was a major contributory factor to pauperism. Throughout the 1840s this link was confirmed by Poor Law officials and doctors working in the field, who identified inadequate diet and clothing, poor housing and sanitation, contaminated water and atmospheric pollution as factors adversely affecting the health of the poor.[16] In 1842, Chadwick's *Report on the Sanitary Condition of the Labouring Population of Great Britain* was issued. This considered among other things, the impact of inadequate sewerage, drainage and water supply on overcrowded populations, arguing that they aggravated both endemic and epidemic disease. In 1844 the findings of this report were supplemented by the investigations of a Royal Commission looking into the sanitary state of large towns and the report

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essays on the historical perception of pestilence (Cambridge, 1992), pp. 125-148, p. 137.

[14] *Ibid.* p.138.

[15] Wohl, *Endangered lives,* p. 3.

[16] *Ibid.* p. 45.

recommended that local sanitary authorities should be appointed and that central government have powers of inspection.[17]

The early public health legislation was permissive rather than compulsory. In 1846 and 1847 legislation was passed giving justices of the peace authority to prosecute those responsible for shortcomings in drainage, poor housing or sewerage. The rights of town authorities to lay water supplies and drains were also consolidated. The Public Health Act of 1848 appointed the Central Board of Health and authorised the setting up of local boards. The Central Board's approach was one of persuasion rather than compulsion and it soon became clear that establishment of a local board was no guarantee of success in implementing improvements.[18] Both the parsimony and the political interests of those who controlled local councils contributed to the lethargy in taking forward public health reform.[19] Although the death rate in Hereford City was 27 per thousand, no local campaign in favour of a board of health was started and in July 1853 the Central Board appointed T. W. Rammel to look into conditions in the town.[20] Significant improvements to the public health infrastructure were not made until after the Hereford Improvement Act of 1854 came into effect.

This chapter provides an overview of the action taken to address public health issues in Herefordshire prior to 1850, with particular reference to the cholera epidemic of 1832. The main primary sources used are the records of the Local Boards of Health established in 1832, the 1853 report into sanitary conditions in Hereford, newspaper reports and private papers. Section 6.1 summarises measures implemented under local Improvement Acts in Hereford

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[17] *Ibid.* pp. 147-148.
[18] *Ibid.* pp.149-151.
[19] *Ibid.* pp.168-169.

and the smaller market towns. Section 6.2 discusses the management of the cholera epidemic of 1831-1832 in the county. Herefordshire was one of only six counties in England to escape with no cases of cholera during the epidemic. [21] However, although the county did not face the acute pressure of a disease outbreak, by the summer of 1832 the disease was expected to strike at any time. Preparations made by the Boards of Health in Hereford and Ledbury are analysed in detail to explore local reaction to the threat of the disease and the preventive measures implemented. These responses are considered in the light of the local political situation and public opinion to identify factors that affected local policy making. The relationship between specific measures to deal with the cholera epidemic and the development of longer-term public health measures is also discussed.

6.1 Public health provision in Herefordshire to 1850

6.1.1 Hereford City

The earliest Improvement Act for Hereford, passed in 1774, appointed 57 Commissioners with authority to raise a rate to improve the streets and lighting. These powers were modified by three subsequent acts to extend jurisdiction beyond the old city walls and to allow for the provision of gas lighting.[22] Among the measures taken to improve the infrastructure of the town were pitching and flagging of the streets, the removal of the old city gates and the rebuilding of

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[20] T.W. Rammel, *Report to the General Board of Health on a preliminary inquiry into the sewerage, drainage and supply of water, and the sanitary condition of the inhabitants of the city of Hereford* (London, 1853).
[21] Durey, *Return of the plague,* p. 202. The six counties unaffected by cholera in 1831-1832 were Herefordshire, Surrey, Sussex, Hertfordshire, Northamptonshire and Rutland. Herefordshire had only one death in 1849.
[22] *Ibid.* pp.19-20. The later Acts were passed in 1816, 1824 and 1838.

various public buildings and bridges over the River Wye. However these measures had had little impact on the crowded living areas in the city. Hereford's population approximately doubled in the century from 1750, increasing overcrowding and pressure on inadequate sewage and water facilities.[23]

Rammel's report to the General Board of Health in 1853 provides a snapshot of the situation at mid century. There was no public supply of water, drinking water was supplied from private wells, supplemented by rain water for washing and river water for brewing.[24] Lavatories were indoor or outdoor privies connected to cesspools. Private tradesmen collected the nightsoil, some of which was processed into manure and the remainder buried. Despite local provisions prohibiting the disposal of night soil into the sewers this was a common occurrence. Sewage from approximately one third of all houses drained into culverts and then into various streams around the city and finally into the River Wye. Particular problems occurred in dry weather when there was insufficient water to flush away the waste matter effectively. There was no map of the sewers and main drains in the city, which had developed in a haphazard fashion aimed at dealing with the drainage of surface water rather than sewage. Heavy storms often caused the drains to overflow. [25] The burial ground around the Cathedral had been closed in 1793 but by the 1850s other cemeteries in the city was also very overcrowded, with some graves only two feet deep.[26] In addition, there were also many slaughterhouses and pigsties in the old city.[27]

Rammel also looked into the detailed statistics relating to deaths over the previous seven years, for which the average mortality had been calculated as 27

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[23] Roberts, *Modern Hereford*, pp.108-112.
[24] Rammel, *Report,* p. 29.
[25] *Ibid.* pp. 32-33.
[26] *Ibid.* pp. 47-51.
[27] *Ibid.* p.43.

per one thousand. Particular attention was drawn to the death rate from zymotic diseases, defined as epidemic, endemic or contagious diseases, which accounted for 280 of the 2,132 deaths recorded in the period 1845 to 1851,13 per cent of the total.[28] Dr Henry Bull, surgeon to Hereford Gaol and Hereford Dispensary, provided a more detailed analysis of the causes of death between 1846 and 1852 to supplement these figures. During his evidence, Bull highlighted specific areas of the city as having particularly poor drains and housing with correspondingly high levels of disease.[29] The report made no detailed comment on the death rates although it was these statistics that had caused the intervention of the Central Board.

Rammel's report recommended that surface and refuse drainage were improved, the number of privies increased, cesspools filled, a pure water supply established and additional burial grounds provided. It also recommended that ventilation and sanitary improvements were made to the worst housing in the city.[30] Under the provisions of the Hereford Improvement Act of 1854, the powers of the Improvement Commissioners were transferred to public control and the city council became the Board of Health. By 1855 pipes discharged the city's sewage directly into the River Wye rather than into cesspools and streams. A water supply was installed in 1856 using water taken from upstream of the city and purified through slow-sand filters.[31]

6.1.2 Market towns and rural areas.

As noted in Chapter 1, early schemes to improve conditions in the market towns very often depended on the tenacity of one individual. An example of this is the

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[28] *Ibid.* p. 16.
[29] *Ibid.* pp. 45-46.
[30] *Ibid.* p. 53.

development of water supplies. In 1709, John Kyrle and some associates had established a water supply at Ross-on-Wye by pumping water from the river up to a reservoir at the top of the town. By the 1820s this provided piped water to most houses and, by the 1830s, sewers had also been laid in the town. Further improvements to the town's water supply did not occur until the 1880s.[32] There is little evidence of other measures to address water and sewerage issues in the rest of the county until the nineteenth century. In Ledbury, efforts to improve the water supply started in 1808 when the town drains were covered. The scheme was extended following a typhoid outbreak in 1826 and in 1828 new reservoirs were completed which provided a piped water supply to every house. In 1835 the Ledbury Improvement Act authorised Commissioners to levy a rate and enforce further improvements.[33] The Kington improvement society was founded in 1829 and among other issues worked to introduce a proper system of sewerage.[34] Living conditions for many of those living in rural areas were very poor. A report submitted by Ledbury to the Central Board of Health in 1831 is reproduced in Appendix 10. This highlights the incidence of fever cases, noting that it was especially prevalent among the poor who were living in filthy conditions with no facilities for sewage disposal. Chadwick's *Sanitary Report of 1842* highlighted these same points. The Relieving Officer for Ledbury is reported as saying, 'that some instances of typhus have occurred in that place which are probably owing to filth or the want of drainage and ventilation'.[35] The Relieving Officer of Madley Union commented that 'we have had several cases of typhus fever owing to the state of repairs and want of drainage'. Daniel West, of Dewchurch, reported that

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[31] Roberts, *Modern Hereford,* p. 113.
[32] Hughes and Hurley, *Story of Ross,* pp.119-122.
[33] Hillaby, *Book of Ledbury,* p.131.
[34] Sinclair and Fenn, *Border janus*, p. 39.

'there have been several deaths in my district from fever, and I have heard the medical officers observe that filth was in great measure the cause of it'. In relation to Kington Union, the report notes that 'very few cottages are provided with privies; very little attention is paid to the important object of proper drainage in this district'.[36] It was not until public health measures became compulsory in the second half of the nineteenth century that more comprehensive measures were put in place. Policies adopted in a locality were affected by local considerations. This is explored in the next section in relation to responses to the cholera epidemic of 1831-1832 in Hereford and Ledbury.

6.2 Cholera in Herefordshire in 1832.

6.2.1 The spread of the disease and central policy

The cholera epidemic that reached England in the autumn of 1831 had started some five years earlier in India. From there cholera spread along land trade routes through Persia to reach Moscow in 1830 and the Baltic ports in the summer of 1831.[37] In the months it took for the disease to spread across Europe, the British government had time to develop its policy for prevention and containment in the light of the experience of other countries and national considerations. The main measures implemented by European states in their attempts to stem the flow of the disease were quarantine regulations and the use of the cordon sanitaire around affected areas. These measures were based on the contagionist theory that argued the disease could spread through infected

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[35] *Report on the Sanitary Condition of the Labouring Population of Great Britain* (London, 1842). p. 110.
[36] *Ibid.* p. 108.
[37] Durey, *Return of the plague,* p.8. The first cholera pandemic began in India in 1817 and by 1824 had infected the whole of Southeast Asia. After a brief respite it began to spread again from 1826.

goods and merchandise in addition to transmission from person to person.[38] The political ramifications of the policies adopted could be considerable as coercive measures were frequently needed to enforce the isolation of infected individuals and communities, while quarantine restrictions disrupted trade. Political radicals argued that some actions, justified by the authorities as necessary to control the spread of the disease, were in fact an attack on personal liberty. Cholera, it was claimed, provided an excuse for the implementation of repressive measures, and undue emphasis on the threat posed by the disease was a way of distracting revolutionary feeling away from political agitation.[39] Medical practitioners were drawn into both the theoretical debates about the management of the disease and the practical difficulties of treating those affected. In addition to the risk of catching the disease from infected patients, they were, on occasion, caught up in the social unrest and personally attacked as representatives of the establishment conspiracy.

Both the spread of disease and the social disturbances across Europe were widely reported in the English papers. John Biddulph, from Ledbury, reflected on the social and political impact of cholera's spread across Europe.

> ...met Mr Koch- who told me that the cholera was spreading fast in Germany and that the powers no longer took any precautions to keep it off. The ignorant peasantry in Russia have killed the medical men whom they believed had brought the Disease, and in Hungary the nobles have been most cruelly murdered and in some places entirely destroyed by the peasants who believe the nobility wish to poison them- surely this is a strong reason for

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[38] Morris, *Cholera,* pp. 23-25.
[39] McGrew, 'The first cholera epidemic', pp. 66-68.

enlightening them and giving them education. Here we are bad enough where the people think machinery is evil. [40]

With no precedent for coercive public health measures and the European experience as a warning, the British government took a cautious approach in its preparations. In November 1830, the 1825 quarantine regulations were invoked and a quarantine station set up in the Medway for ships coming from the Baltic. However, it was not until June 1831 that a Board of Health was established.[41] Chaired by Sir Henry Halford, President of the Royal College of Physicians, this was given the remit of assessing information on the nature of the disease and its treatment. Throughout the summer of 1831 a debate was conducted between the contagionists and those who supported the alternative miasmatic theory which claimed that the disease was due to more general atmospheric considerations. The Central Board leaned towards the contagion theory and recommended a series of measures to be adopted by local boards that included separating those infected from the general population, purifying infected homes and burying the dead in separate burial grounds. The Central Board favoured the introduction of compulsory measures and considered that the use of troops and police cordons would be justified in extreme cases.[42] The Government considered these measures to be too extreme given the political climate and nothing was issued until after the first cases of cholera in the country were confirmed in October 1831. The directions issued the following month were less prescriptive than those put forward by the Board of Health. They recommended that the sick should only be taken to separate cholera hospitals with the agreement of their relatives. Infected houses were to be thoroughly cleaned and the dead buried in a

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[40] HRO, G2/IV/J/60. Diary of John Biddulph, Sept. 1831.
[41] The quarantine regulations were based on those used to regulate the plague.
[42] Morris, *Cholera,* pp. 28-32.

detached plot of land.[43] Soon afterwards the original Board of Health was dismissed on the basis that its quarantine regulations had failed to stop the disease from reaching Britain. [44] The new Board favoured persuasion rather than coercion and placed less emphasis on the need for quarantine and more on preventive measures to improve the conditions of the poorest and most vulnerable as a means of preventing the disease taking hold. Actions proposed included the dissemination of advice on diet and clothing, including a reduction in alcohol consumption, the cleaning of drains and watercourses and the removal of 'nuisances'.[45]

By January 1832 cholera had spread from Sunderland to Edinburgh and had infected several urban areas including Newcastle and the smaller towns and villages of Northumberland, Durham and the Scottish border counties. Despite the continuing quarantine regulations on international and coastal shipping, cholera reached London in early February, transmitted by vessels carrying coal from the north. Although it was clear that the disease spread along roads and inland waterways, no restrictions were placed on inland travel and the disease continued to spread up towards the West Midlands. Some commentators challenged this policy, and a leading Sheffield newspaper noted disparagingly that cholera was welcomed to London in a coach and pair but must not arrive by coal barge up the Thames![46] By June 1832 the disease was spreading more rapidly and mortality peaked between July and September before petering out in late 1832 and early 1833.

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[43] Durey, *Return of the plague,* p.20.
[44] *Ibid*, p. 25.
[45] *Ibid*, p. 35.
[46] *Ibid.* pp. 32-33.

6.2.2 Preparations in Hereford City

By June 1832 there were confirmed cholera cases in Gloucester, Shropshire, Worcestershire and Monmouthshire and there was every reason to expect that the disease would spread into Herefordshire.[47] The edition of the *Hereford Times* printed on 21 July 1832 included several items on the subject of cholera urging the local corporation to take action to establish a board of health. An anonymous correspondent, 'Pieta', commented:

> When the Cholera is raging with appalling virulence in different parts of the kingdom, and when it has laid deathy hands on Worcester, Gloucester and Newport, is it not extraordinary that our Board of Health should remain in that lethargic state which argues either culpable indifference or presumptive confidence?[48]

Medical practitioners in Hereford were also concerned at the delay. A special meeting was held at which they resolved that the mayor be requested to take the necessary measures to establish a board of health in Hereford. They also called for another survey of the city to be completed and that 'any nuisances prejudicial to the Public Health be immediately removed'.[49] As a result of this public pressure, William Bennett, the mayor convened a meeting of the 'magistrates, gentry, clergy, and inhabitants' the following week at which it was agreed that an application should be made to the Privy Council to establish a board of health for Hereford.

The principle behind the boards of heath was that they should include broad representation from local society but in many places the established

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[47] G. P. Jones, 'Cholera in Wales', *National Library of Wales Journal*, 10 (1958), pp. 281-300.
[48] *Hereford Times*, 21 July 1832.
[49] *Ibid.*

political elite were the dominant interest.[50] The membership of the Hereford Board of Health is summarised in Table 6.1. In total there were forty-two members, the majority of who represented the six city parishes. The mayor, escheator and six aldermen represented the city corporation. A medical subcommittee was appointed comprising the six honorary medical practitioners at the Infirmary, of which two were aldermen.[51] While members of the corporation were not in the majority on the board, they did exercise significant influence and also controlled the medical advice provided.

Table 6.1: Members of the Board of Health at Hereford, 1832.

Mayor and Aldermen (2 were medical practitioners) Honorary medical practitioners at the Infirmary Parish representatives Parish clerical representatives	8 4 26 4
Total	**42**

Source: HRO, BH37/2/1b. Letter dated 28 July 1832 confirming the appointment of a board of health at Hereford.

As discussed in Chapter 1, Hereford corporation was a self-elected Tory oligarchy. Many of its members were actively involved in the election campaign. One of the aldermen, John Gwillim, seconded the nomination of Mr Blakemere, the Tory candidate for Hereford City for the December 1832 election. Later in the campaign, John Bleek-Lye, an alderman and honorary physician at the Infirmary, was implicated in fraudulent electioneering on Blakemere's behalf.[52] Michael Durey has argued that middle-class radicals perceived cholera as a potential threat to the momentum for reform as it provided an opportunity to use the impact

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[50] Durey, *Return of the plague,* p. 78.
[51] HRO, BH37/2/1b. Letter dated 28 July 1832 confirming the appointment of a Board of Health at Hereford.

of the disease to divert attention away from the reform agenda.[53] However, while the establishment of the Hereford Board of Health may have provided the Tory corporation with the opportunity to use some diversionary strategies, it also exposed them to additional risk of political attack. The Tories were entering the local election at a distinct disadvantage. Electoral reform had reduced the electorate for Hereford from 1,110 to 920. Many of those who had been excluded were non-resident freemen whose freeman status had been purchased or granted by the corporation. Any opportunity for criticism of the corporation was likely to act as a focal point for those supporting the Reform Party. The actions of the corporation on the Board of Health were, therefore, subject to close local scrutiny and they had to find a balance between the need to manage the threatened epidemic while maintaining calm and promoting support among the electorate.

Despite its late start, the Hereford Board moved quickly to prepare for the threat of the disease and started work on a comprehensive set of measures that included both preventative work and preparations for dealing with an outbreak. As a first step, however, it had to determine the limits of its authority and find a way to finance its activities. The customary way of funding emergency measures was through public subscription but it was left to each local area to decide whether to raise funds by this method or through the poor rate.[54] The Board requested the six parishes to consider 'what and how many of the powers enumerated in the supplement of the London Gazette for Friday July 20 1832 they may think it expedient to invest the Board with'. [55] Five out of the six

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[52] *Hereford Times*, 18 Dec. 1832. Report on Hereford City Election and HRO, G2/IV/J/60, Biddulph diary, 21 July 1832.
[53] Durey, *Return of the plague,* p. 189.
[54] *Ibid.* p. 84.
[55] HRO, BH 37/1. Minutes of the Board of Health at Hereford, 1 Aug. 1832.

parishes agreed to support the Board but All Saints Parish refused to grant any of the suggested powers or to contribute any financial assistance.[56] The Board's response was to obtain an enforcement order from the Privy Council on the grounds of public safety.[57] All expenditure was to be funded from the parishes and, unlike other places, no public subscription seems to have been considered, despite the fact that the late Bishop had donated £20 earlier in the year. This approach was not accepted without complaint, and in addition to continuing opposition from All Saints parish, St Martin's also resisted. Payment was eventually enforced through by a magistrate's order in October 1832. [58]

Satire was one effective strategy used by local advocates of reform to attack both the Tory corporation and the Cathedral clergy.[59] The political undertones are clear in Pieta's satirical musings on the potential uses of buildings in the Cathedral precinct.

> As there does not appear to be any building fixed upon for a Cholera Hospital, allow me to repeat a suggestion which this morning I heard from the lips of a clergyman. The great desiderata of such a Hospital would be – isolation from inhabited houses, ventilation in the chambers, and convenience for the removal of the dead, without passing near our thoroughfares. Sir, the College affords all these desiderata, and considering the non-occupancy of the chambers, and that one of the first duties of a Christian Minister is ' to comfort and help the weak hearted' I have no doubt of the practicality of the plan. In case the College be not ceded, the

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[56] *Ibid.* 8 Aug 1832.
[57] *Ibid*, 29 Aug. 1832.
[58] HRO BH 37/2/4, Order of Privy Council authorising the collection of monies from the parishes, dated 25 Aug. 1832.

palace or deanery (the Bishop and Dean being absent) might be easily converted into a Cholera Hospital.[60]

Despite the tongue in cheek nature of the proposal, Pieta was drawing attention to a pressing concern, as the acquisition of suitable premises for a cholera hospital was one of the Board's first priorities. The first option considered was the poor house in St Peter's but the parish refused to make it available.[61] Just over a week later, the committee asked each parish to identify a suitable site and, as a fall back measure, also wrote to the Privy Council asking for the loan of a tent for use as a hospital. Although the Privy Council agreed that a tent could be used, they refused to loan one. As no buildings were identified, the board agreed to rent a meadow at a cost of £15 and also acquired a tent from a local man.[62] As a further contingency, a contract was agreed to build two temporary rooms within forty-eight hours, should they be required.[63] An appropriate heating system for the tent was debated and board members obtained a variety of baths and other appliances. In drawing up their arrangements, the Board took advice from others with direct experience of managing cholera, consulting with, among others, Dr Stretton of the Worcester Cholera hospital and John Senior from Bilston.

The difficulties facing the Board became more intractable when it came to recruiting personnel to care for the sick. In early August, parishes were instructed to compile a list of potential nurses and porters to transport the sick and dead. No volunteers were identified and the Medical Committee were asked to 'select,

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[59] Durey, *Return of the plague,* p. 190. The attack on the clergy was due to the opposition of the Bishops to the Reform Bill.
[60] *Hereford Times*, 21 July 1832.
[61] HRO, BH 37/1, Hereford Board of Health, 8 Aug. 1832.
[62] HRO, BH 37/2/3. Letter from the Central Board declining to provide a tent for cholera purposes.
[63] HRO, BH 37/1, Hereford Board of Health, 24 Aug. 1832.

appoint and register at least four nurses who may agree to attend cholera patients when called upon to do so'.[64] After ten days they reported that they had failed to identify anyone and each parish was then instructed to find their own nurse.[65] Difficulties persisted, for example, at St John's, where Jane Farrington first agreed to work as a nurse, but later withdrew. The Board's accounts show that only one nurse was ever appointed, a woman called Elizabeth Jones who was employed from 22 September until 12 December.[66]

Although relieved of the responsibility of identifying nurses, the Medical Board was not able to duck the issue of medical attendance so easily. They were asked to advise on the types and quantities of drugs to be purchased together with arrangements for their distribution. Their recommendation was that a central Dispensary be set up in High Town under the control of a dispenser.[67] In early September, John Senior attended the Board to provide a first-hand account of the effect of the cholera outbreak at Bilston, where 2,000 out of a population of 16,000 had fallen ill with 570 fatalities. The town had made no preparations to deal with an epidemic so the workhouse had been rapidly converted to a cholera hospital, nurses appointed and a driver found to transport the sick and dead around the town. These arrangements failed to cope with the epidemic and collapsed after two medical practitioners succumbed to the disease. The situation had only been salvaged when the Central Board sent a doctor to Bilston with additional help called in from Birmingham.[68] Faced with this first-hand evidence of the potential ravages of an epidemic, the Board asked the Medical Committee to identify two resident dispensers for the sick house, a request they responded

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[64] *Ibid*, 10 and 15 Aug. 1832.
[65] *Ibid.* 24 Aug. 1832.
[66] *Ibid.* 5 Sept. 1832.
[67] *Ibid.* 8 Aug. 1832.
[68] *Ibid.* 26 Sept. 1832.

to with the comment that the arrangements already made with Mr Dowding were sufficient. On 24 September, it was reported that a Mr Boveley had offered his services as resident dispenser but the Board agreed to defer a decision pending further discussions between the Secretary and Samuel Hughes and John Bleek-Lye, 'the two senior physicians in the city'.[69] While it was clearly important that sufficient medical support was identified, it was also important that the medical establishment was seen to be an integral part of the Board's preparations. On 2 October, Hughes and Bleek-Lye reported that they had made 'an arrangement with the Medical Gentlemen of the City which gave promise of regular medical attendance wherever their services should be required'.[70] Further details of the arrangements were not given and in the event the arrangements were never put to the test.[71]

In addition to preparations for coping with a potential outbreak of disease, the Board also undertook work of a more preventive nature principally the identification of 'nuisances' felt to be a health hazard. Two medical inspectors were appointed for each parish, who were charged with inspecting premises in their area and issuing notices for the removal of any hazards by the appropriate authority. Considerable effort was put into attempting to use the authority of the Commissioners for Lighting and Paving to clear pigsties from the residential areas and to encourage the Turnpike Trusts to clear ditches. Several buildings were subject to compulsory lime washing and consideration was given to banning the sale of herrings in the market. In taking these actions, the Board was forced

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[69] *Ibid.* 2 Oct. 1832. Hughes and Bleek-Lye were both aldermen.
[70] *Ibid.* 6 Aug. 1832.
[71] M. Durey, 'Medical elites, the general practitioner and patient power in Britain during the cholera epidemic of 1831-2', in I. Inkster and J. Morrell, *Metropolis and Province: science in British culture, 1780-1850* (London, 1983), pp. 257-278. Durey discusses examples of conflict within the medical community for control

to tread carefully, enforcing measures to protect the population using existing powers and organisations. This cautious approach is evident in the consideration given to suitable burial grounds. The central guidelines recommended that cholera victims were buried in separate burial grounds, but the Hereford Board were not prepared to endorse this, concluding that,

> the church yards and burial grounds being consecrated it was thought best under all the circumstances and the feelings of the public to consider them as sufficient for the present, as people dying of cholera would be wrapped in a seer cloth as recommended by the government. [72]

Across the country, vagrants were identified as a likely source of contagion and the board made efforts to control their entry into the town. In early August they agreed that

> the sword bearer and two of the mayors officers and the deputy overseer of each parish (were) to visit every lodging house in each parish and make out a list of inmates and to adopt any measures for removing any vagrants which they have the power to put in force. [73]

The issue became more pressing as the annual race week approached and measures to reduce the number of tramps in the town were considered. One suggestion put forward was that they should be obliged to stay in a tent on Widemarsh Common, on the outskirts of the town, but this was eventually rejected on account of expense. Cost was an issue in many of the Board's activities, as shown when the Commissioners of Lighting and Paving refused to

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over the Boards of Health in several provincial cities. There is no evidence of this in Hereford.

[72] HRO, BH 37/1, Hereford Board of Health, 20 Aug. 1832.

agree to improve drainage in a culvert in Bewell Street on the grounds that 'the funds for lighting and paving were not strong'.[74]

Public information was also a major consideration, in particular the need to publicise the Board's efforts. In addition to regular reports in the local newspapers, this was addressed through the distribution of handbills that were displayed around the city and also sold at a halfpenny each. The handbill was a mixture of public information and propaganda. Instructions on preventive strategies was limited to advice that 'the best means of preserving ourselves from an attack – are a clean house, clean linen, not to sit in wet clothes, not to get drunk, not to eat unripe fruit, but to live temperately'.[75] Much more emphasis was given over to advertising the measures put in place by the Board of Health, and in particular the need to seek medical assistance from the temporary Dispensary.

> Its attacks are sudden and without speedy assistance, by Medicine, prove fatal. -Therefore gladly embrace the advantages that are offered you by the Board of Health - fly to their Dispensary for assistance, and thankfully receive those benefits which it offers; and believe that its exertions, in conjunction with the Medical men, are for your good, without any possible advantage to themselves; and that the outlay of money and personal risk and exertions are to stay the Plague and to save you- your neighbour, and the Public from excruciating pains and an appalling Death. [76]

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[73] *Ibid.* 9 Oct. 1832.
[74] *Ibid.* 9 Oct. 1832.
[75] HRO, BH 37/4/5, *History of the rise and progress of the spasmodic cholera (Hereford, 1832)*
[76] *Ibid.*

By November 1832, the prevalence of the disease had declined sufficiently for the Board to agree to wind up the precautionary measures put in place. Nurse Jones was laid off and the lease on the field given up. The special notice board was removed from the Dispensary and the handbarrow acquired for transporting patients was donated to the Infirmary.[77] The final accounts showed that a total of almost £60 had been spent, £20 of which was the late Bishop's donation with the remaining sum charged to the six city parishes. The major items of expenditure had been £15 for the rent of the field, £10 on the contract with James Boulders for further buildings, £13 on printing handbills and £4 paid to Nurse Jones.[78]

Several features of the preparations made in Hereford emerge from this review. The city did not respond to the early recommendations of the Central Board of Health issued in the autumn of 1831 and little was done until July 1832. By this time the arrival of the disease was imminent, cholera had reached all the neighbouring towns and evidence of the consequences of a failure to act was apparent from the experiences at Worcester and Bilston. The threat of epidemic posed an additional political risk to the city corporation who faced a threat to their power base in the forthcoming elections. The mayor and aldermen supported the Tory candidates in the election. During the course of the summer at least one of their number, John Bleek-Lye, physician to the Infirmary, was caught up in allegations of corruption concerning the registration of votes and the use of private funds to influence electors. Given this political situation, it was crucial that nothing was allowed to further undermine the corporation's reputation among the population and that the opposition was not able to gain any political advantage

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[77] HRO, BH 37/1, Hereford Board of Health, 5 Nov. 1832, 5 Nov. 1832 and 27 March 1833.

from mismanagement of the epidemic. The measures taken against cholera were framed with these considerations in mind.

The elite of the medical profession in the town, all associated with the Infirmary and the city corporation, were included in the Board of Health. Their influence was important in shaping the response of the medical community to the disease and in maintaining public confidence. A general meeting of medical practitioners in Hereford had called for the Board of Health to be established in July 1832 but once the Board was convened, the medical input was controlled through the medical subcommittee. The Board of Health also worked through established channels with the local Commissioners of Lighting and Paving and with the Turnpike Trusts to remove health hazards and improve drainage within the limits of the normal powers of those authorities. Finance was raised from the parishes in preference to a general subscription, which may have afforded opportunities for others to raise their personal profile in the city, and issues of accountability for the Board. In summary, the Board worked through established institutions and processes. The threat of epidemic did not act as a catalyst for new improvements to the city's infrastructure, but rather reflected the conservative approach of the established powers in the city. Although the Tory-dominated city corporation were replaced by an elected council in 1835, policy towards public health reform did not alter substantially, as shown by Rammell's investigation in 1853. [79]

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[78] HRO, BH/37/2/4, June 1833, Accounts of the Medical Board of Health at Hereford.
[79] Mitchell, 'Hereford in the age of reform', pp. 98-114.

6.2.3 Preparations in Ledbury

The response of the authorities in Ledbury was both more integrated with their ongoing activities of poor relief and more radical in approach. John Biddulph, a local landowner and banker who divided his time between London and his country estate, played a major part in these preparations. Biddulph was actively involved in the public life of the locality, playing a leading part in the Canal Company, the Turnpike Trust, the vestry, the Dispensary, and the 1832 Ledbury Board of Health. By 1832, the family also had wider political interests in the county as John's son, Robert, was standing as one of two reform candidates for Hereford City.

In the autumn of 1831, prior to the issue of any directions on cholera from the Central Board of Health, the Ledbury vestry were considering a range of issues relating to poor relief. Biddulph attended a Dispensary meeting on 29 October, after which he noted in his diary that the Dispensary is

> a most excellent institution if properly attended to. This sickly season no less than 1,010 patients have been relieved since 25th March last- and 211 vaccinated- to this circumstance is mainly attributed the absence of small pox in this Town tho' it has been very virulent in the neighbourhood.[80]

The same week Biddulph also attended a parish meeting that resolved that a committee should be appointed to look into several schemes for poor relief. These included the practicalities of providing a 'receiving house for destitute paupers and an infirmary', the most efficient way of providing work for unemployed youth and the possible advantages of supporting emigration. Two

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[80] HRO, G2/IV/J/60, Biddulph diary, 29 Oct. 1831.

weeks later, the committee had agreed that paupers should be put to work on widening the footpaths leading into the town and that the parish should acquire a double cottage in the town for conversion into a sick house for the care of patients 'afflicted with any infectious disorder'.[81] The vestry was quick to take up the recommendations of the Central Board of Health and Biddulph's diary for the 21 November reads:

> Employed all day in organising a Board of Health, by direction of the Government, who apprehend the Cholera. We have now and indeed have had for some months a bad fever which has carried off many – but the year had been particularly unhealthy, augmented in our town by keeping pigs, and a collection of nuisances, almost indescribable, indeed it will hardly be believed that one or two individuals have built next to houses and encouraged inhabitants to keep pigs and make all sorts of dung and filth for their benefit as manure- no wonder these poor people die of fever- the wonder is that we have not all got the plague. [82]

The Central Board of Health had invited reports from Local boards and the Ledbury Board submitted one in November 1831, which is set out in Appendix 10. The report starts with a summary prepared by Congreve Selwyn, the surgeon at the Dispensary, which noted the number and type of fever cases, categorising them as 'of the typhus character'. He continues that the cases primarily occur in close, confined and dirty houses and notes that the measures now being put into place by the board of health should contribute to an improvement in health and a reduction in fever cases. The surgeon's report was sent to the Central Board of

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[81] HRO, B 092/61, Minutes of Ledbury overseers and Board of Health, 1831-1832.
[82] HRO, G2/IV/J/60, Biddulph diary, 21 Nov. 1831.

Health with additional notes prepared by John Biddulph. Biddulph confirmed the Board's commitment to the removal of nuisances, in particular pigsties, but bemoans the fact that the board has no increased powers of enforcement in relation to the removal of hazards. Clearly both Biddulph and Selwyn believed that sanitation and other public health measures would improve the health of the poor and were keen to use the impetus afforded by the creation of the boards of health to extend their existing powers to implement further improvements. These difficulties have been widely recognised as one of the limitations of the efforts of the Central Board of Health as although their recommendations were radical no new powers were made available to enforce decisions. By 1832 the Ledbury reformers had achieved considerable improvements in the town and their activities in 1832 were a continuation of these measures. Their response was primarily social rather then medical, rooted in prevailing attitudes and opinions and drawing on measures and institutions already used.

Between January and July 1832 Biddulph was in London. His diary entry for 11 January reads

> The cholera has appeared in London and the consternation is excessive. Business neglected and the Customs House has refused to grant a Clean Bill of Health so that the shipping now ready to sail with their whole cargoes aboard are forced to remain to the cost of the merchants' owners. How will all this end- the Hospitals refuse to take in Cholera patients and the Govt have placed a ship in the River to receive them. [83]

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[83] *Ibid.* 11 Jan. 1832.

On 11 March he wrote, ' the cholera increases and at the present rate if it continues a year will carry off 50,000 inhabitants.' [84] On 21 March he joined the crowds at Church for the general day of fasting but was still of the belief that 'it is however still confined to the lower classes'. Biddulph doubted the accuracy of reports of the epidemic's progress and noted 'it is confidently affirmed that the cholera cases published, which are about 100 a day in all Gt. Britain, are not 1/10 of the real number'.[85] However just four days later he was informed by a fellow dinner guest, Sir William Halwood, the Chief Medical Officer of the Board of Health, that cholera in London was decreasing. Halwood was of the opinion 'that the English however poor live so much better than the foreigners in general that they are not so much subject to its attacks'. [86] Biddulph was sceptical, putting the decline in the disease down to the cold weather.

On 13 July Biddulph left London for Ledbury, by which time the epidemic had taken a turn for the worse and had reached both Worcester and Gloucester. As soon as he arrived, Biddulph was visited by the Churchwarden who had came to consult about further preparations for the management of cholera and reported that the town was 'most disorderly'. Directions were given for cleaning and whitewashing cottages and poor houses.[87] By the following week, the first case of the disease was felt to be imminent and a boat from Gloucester was intercepted on the canal outside the town as a precaution against any carriers entering the town.[88]

On the 26 July, a building was hired for use as a cholera hospital outside the town on Richard's Hill. Further preventive measures were considered and

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[84] *Ibid.* 11 March 1832.
[85] *Ibid.* 3 April 1832.
[86] *Ibid.* 4 April 1832.
[87] *Ibid.* 13 July 1832.
[88] *Ibid.* 20 July 1832.

Biddulph inspected the hills around the town with a view to improving the town's water supply. By the end of August the anxiety of the townspeople had declined as cholera failed to break out in Herefordshire and began to abate in neighbouring areas. The vigilance of the board of health continued however. In August they considered the risk posed by 'tradesmen and beggars' attending the annual races scheduled for the 7 September and wrote to the race committee suggesting the races be cancelled. The suggestion was not welcomed.

> The Committee and people interested in the races seem very unwilling to give up the races- having had their horses trained, their dinners provided and the whole town in a ferment at the idea of preventing the Races.[89]

Biddulph referred the response to the magistrates who advised 'that after the notice given by Mr Higgins to the Race Committee with our advice to postpone it- we had done our duty and we had better trouble ourselves no further about it'.[90] The races passed off without incident. On the 22 September a charity sermon was preached in the town for the benefit of the 200 orphans of cholera victims at Bilston, but as the threat of the disease declined so too did the activities of the board of health. Nevertheless, the perennial problem of the poor continued, and on 15 November, Biddulph attended 'a very numerous meeting of the neighbouring gentlemen to try to establish a sort of benefit society'.[91]

Summary

Hereford did not escape the ravages of the cholera epidemic in 1832 due to the preventive measures adopted by the local Boards of Health. The most important

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[89] *Ibid.* 20 Aug. 1832.
[90] *Ibid.* 27 Aug.1832
[91] *Ibid.* 15 Nov. 1832

contributory factor was the relative isolation of the county, due to the poor transport infrastructure, particularly the absence of a developed canal network. [92] The threat of disease elicited very different responses in Hereford and Ledbury and it has been argued throughout this chapter that local political factors were an important influence on the policies adopted in the two areas. In Ledbury, a Board of Health was established in the autumn of 1831, as soon as directions were received from the Central Board of Health. A variety of measures were put in place, lead by John Biddulph and the local clergyman and surgeon. Some of these centred on extending the existing functions of the Dispensary while others sought to build on public health and sanitation measures they had been attempting to implement over a period of years. Where they felt it necessary, the Board were prepared to push their existing legal powers to the limit, as shown in their attempts to enforce the removal of nuisances and in their recommendations that the races be cancelled. In both these instances they were unable to achieve their aims due to insufficient powers being delegated from the Central Board.

In contrast, in Hereford no attempt was made to use the cholera regulations to change existing practices. The corporation did not establish a Board of Health until the threat of the disease was imminent and thereafter limited its activities to preparations for a medical emergency. It has been argued that this response was influenced by the political climate in the run up to the 1832 election in Hereford. R. J. Morris has argued that the experience of the cholera epidemic had little effect on public policymaking in the decade after 1832.[93] This appears to have been the case in Hereford where no further improvements were put in train in the period to 1850. In contrast, a further Improvement Act for Ledbury was

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[92] J. Ross, 'Hereford and cholera- why did we escape it', *Journal of the Royal College of Physicians of London,* 24 (1990), pp. 238-241.
[93] Morris, *Cholera,* p. 200.

passed in 1835, which authorised Commissioners to levy a rate and enforce further improvements.

Conclusion

Many features of medical services changed radically between 1770 and 1850. The aim of this study has not been merely to describe the detail of these changes in Herefordshire but to relate them to other aspects of social life, in particular to political relationships and institutions. John Pickstone has stressed the opportunity provided by local research to study 'medical dynamics as social history', to contextualise medical services and to consider how these interrelated with other social structures and pre-occupations.[1] This thesis has examined the factors that shaped the development of local medical services and particular institutional forms in Herefordshire, and has considered examples of occasions where medical issues became central to wider social concerns.

The conceptual model of the mixed economy for medical services has been used to structure the thesis. The categories of private, public, philanthropic and mutual sectors offer a useful way to delineate the variety of relationships and institutional forms that operated to provide medical services or deal with medical issues in the period. One of the main themes explored is the complexity of the interrelationships between these different sectors and the ways in which they operated together. The sectors did not function independently of each other and consideration has been given to how the boundaries between their activities were negotiated.

The historiography of several specialisms within the social history of medicine has been discussed in the preceding chapters. The principal ones are changes within the medical profession, the development of forms of medical philanthropy, the impact of the New Poor Law on medical services, the movement for reform of the care of the insane and the development of the public

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[1] Pickstone, 'Uses of local studies', pp. 202-203.

health infrastructure. One of the benefits of incorporating a number of specialisms within a single study has been the ease of transference of discourses developed in one area into discussion of another. For example, a number of themes from the historiography of charity and medicine are central to this study. In particular the awareness of the complexity of the motivations of donors, the potential for power struggles between patrons and recipients and between lay and medical interests.[2] These approaches have informed the analysis of relationships in other sectors of the mixed economy for medical services, for example, the relationships between Poor Law Medical Officers and the Boards of Guardians.

Throughout this thesis it has been argued that many of the influences that determined local policy towards medical services were closely associated with political institutions and influence. This case study has provided a number of striking examples of the interaction between medical issues with political interests. The most notable of these are the association of the subscription appeal for the General Infirmary with the contested parliamentary election of 1774, the events that led to a Parliamentary enquiry into conditions at the private Hereford Asylum in 1839 and the management of the threat of cholera in 1831-1832.

By 1770, it was clear that an unregulated market for medical services could not successfully address the health needs of many people as a large minority of the population could not afford to purchase these services privately. This market failure was not restricted to medical services but applied equally to education and social insurance. Philanthropic organisations were recognised as able to provide a means of tackling these issues in an era of laissez-faire political economy that restricted state intervention to helping the poorest and most

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[2] J. Barry and C. Jones, (eds), *Medicine and charity before the welfare state* (London, 1991).

vulnerable members of society.[3] In relation to medical services, the period to 1850 saw an expansion in models of provision in every sector rather than dominance by any particular area. These are illustrated in Figure 7.1.

Figure 7.1: New organisations in the mixed economy for medical services in Herefordshire.

	1770-1800	1800-1835	1835-50	Post 1850
Philanthropic	Infirmary Charitable Asylum Jarvis Charity	Dispensaries Other, e.g. Leominster Lying-in charity	Dispensaries Medical Clubs	Specialist and cottage hospitals
Public	*Old Poor Law Licensing and inspection of lunatic asylums	Temporary Board of Health and dispensary (1831-32)	New Poor Law Medical Services and workhouses	Public Asylum, 1851 Medical Registration, 1858 Board of Health
Private	Hereford Improvement Act	Private Asylum Improvement Acts		Herefordshire Medical Association
Mutual	*Friendly societies		Medical clubs	

*Organisations operating prior to 1770.

Prior to 1770, the only formal mechanisms operating in the field of medical services were Poor Law provision paid for by parishes and any services funded via friendly societies. The last decades of the eighteenth century saw the development of a charitable Infirmary and Asylum in Hereford. Although the format of the provincial voluntary subscription infirmary had been developed for some thirty years, it was not adopted in Hereford until the late 1770s when it coincided with a period of sustained modernisation of the city. In this period the mechanism of the public subscription was also used to fund other public buildings, including the cathedral rebuilding and the renewal of several

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[3] Gorsky, *Patterns of philanthropy,* p. 231.

almshouses in the city. Hereford corporation was also actively engaged in reforming the operation of existing charitable trusts. The first Hereford Improvement Act, which granted improvement commissioners restricted powers to take action over 'nuisances' within the city boundaries, was also passed in 1774, the year of the launch of the Infirmary appeal. Although the commissioners' powers were defined by an Act of Parliament, this has been recorded in Figure 7.1 as an expansion of the private sector as the commissioners were a separate body independent of both the central state and Hereford corporation. However, this serves to illustrate the difficulty in establishing clear demarcations between the different sections of the mixed economy in this period.

Charitable giving was an integral part of the wider role of the elite and it developed to use the administrative and financial structures of the day. The joint-stock principle adopted by many new charitable foundations was also used to fund the development of basic infrastructure, notably the funding of improvements in roads through turnpike trusts and attempts to develop canals within the county. It was down to individuals to promote the development of their local area, through pressing for an Act of Parliament authorising the establishment of the project. In Herefordshire, the majority of these schemes were established from the second half of the eighteenth century onwards and many ran into financial difficulty. Attempts to reform some of the ancient charitable endowments were undertaken by the same men who were trying to develop canals or roads, remodel Hereford city or set up local schools or dispensaries. In small communities it was frequently one or two people who drove developments in many or all of these fields.

The interrelationships between the various sectors of the mixed economy are also well illustrated by the early history of Hereford Asylum. As discussed in Chapter 5, after only a few years, the charitable asylum was closed and leased to two doctors to run as a private madhouse. However, the new institution remained

integrated with both the philanthropic Infirmary and Poor Law authorities. It was provided with a building on a peppercorn rent by the Infirmary and the parishes funded the care for the majority of its patients. There was additional public involvement via the licensing and inspection regulations.

The introduction of the New Poor Law had a marked effect on the provision of medical services both through the work of the newly appointed Medical Officers and in the care of pauper lunatics. As discussed in Chapter 2, the expansion in Poor Law appointments was an important factor in expanding the number of medical practitioners in the county, particularly in rural areas. The development of local policy by the guardians was influenced by charitable provision available within the county. For example, the rules of the General Infirmary were altered to allow Unions to subscribe and all did so after 1838, obtaining the right to recommend pauper patients to the charitable institution.[4] As shown in Chapter 3, Dore Union took account of the activities of the Jarvis Charity in drawing up its medical provision for individual parishes. Several Unions actively sought to promote the mutual model of medical clubs, both to fund services for paupers and to address the problems of the non-pauper poor.

In several areas where state intervention increased in the period to 1850, the early legislation was enabling rather than compulsory. Legislation relating to both lunacy provision and public health first provided optional powers that local people could choose whether or not to take up and act upon. The range of options for local adoption increased but a particular model was not prescribed. It has been argued throughout this study that the precise pattern of provision and the balance between public, private, philanthropic and mutual services that emerged in a locale depended on a complex web of factors, not always dominated by medical issues.

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[4] HRO, S60, Hereford General Infirmary, *Annual Report, 1838.*

The impact of both institutions and individuals has to be factored into a discussion of agency and influence over medical services. Membership of the social and political elite was restricted and many individuals who chose to become involved in public affairs held a multiplicity of roles in various institutions and organisations. This served to further blur the boundaries between the various sectors in the mixed economy. Several examples will suffice to demonstrate the importance of this point.

John Cam, mayor of Hereford in 1774, was a member of an established medical dynasty in the City and one of a handful of university educated physicians in the county. The opportunity of his inaugural feast was used to launch the third subscription appeal for an Infirmary in Hereford. He became one of the first honorary physicians at that institution and together with his colleagues on Hereford corporation dominated its management. Cam was also a justice of the peace. Jonathan Gough, mayor of the reformed Hereford council in 1839 was a subscriber to the General Infirmary, a Poor Law guardian for Hereford Union and one of the magistrates appointed to the visiting committee of Hereford Asylum.

John Biddulph was a London based banker and businessman but also active in philanthropic and public affairs in Ledbury, where he had a country estate. Several members of his family also had political ambitions in the county. Biddulph was a justice of the peace, active in the local vestry, supported the Ledbury Dispensary charity and played a leading role in the Ledbury Board of Health during the cholera epidemic of 1831-1832. He was also an active consumer of medical services, drawing on both local medical expertise and London based practitioners. He was a governor of the Hereford Infirmary and his banking firm acted as the charity's bankers. He took a leading role in promoting the Gloucester to Hereford canal, the Ledbury Improvement Act and various schemes to improve the town's water supply.

Thomas Harley was a member of an aristocratic family and served as MP for the county for almost twenty years. The association of the subscription appeal for the Infirmary with the contested election of 1774 is discussed below. Harley was one of the initial subscribers to the Infirmary charity and his elder brother donated the site for the new building. He was appointed a trustee for both the Infirmary's investments and for the Jarvis charity and was involved in the development of proposals for the distribution of the Jarvis charity's funds in 1802. As these examples make clear, the boundaries between public appointments, political office and philanthropic activity were not simple and these complexities are important in understanding the opportunities available to influence medical services.

Evidence presented in Chapter 2 showed that even the private market for medical services was mediated through a variety of social relationships. For example, a wealthy householder exercised influence by paying for medical services for members of his extended household. This included family members and servants and frequently extended to other individuals on a charitable basis. Medical practitioners also exercised discretion in the levying and collection of fees from individual patients.

As a member of a parish vestry under the Old Poor Law or a New Poor Law guardian, an individual assessed entitlement and approved referral for medical treatment. The detailed examination of the operation of the medical services of the New Poor Law showed that Relieving Officers, the Poor Law Commissioners and patients, in addition to Medical Officers, all had some influence over the provision of medical relief. A variety of mechanisms developed which reflected this. One of these was the arrangement for recording and investigating complaints against Medical Officers. The guardians formally recorded all complaints and allegations before investigating them and were able to resolve many of the complaints themselves. However, mechanisms also

developed for escalation, including seeking a second opinion from another medical practitioner and referral to the Poor Law Commissioners.

As a subscriber to a charity, an individual had the right to recommend an individual as a patient to that institution. If one chose to become a governor, one had more extensive rights of involvement in the management processes of the charity. Despite the theoretically democratic nature of these institutions, the experience in Hereford was that the Infirmary charity came to be dominated by members of the Hereford corporation.

An appreciation of the informal, personal links between institutions is essential to an understanding of the ways in which they operated together and how control was exercised. It has been the contention of this study that the local patterns of provision that emerged were based on pragmatic solutions that suited the dominant political elite. The introduction of the New Poor Law and municipal reform in the 1830s disrupted this balance and resulted in attempts to reorganise medical services, leading to the establishment of Hereford Dispensary and proposals for a public lunatic asylum for the county.

This case study has provided three striking examples of the interaction between medical issues and political interests. The first of these examples is the association of the subscription appeal for the General Infirmary with the political ambitions of rival candidates in a parliamentary election. Efforts to promote an Infirmary began in the 1760s but had failed to generate momentum despite support from the clergy, Bishop and some leading landowners. The opportunity to become associated with the appeal provided a welcome opportunity for Thomas Harley to launch his candidature. Once the appeal was launched, the symbolic importance of the proposed Infirmary was such that all the candidates publicly endorsed the subscription in order to safeguard their political interests.

The second example of a conjunction between medical services and political conflict is the dispute over lunacy reform in the late 1830s. As discussed

in Chapter 5, the local struggle for control over policy development eventually led to a Parliamentary Select Committee Enquiry into conditions at the private Hereford Asylum. The struggle arose from the separation of responsibility for policy development, which lay with the county magistrates, from financial responsibility for pauper lunatics, which rested with the Poor Law Unions. Earlier conflict between the newly reformed Hereford council and the justices for the county contributed to a situation in which local mechanisms for negotiation broke down. The third example considered in detail is the management of the threat of the cholera epidemic of 1831-1832. Comparison of the measures put in place in Hereford and Ledbury show how local political considerations framed the response of the responsible authorities to the threat of disease.

These three examples clearly demonstrate both the influence of political interests in the development of local medical policy and the importance that medical issues had within local society. Changes to the mixed economy for medical services were a result of both national initiatives and local socio-political factors. The funding, development and management of new organisations providing medical services has been shown to be inextricably linked with the wider political interests of local elites. They pursued these interests through a variety of avenues, including political institutions, voluntary and mutual associations and public authorities.

APPENDIX 1

DEVELOPMENTS IN THE COMMUNICATIONS INFRASTRUCTURE IN HEREFORDSHIRE TO 1860

Roads

1721	Ledbury Turnpike Act
1730	An Act for repairing the roads leading into the city of Hereford, 1730, 3 Geo. II, c.18
1735	Hereford Turnpike Bill including Leominster
1749	Ross Road Act
1751	An Act for repairing several roads leading from the town of Bromyard, 1751, 25 Geo. II, c.56
1756	Kington Turnpike Trust
1844	County Road Boards set up.

River Wye

1662	Rivers Wye and Lugg Navigation Act
1809	Rivers Wye and Lugg Navigation Act Development of Horse Towpath

Canals

Gloucester to Hereford

1791	Hereford- Ledbury- Gloucester canal proposed
1798	Gloucester to Ledbury completed.
1839	Act to complete the canal
1845	Completion of canal to Hereford

Kington- Leominster - Stourport

1789	Survey for Kington- Stourport canal.
1791	Act for a canal from Kington, via Leominster to Stourport
1796	Section from Leominster to the Mambles coal pits opened.

Monmouth- Brecon Canal and linked infrastructure

1790	Canal opened to Brecon via Abergavenny
1816	Railway to Hay from Brecon completed
1820	Tramway from Hay to Kington opened.
1825	Tramway from Hereford to Grosmont opened
1828	Tramway extended from Grosmont to Abergavenny canal

Railways

1838	Birmingham to London opened, making London accessible from Kington in a day via Worcester.
1853	Shrewsbury- Leominster- Hereford railway line opened.- possible to reach the capital in 7 hours.
1853	Hereford to Abergavenny and Newport Railway opened.
1855	Gloucester- Ross- Hereford Line opened
1856	Leominster to Kington line opened.
1857	Hereford to Hay and Brecon via Leominster and Kington
1861	Worcester to Hereford railway opened with stations at Ledbury & Malvern.
1862	Kington to Eardisley railway approved.

APPENDIX 2

Families with major political interests in Herefordshire c.1770-1850

Family, title and estate	Seat in House of Lords	M.P. for Herefordshire or other local constituency	County appointments
Bateman of Shobdon Court			
John 2nd Viscount Bateman (172? -1802)		Leominster 1768-1784	Lord Lieutenant and Custos Rotulorum 1747-1802
Biddulphs of Ledbury			
Robert Biddulph (1761-1814)		County Hereford 1796-1802	
Robert Biddulph nephew of above (1801-1864)		Hereford 1832-1837	
Coningsby of Hampton Court			
George Conningsby, 6th Earl of Essex (1757-1839)	1799-1839		Lord Lieutenant and Custos Rotulorum 1802-1839
Cotterell of Garnons			
Sir John Geers Cotterrell, Knight(1727-			
John Geers Cotterrell (Baronet 1805), (1761-1845)		County Hereford 1802-1803 and 1806-1831	Major of Herefordshire Militia, 1796-1803
Cornewalls of Moccas			
Velters Cornewall (c1695- 1768)		County Hereford, 1722-1768	
Sir George Cornewall Baronet (son-in-law of above)(1749- 1819)		County Hereford, 1774-1796 and 1802-1807)	Hereford Militia, captain 1794, Colonel 1805 & Major Commandant 1806)
Foleys of Stoke Edith			
Thomas, created Ist Lord Foley, 1776 (1716-1777)	1776-1777	County Hereford 1768-76	
Thomas, 2nd Lord Foley (1742-1793)	1777-1793	County Hereford 1767-74	
Thomas Foley(nephew of 2nd Lord Foley) (1778-1822)		County Hereford 1807-1818	
Edward Thomas Foley(1791-1846)		County Hereford 1832-1841	
Harleys, Earls of Oxford and Mortimer			
Robert Harley, brother of 3rd Earl of Oxford (1707-1774)		Leominster 1734-41 & 1742-7; Driotwich 1754-1774	Recorder of Leominster, 1732-74
Edward, Lord Harley, 4th Earl of Oxford & Mortimer (1726-1790)	1755-1790	County Hereford 1747-1755 when became 4th Earl	Chief Steward of Hereford, 1755-1790
Thomas Harley, younger brother of 4th Earl (1730-1802)		County Hereford 1776-1802	
Edward, 5th Earl of Oxford (nephew of 4th Earl)			
Alfred, 6th Earl, brother of 5th Earl.			
Payne-Knight of Dowton			
Richard Payne Knight (1750-1824)		Leominster 1780-1784, Ludlow 1784-1806	
Price of Foxley			Robert Price (1786-1857)
Uvedale Price , Baronet (??- 1829)			
Robert Price (1786-1857)		County Hereford 1818-1841, Hereford 1845- 1857	Chief Steward 1845-57
Scudamore of Holme Lacy			
Charles Fitzroy Scudamore (1707-1782)		Hereford 1754-1768	
Charles Howard, Earl of Surrey (1745-1815) m	1786-1815	Hereford 1784-1786	Chief Steward Hereford 1790-1815
Francis daughter of above in 1771, became 11th Duke of Norfolk in 1786			
Daniel Higford Davall Burr(1811-1885), succeeded to Home Lacey of death of francis in 1820		Hereford 1837-1841	
Scudamore of Kentchurch			
John Scudamore (1727-1796)		Hereford 1764-1796	Colonel Herefordshire Militia
John Scudamore (1757-1805)		Hereford 1796-1805	
Richard Philip Scudamore (1752-1831)		Hereford 1805-1818 and 1819-26	
Somers of Eastnor			
John Somers-Cocks (1788-1852), became Viscount Eastnor 1821 and succeeded as 2nd Lord Somers 1841	1841- 1852	Hereford 1818-1832	Lord Lieutenant and Custos Rotulorum 1845-1852, Chief Steward 1816-1852, Col of Militia
Francis Richard Haggitt, son - in- law of 3rd Earl Somers		Hereford , 1847-52	
Symonds of Pengethley			
Thomas Powell Symonds (1762-1819)		Hereford 1800-1819	
Thynne, Marquis of Bath			
Hon Thomas Thynne, Viscount Weymouth (1765-1837), succeeded as 2nd Marquis of Bath 1796	1796-1837	Weobley, 1786-90	
Lord George Thynne, brother of above,(1770-1838), succeeded as 2nd Lord Carteret	1826-1838	Weobley, 1790-1812	
Lord John Thynne (1772-1849), succeeded as 3rd Lord Carteret	1838-1849	Weobley 1796	

Sources:

L. B. Namier and J. Brooke, *The history of Parliament: the House of Commons, 1754-1790* (London, 1964)
R. G. Thorne, *The history of Parliament: the House of Commons, 1790-1820* (London, 1986)
W. R. Williams, *Herefordshire members, 1213-1896* (Brecon, 1896)

APPENDIX 3

Register of Medical Practitioners in Herefordshire in 1783 and c.1851.

Name (Surname first)	Place	On 1783 register	On 1851 register	Where recorded (see source information)	Qualifications
Barrow William	Hereford	1			Surgeon/apothecary
Cam John	Hereford	1		1783, 1793, 1811,	MB (Cambridge)
Cam Thomas	Hereford	1		1783, 1793, 1811	Surgeon
Cam William	Hereford	1		1783	Surgeon
Campbell Francis	Hereford	1		1783, 1793	MD (Glasgow)
Cheese	Hereford	1		1783	Surgeon/apothecary
Gwillim John	Hereford	1		1783	Surgeon/apothecary
Hardwicke Richard	Hereford	1		1783, 1793	Surgeon
Hathway Robert	Hereford	1		1783	Surgeon/apothecary
Holmes William	Hereford	1		1783	Surgeon/apothecary
Laycock Edward	Hereford	1		1783, 1793	Surgeon/apothecary
Mason Edmund	Hereford	1		1783, 1793	Surgeon/apothecary
Matthews John	Hereford (Belmont	1		1783, W&W	MD (Oxon)
Palmer John	Hereford	1		1783, 1793, 1811	Surgeon/apothecary
Price Weaver	Hereford	1		1783, 1793	Surgeon/apothecary
Blount Thomas	Hereford			1793	Physician
Dunne Thomas	Hereford			1830	Physician
Hughes Samuel	Hereford			1830, 1835	Physician
Symonds William	Hereford			1793, 1830, 1835	Physician
Walrond Mainswete	Hereford			1830, 1835	Physician
Beavan Henry Augustus	Hereford			1830, 1835, 1841	
Cheese	Hereford			1830	
Cotes Thomas	Hereford			1793	Surgeon
Davies Isaac	Hereford			1835	
Eyre James	Hereford			1830	
Garbett Henry	Hereford			1830, 1835	
James Philip	Hereford			1830, 1835, 1841	
Jones John Julius	Hereford			1830, 1835	
Jones Walter	Hereford			1830	
Kemsey William	Hereford			1830	
Morgan William Hoskins	Hereford			1835, 1841	
Morris John	Hereford			1841	Surgeon
Pateshall John S L	Hereford			1811, 1830, 1835	
Price P P	Hereford			1793	Apothecary
Rootes MS	Hereford			1841	
Taylor Thomas	Hereford			1835	? and Dentist
Wasw Benjamin	Hereford			1841	
Williams George	Hereford			1830	
Bleek-Lye John	Hereford		1	1830, 1835, 1841, 1851	MD (Edinburgh)
Gilliland William	Hereford		1	1830, 1841, 1851	MD, LRCS (Edinburgh) 1830
Lambe Lacon	Hereford			1835, 1851(retired)	Physician
Morris Edward John	Hereford		1	1841, 1851	MD, MRCS 1818
Archibald Robert	Hereford		1	1841, 1851	MRCS 1827, LSA 1835
Aveline J	Hereford			1851(retired)	
Barra R T	Hereford			1851(retired)	
Beavan Edward	Hereford		1	MD (St Andrews) 1818	
Braithwaite Francis	Hereford		1	1830, 1835, 1841, 1851	MRCs 1827, LSA 1826, FRIS 1844
Bull Henry Graves	Hereford		1	1841, 1851	MD LSA (Edinburgh) 1841,
Cam Samuel	Hereford		1	1841, 1851	MRCS 1837, LSA 1838
Egston Basil	Hereford		1	1851	MRCS 1849
Gilliland John	Hereford		1	1835, 1841, 1851	LRCS (Edinburgh) 1820, LSA 1824
Griffiths John	Hereford		1	1830, 1835, 1841, 1851	MRCS, LSA 1821
Gwillim W	Hereford		1	1830, 1835, 1851	MD Erlingen, LSA 1819, MRCS 1821
Kidley Robert Allen	Hereford		1	1841, 1851	MC (Glasgow) 1845
Lingen Charles	Hereford		1	1841, 1851	MD Heidelberg 1836, MRIS 1835, FRCS 1844
Price James	Hereford		1	1830, 1835, 1841, 1851	MRCS 1806
Terry George Robert	Hereford		1	1835, 1841, 1851	MRCS 1830
Tully Philip	Hereford			1830, 1835, 1841, 1851(ret	Apothecary pre 1815
Turner James Philip	Hereford		1	1851	MRCS 1813
Vevers Henry	Hereford		1	1851	MRCS 1844, LSA 1847
Waudby Samuel	Hereford		1	1841, 1851	LSA 1841, MRCS 1842
Sub total Hereford		**15**	**19**		
Stead Thomas	Bromyard	1		1783, W&W	Surgeon, apothecary
Maxwell John	Bromyard	1		1783, W&W	Surgeon/ Apothecary

APPENDIX 3

Register of Medical Practitioners in Herefordshire in 1783 and c.1851.

Name (Surname first)	Place	On 1783 register	On 1851 register	Where recorded (see source information)	Qualifications
Severn Joseph		1		1783, W&W	Surgeon/ Apothecary
	Bromyard				
Walker Delabere	Bromyard			pre 1830?	app to Joseph Severn above
Dangerfield George	Bromyard			1830, 1835	
Pitt Thomas	Bromyard			1830, 1835, 1841, 1848	Surgeon- no details in 1848, not in 1851
Brown Shelton	Bromyard			1830, 1835	Surgeon, app to John Maxwell above
Seward Edmund	Bromyard			1835	
Howey Edward	Bromyard		1	1841, 1848, 1851	Surgeon, MRCs 1831, LSA 1829,
John Shelton Brown	Bromyard		1	1841, 1848, 1851	MRCS 1824, LSA 1824
Grape W	Bromyard		1	1848, 1851	retired
Walcott John A	Bromyard		1	1848, 1851	MD, MRCS 1845
Owen John	Bromyard		1	1851	MRCS Eng 1848, LSA 1847,
Subtotal Bromyard		**3**	**5**		
Thomas Benjamin	Kington	1		1783, W&W	MD Edin
Passey	Kington	1		1783	
Thomas John	Kington	1		1783, W&W	Surgeon, Apprentice to Henry Price 1746
James Gwynne	Kington	1		1783, W&W	Surgeon
Guest Benjamin	Kington	1		1783, W&W	Apothecary,
Michell John	Kington			1830, 1835	Surgeon
Walker Edward	Kington		1	1830, 1836. 1848, 1851	Surgeon- No details in Med Dir 1848
Pritchard Thomas	Kington			1835	Surgeon
Blakeley, William	Kington		1	1841, 1848, 1851	Surgeon, LSA 1836
	Kington			1841, 1848, 1851	Surgeon, MD Glasgow 1838, MRCS 1836,
Marshall George Henry			1		LSA 1836
Thompson William	Kington		1	1841, 1848, 1851	Surgeon, MRCS 1830, LSA 1829
James Edward	Kington		1	1848, 1851	MD Edin 1835, MRIS 1830, M&LSA 1828
Sub total Kington		**5**	**5**		
James Gervase	Ledbury	1		1783, W&W, 1793	Surgeon/ apothecary
Hill Thomas	Ledbury	1		1783, W&W, 1793	Surgeon/ apothecary
Woodward Geoge	Ledbury			1793	Apothecary
					Apothecary, Surgeon, Man-midwifeSurgeon/
					apothecary, apprenticed to William Barrow of
Woodyatt George	Ledbury			1793, W&W	Hfd in 1780 of 5 yrs for £100.(1 of 5)
Bayliss, Robert	Ledbury			1830, 1835	Surgeon
Brydges, William Henry	Ledbury			1830	Surgeon
Jenkins John	Ledbury			1830	Surgeon
Nott Francis William	Ledbury			1830	Surgeon & Chymist & Druggist
Selwyn Congreve	Ledbury			1830, 1835	Surgeon
Tanner, John	Ledbury		1	1841,1848, 1851	MD, MRCS 1828, LSA 1827
Wood, James	Ledbury			1835	
Goate, C.E.V	Ledbury		1	1841,1848, 1851	MD Edin 1846, MRCS 1846, LSA 1846
Griffin, William	Ledbury		1	1841,1848, 1851	MRCS 1838
Wood, Miles Astman	Ledbury		1	1841,1848, 1851	MRCS 1830, LSA 1830
Kingdon, Francis Francis	Ledbury		1	1841,1848, 1851	surgeon
Colston, John	Ledbury			1841	surgeon
Sub total Ledbury		**2**	**5**		
Geary Nicholas	Leominster	1		1783, W&W,1793	Surgeon Apothecary
Wyke Zachary	Leominster	1		1783, W&W,1793	Surgeon Apothecary
Wyke Abraham	Leominster	1		1783, W&W,1793	Surgeon Apothecary
Bennett Weaver	Leominster	1		1783, W&W,1793	Surgeon Apothecary, apothecary in W&W
Proctor Richard, jun,	Leominster			1793	
Proctor Thomas	Leominster			1793	
Proctor, Richard, MD	Leominster			1793, W&W	
Bradley Joseph (dentist)	Leominster			1793, W&W	
Farrell John	Leominster			1830	Surgeon
Lewis Hugh Aythen	Leominster			1830, 1835	Surgeon
				1830, 1835, 1841, 1848,	
Rudge Henry	Leominster		1	1851	Surgeon, MD Erlingen, in practive prior to 1815
Swift James	Leominster		1	1830, 1835, 1848, 1851	Surgeon
				1830, 1835, 1841, 1848,	
Watling Thomas (& Wyatt fror	Leominster		1	1851	Surgeon, MRCS 1813
Wyatt-Watling Henry	Leominster		1	1848, 1851	Surgeon, MRCS 1843, LSA 1844
Burlton Thomas	Leominster		1	1841, 1848,1851	Surgeon, MRCS 1835, LSA 1834
			2		

APPENDIX 3

Register of Medical Practitioners in Herefordshire in 1783 and c.1851.

Name (Surname first)	Place	On 1783 register	On 1851 register	Where recorded (see source information)	Qualifications
Colt, James Archer	Leominster			1841	MD
Marshall John	Leominster		1	1841, 1848, 1851	Surgeon, MRCS 1841
Lewes HA	Leominster		1	1848, 1851	No details
Morris RP			1	1848, 1851	
Sub total Leominster		**4**	**8**		
Pope William	Ross-on-Wye	1		1783, W&W	Surgeon/ Apothecary
Bond, John	Ross-on-Wye	1		1783, W&W	Surgeon/ Apothecary
Newman Robert	Ross-on-Wye	1		1783, W&W	Surgeon/ Apothecary
Wood William	Ross-on-Wye	1		1783, W&W	Surgeon/ Apothecary Apprentice to Joseph Wood, Ross, 7 yrs for £24 in 1724, son of Ellen Wood, widow of Bewdley, Worcs
Dobles Nicholas	Ross-on-Wye	1		1783, W&W	Surgeon/ Apothecary
Paytherus T	Ross-on-Wye	1		1783, W&W	Surgeon/ Apothecary, Apprenticed to Richard Cheston in Glos , 1769
Hill, Mr	Ross-on-Wye	1		1783, W&W	Surgeon/ Apothecary
Evans Richard- Physician	Ross-on-Wye			1830, 1835	Physician (app to Paytherus above)
Evans Thomas- Physician	Ross-on-Wye			1830, 1835	Physician
Aveline George	Ross-on-Wye			1830, 1835	Surgeon
Brooks, Samuel Philpot	Ross-on-Wye			1830	Surgeon
Rootes George	Ross-on-Wye		1	1830, 1835, 1841, 1848, 1851	Surgeon, MRCS 1812
Wilmott Edward	Ross-on-Wye			1830, 1835	Surgeon
Thompson Charles	Ross-on-Wye		1	1835, 1851	MRCS, LSA 1828
Ward Henry	Ross-on-Wye			1835	Surgeon
Barrett Joseph Gilman	Ross-on-Wye		1	1841, 1848, 1851	Physician, MD St Andrews, MRCS 1842, LSA 1842
Cockburn William Archibald	Ross-on-Wye		1	1841, 1848, 1851	Physician, FRCS Edin
Jones Edmund	Ross-on-Wye		1	1841, 1848, 1851	Physician, MD St Andrews 1846
Rootes William Symonds	Ross-on-Wye		1	1841, 1848, 1851	Physician, MD Edin 1839, MRCS 1845, LSA 1845
Strong George	Ross-on-Wye		1	1841, 1848, 1851	Physician, Surgeon, MD Edin 1835, MRCS Edin 1835
Wilmott Abraham Taylor	Ross-on-Wye		1	1841, 1848, 1851	Surgeon, LSA 1841
Ishell, Edwin James	Ross-on-Wye		1	1841, 1848, 1851	Surgeon, MRCS 1841
Thompson John	Ross-on-Wye		1	1841, 1848, 1851	Surgeon, MRCS 1828, LSA 1828
Subtotal Ross-on-Wye		**7**	**10**		
Rural Areas					
Wyke Isaac	Eyton	1		1783, W&W	Surgeon, apothecary
Driver James	Lyonshall	1		1783, W&W	Surgeon, apothecary
Sayre Robert	Madley	1		1783, W&W	M B Oxon
Whitney John	Weobley	1		1783, W&W	Surgeon, apothecary, app 1772 to William Jones
Hughes Snead	Weobley	1		1783, W&W	Surgeon, apothecary, apprenticed 1761
Markham Timothy	Weare	1		1783	Apothecary
George John	Pembridge			1841	Surgeon
Morris Robert	Kingsland			1841	Surgeon
Brunton James	Bacton (Longtown)		1	1848, 1851	MRCS 1838, LSA 1840
Giles Peter Broom	Byford		1	1848, 1851	MRCS 1840, LSA 1841
Barnard, Henry Clapton	Canon- Pyon		1	1848, 1851	MRCS 1834, LSA 1833
Blakely W	Eardisley		1	1851	LSA 1836
Woodcock George,	Eardisley		1	1848, 1851	MRCS 1839, LSA 1840
Davis John Arthur -1851)	Eardisley		1	1851	MRCS Eng & LSA 1840
Denham, William Hempson	Fownhope		1	1848, 1851	MRCS 1829, LSA 1828
Lane James	Grosmont		1	1848, 1851	MRCS 1813
Pope Richard	Llangarron		1	1848	in practice prior to 1815
Russell Samuel King	Leintwardine		1	1848, 1851	MRCS 1837, LSA 1838
William James	Leintwardine		1	1848, 1851	MRCS 1843, LSA 1844
Gingell Daniel	Leintwardine		1	1851	MRCS 1833, LSA 1834
Williams Evan	Lugwardine		1	1851	LSA 1831
Jenkins Henry J	Madley		1	1848, 1851	MRCS 1829, LSA 1828
Morgan William Hoskyns	Mordiford		1	1848, 1851	MRCS 1827
Langston William	Pembridge		1	1848, 1851	MRCS 1842, LSA 1842
George John	Pembridge		1	1848, 1851	MRCS 1840, LSA 1841
Gwillim George	Tarrington		1	1848, 1851	MRCS 1843, LSA 1844
Lomax Charles	Weobley		1	1848, 1851	in practice prior to 1815
Palmer John Sherborne,	Weobley		1	1848, 1851	MRCS 1830
Powell Z	Weobley		1	1848	no detials, not in 1851
Bridges W H	Weston - Beggard		1	1848, 1851	no details
Millard Samuel	Whitchurch		1	1848, 1851	MRCS 1826, LSA 1825

APPENDIX 3

Register of Medical Practitioners in Herefordshire in 1783 and c.1851.

Name (Surname first)	Place	On 1783 register	On 1851 register	Where recorded (see source information)	Qualifications
Mailes William	Woolhope		1	1848, 1851	no details
Subtotal Rural areas		**6**	**24**		
Total on Registers		**42**	**76**		

Source Information.

W&W	Wallace & Wallace
1783	Medical Register 1783
1793	Universal British Directory 1793
1811	Holden's Annual and County Directory 1811
1830	Pigot's 1830
1835	Pigot's 1835
1841	Slaters 1841
1851	Medical Register 1851

SUMMARY OF ENDOWED CHARITIES IN HEREFORDSHIRE c1865

(Endowments over £1,000 or annual income over £100)

Parish	Charity	Date of Endowment	Endowment		Income			Application of Income						
			Realty (houses and lands) £	Personalty (stocks and securities) £	Realty £	Personalty £	Total Income £	Support of Almshouses	Education	Distribution in money or in kind	Medical	Clergy, sermons etc	Apprentice-ships & Other	Check Total
City of Hereford **	St. Ethelbert's Hospital	1230	215	3,083	57	109	166	166						166
**	Dean Langford	1607	Land		105		105		105					105
	Tomson		Farm & land	308	130	12	142			106			36	142
	Phillpotts	1615	House	5,034	8	177	185		185					185
	Cope	1821	0	1,000	0	40	40			40				40
	Lazarus Hospital		Land	100	8	5	13	13						13
	St Giles Hospital	1290	Land & Houses	1,033	110	31	141	141						141
*	Trinity Hospital	1607	Houses	3,319	150	100	250	250						250
*	William's Hospital	1601	Land	3,619	210	109	319	319						319
*	Price's Hospital	1604	Land & tithes	2,062	403	62	465	465						465
*	Duke of Chandos	1721		500		20	20	10		10				20
	General Infirmary	1775		35,412	0	1,078	1,078				1,078			1,078
*	William Harper	1640	2 Houses	421	27	13	40						40	40
*	Willam Brydges	1763		1,452	0	44	44			8		36		44
*	Lord Scudamore	1698	House	5,197	6	158	164		164					164
	Blue Coat School	1710		4,850	2	139	141		141					141
	Sir Thomas Coningsby	1617			200		200	200						200
Sub total Hereford			215	67,210	1,418	2,097	3,513	1,564	595	164	1,078	36	76	3,513
Brilley	John Morris	1632				50	50		50					50
Clehonger	Haggit	1860		1,000		30	30		30					30
Clifford	John Smith	1722	Farm land- £384	4,928	305	148	453	123	330					453
Kingstone	Mary Morgan	1778		913		28	28			28				28
St Weonards	Mary Morgan	1778		913		28	28			28				28
Kington	Lady Hawkins	1619	Farm & grassland		304		304		304					304
Ledbury	St. Catherine's Hospital	1232	House and lands	88	1,717	3	1,720	1,720						1,720
	Elizabeth Hall & others	1708	Houses	633	67	19	86		86					86
Leominster	Marlowe		Houses	1,600	78	48	126		3			123		126
	Hester Clerk			1,000	30		30	30						30
Letton	Jarvis	1793					0	51	180	164	87		24	486
Bredwardine	Jarvis							118	338	405	168		24	1,053
Staunton on Wye	Jarvis		Houses & £57	76,015				80	354	310	141		6	891
Total Jarvis Charity					150	2,280	2,430	249	872	879	376	0	54	2,430
Lucton	Free School	1711	Land & tithes	24,010	1,184	615	1,799		1,253			200	346	1,799
Ludford	Charlton's Hospital		Farm		112		112	112						112
Lyonshall	Beavan			1,052		32	32			32				32
Ross on Wye	Scott's Bluecoat school	1786		5,750		207	207		207					207
	Webbs Hospital	1612	193	564	220	21	241	241						241
	Baker's Charity	1835		19,201		576	576			576				576
Total for Herefordshire			**823**	**272,087**	**6,563**	**6,162**	**11,766**	**4,039**	**3,730**	**1,707**	**1,454**	**359**	**476**	**11,766**
						% spend in each category		34%	32%	15%	12%	3%	4%	

* Managed by Hereford Corporation
** Managed by the Dean & Chapter

Source
E. Clark, *The Reports of the commissioners in England and Wales relating to the County of Hereford , 1819-1837* (London, 1837)

APPENDIX 5

HEREFORD INFIRMARY: LEGACIES AND BENEFACTIONS OF £20 AND OVER, 1775-1850.

Surname	First name & Title	Recorded place of residence	Date	Total £	Legacy £	Biographical notes
Talbot	Rev Dr Thomas	Ullingswick	pre Feb 1775	500.0		Vicar of Ullingswick, Herefordshire from 1739.Original promoter of the Infirmary in three printed addresses.
Cornewall	Sir George bart.	Moccas	pre Feb 1775	200.0		Local landowner. MP County Hereford 1774-1796 & 1802-1807.One of the initial trustees.
Foley (1716 - 1777)	Lord Thomas	Stoke Edith	pre Feb 1775	200.0		Local landowner. Parliamentary interests in Droitwich and Hereford. MP County Hereford 1768-1776 when created a peer. Dec'd by 1785.
Guys	Hospital Governors	None	pre Feb 1775	200.0		Owned extensive estates in Herefordshire.
Bach	Rev Mr	Leominster	pre Feb 1775	150.0		Gave another £50 after 1785.
Biddulph	Michael	Ledbury	pre Feb 1775	150.0		Local landowner near Ledbury. Partner in the London bank that held the Infirmary bank account. Active in promoting communication and town improvements in the Ledbury area.
Bateman (172?- 1802)	Lord Viscount	Shobdon	pre Feb 1775	100.0		2nd Viscount Bateman of Ireland, MP Leominster 1768- 1784. Funded the printing of Dr Talbot's addresses calling for an infirmary.
Bath	Thomas, Marquis of	Weobley/ Ross	pre Feb 1775	100.0		Thomas, Viscount Weymouth, created 1st Marquis of Bath in 1789. Owned land in the county. Controlled pocket constituency of Weobley.
Bourne	Mrs	Witney Court	pre Feb 1775	100.0		Local gentry.
Corporation		Hereford	pre Feb 1775	100.0		City Council.
Egerton	Rev John	None	pre Feb 1775	100.0		Bishop of Durham from 1771, Rector at Ross-on-Wye from 1745-1771. Promoted the picturesque river trip down the Wye from Ross to Chepstow.
Freeman	John	Letton	Feb 1775	100.0		Ist Chairman of Governors. Major contributor to lunatic asylum appeal in 1794.
Freeman(jnr)	John	Letton	Feb 1775	100.0		Local gentry.
Harley (1730- 1804)	Thomas	Brampton Bryan	pre Feb 1775	100.0		Brother of the Earl of Oxford who donated the land for the new infirmary. Proposed the subscription at the Mayor's feast in 1774. Parliamentary candidate 1774, MP County Hereford 1776-1802. London merchant, Mayor of London and president of St. Bartholomew's Hospital 1758-1804.
Payne Knight (1750-1824)	Richard	Downton Castle	Feb 1775	100.0		Well known classical scholar, poet, critic and virtuoso, built Downton Castle and laid out grounds in picturesque style. MP Leominster 1780-84 and Ludlow (Shropshire), 1784-1806.
Price (1747- 182?0	Uvedale	Yazor- Foxley	Feb 1775	100.0		Local landowner, well known as the author of *Essays on the Picturesque.*
Scudamore (1727- 1796)	John	Kentchurch	Feb 1775	100.0		Local landowner, MP Hereford 1768-1796.
Symons (d 1796)	Sir Richard bart.	None	Feb 1775	100.0		Local landowner, made a baronet 1774. MP Hereford City 1768-1784.
Biddulph	Francis	London	pre Feb 1775	50.0		Member of the Biddulph banking family from Ledbury.
Biddulph	Rev Mr Benjamin	More Court, Hereford	pre Feb 1775	50.0		Member of the Biddulph banking family from Ledbury. Also supported Worcester and Stafordshire Infirmaries. Dec'd by 1785
Cocks	Mrs	Eastnor, Castleditch	Feb 1775	50.0		Member of the Cocks banking family from Eastnor Castle, Ledbury. Mother of J.S. Cocks, MP Hereford City 1818-1832.
Marlow	Mrs	Leominster	Feb 1775	50.0		
Whitmore	John	Hereford	Feb 1775	50.0		
Gorges	Richard	Eye	pre Feb 1775	31.5		Son of Richard Gorges, MP Leominster 1754-1761.
Powell	Thomas Symonds	Pengethley	March 1775	31.5		
Hereford	Sir James	Sufton Park, Mordiford	March 1775	30.0		married Mary Scudamore of Kentchurch.
Davies	Thomas	Newhouse	Apr 1775	21.0		
Elton	William	Bristol- Ledbury	Oct 1775	21.0		
Evans	Rev Mr	Pembridge- Byeletts	March 1775	21.0		
Geers	James	Pershore	Apr 1775	21.0		Dec'd 1785.
Gregory	William Cope	Woolhope	March 1775	21.0		
Griffith	Rev Mr	Ewithington	June 1775	21.0		
Poole	James	Stretton Grandison	March 1775	21.0		
Vaston	Thomas	Leominster	Feb 1775	21.0		
Westfaling	Philip	Rudhall	Feb 1775	21.0		
Bennett	Mrs	Hereford	March 1775	20.0		
Cotterell	Sir John	Mansell Gamage	Feb 1775	20.0		Married Anne Geers of Gamons. Father of John Geers Cotterell, MP for Herefordshire from 1806.
Total to end 1775				3,172.0	0	(Including £70 from women donors)
Harris	Dr George	Chancellor of diocese	1775-1785	20.0	20.0	Left £5,000 on his death. See below.
Swift	Sara	Worcester	1775-1785	500.0	500.0	
Foley	Lord	Stoke Edith	1777	300.0	300.0	See above, one of original subscribers. Died 1777.
Charlton	Sir Francis	None	1775-1785	100.0	100.0	
Coningsby (1709-1781)	Lady Francis	Hampton Ct, Bodenham	1775-1785	100.0		Wife of Charles Hanbury Williams, MP for Leominster 1754 until his death in 1759. Grandmother of George Coningsby, 6th Earl of Essex.
Foley	Andrew	Stoke Edith	1775-1785	20.0		Of Foley family of Worcestershire.
Scudamore	Rowles	Bristol	1775-1785	150.0		
Howard (1746-1815)	Duke of Norfolk	Holme Lacy	1775-1785	100.0		Charles Howard, Earl of Surrey and 11th Duke of Norfolk, married Frances Scudamore of Holme Lacey in 1771. She died a lunatic in 1820.
Jauncey	Mrs	Hereford	1775-1785	70.0		

APPENDIX 5

HEREFORD INFIRMARY: LEGACIES AND BENEFACTIONS OF £20 AND OVER, 1775-1850.

Surname	First name & Title	Recorded place of residence	Date	Total £	Legacy £	Biographical notes
Birch	John Peploe	Weobley- Garnstone	1775-1785	50.0		Descendent of Col. Birch, renowned Parliamentarian in the civil war.
Bright	Henry	Bristol	1775-1785	50.0		Bright family of Colwall with interests as Bristol merchants and in the West Indies. - also lined to Bright Ames, one of the Infirmary bankers.
Brydges	F.W.T.	Tibberton	1775-1785	50.0		
Davies	Jacob	Ludlow	1775-1785	50.0	50.0	
Evans	Arthur	Buckland	1775-1785	31.5		
Miles	William	Bristol	1775-1785	31.5		
Bright	Lowbridge	Bristol	1775-1785	26.3		As above.
Bright	Richard	Bristol	1775-1785	26.3		As above.
Barnett	William Birch	Llanwarne	1775-1785	21.0		
Bernard	Thomas	Weobley	1775-1785	21.0		
King	James	Stanton on Arrow	1775-1785	21.0		
Thomas	Francis Baladon	Hereford	1775-1785	21.0		
Chinn	Mary	Coughton, Walford	1775-1785	20.0	20.0	
Clarke	Samuel	London, Hill Court	1775-1785	20.0		
Davies	Philip	Hereford	1775-1785	20.0	20.0	
Eckley	Edmund	Credenhill	1775-1785	20.0		
Garlick	Edward	Bristol	1775-1785	20.0		Contributor to Worcester Infirmary.
Grand	Reverend Mr	Dirham, Glos	1775-1785	20.0		
Unknown		Dr Talbot	1775-1785	20.0		
Total to 1785				**5,071.5**	**1,010.0**	**(Including £260 (legacies £20) from women donors)**
Harris	Dr George	Chancellor of diocese	1796	5,000.0	5,000.0	Chancellor of Durham, Hereford and Llandaff diocese. His father had been Dean of Hereford in 1729 and Bishop of Llandaff. Was first an annual subscriber, then donated £20 and a legacy on his death in 1796.
Powell	Ann	Hereford	1785-1799	500.0	500.0	
Hankins	Joan	Hereford	1785-1799	200.0	200.0	
Skynner	Sir John	Ledbury?	1785-1799	100.0		
Silsea	Lord	None	1785-1799	20.0		
Smith	Eliza	Hinton	1785-1799	150.0	150.0	
Jay	Anne	Wintercot	1785-1799	100.0	100.0	
Phillips	Thomas	Newton	1785-1799	63.0		
Miles	John	Ledbury	1785-1799	21.0		
Hill	Richard	Ledbury	1785-1799	21.0		
Toldervey	William	Leominster	1785-1799	21.0	21.0	
Wainwright	William	Hereford	1785-1799	21.0		
Barry	Reverend Mr	Gloucester	1785-1799	20.0		
Garnons	William	Trelough	1785-1799	20.0		
Total to 1799				**11,328.5**	**6,981.0**	**(Including £1,010 (legacies £770) from women donors)**
Butler	Right Reverend	Bishop of Hereford	1804	100.0	100.0	
Maddy	B. Esq.		1808	20.0	20.0	
Powell	D.		1808	20.0	20.0	
Miles	Philip Esq.	Clifton	1811	100.0		
Monnington	Miss		1811	100.0	100.0	
Marsh	Walter	Gwerlodith	1814	20.0		
Coupland	P. Esq.		1814	20.0		
Prosser	Paul	Garway	1814	21.0		
Jones	Henry		1818	2,000.0	2,000.0	
Symonds	William		1818	100.0	100.0	
Simpkinson	James	Court of Noke	1818	50.0	50.0	
Vaughn	William		1818	50.0	50.0	
Parry	William		1818	40.0	40.0	
Woodward	James	Broomy Close	1818	20.0		
Hopton	Mrs	Canon Frome	1819	600.0	600.0	
Bengough			1819	100.0	100.0	
Jones	Robert		1820	20.0		
Gomond	Samuel		1821	90.0	90.0	
Holmes	William		1821	90.0	90.0	
Gorsuch	Thomas Talbot		1822	200.0	200.0	
Philpotts	J. H.		1822	54.0	54.0	
Acrigg	Charles		1822	30.0	30.0	
Cope	Reverend Dr		1823	200.0	200.0	Canon Residentiary, left other bequests to almshouses
Allen	Mrs Elizabeth		1823	20.0	20.0	
Powell	Mrs Mary		1823	20.0	20.0	
Russell	Thomas		1825	500.0	500.0	
Prosser	Reverend Archdeacon		1825	20.0		
Palmer	John		1826	20.0	20.0	
Lilly	Reverend Archdeacon		1827	100.0	100.0	
Roberts	Sarah		1827	50.0		
Blizard	Thomas		1827	20.0		
Sherburne	J.		1828	800.0	800.0	
Carless	Miss D		1828	100.0	100.0	
Seward	Mrs Jane		1828	25.0		
Brydges	Mrs		1829	500.0	500.0	
Deykes	W.	Newent	1829	45.0		

APPENDIX 5

HEREFORD INFIRMARY: LEGACIES AND BENEFACTIONS OF £20 AND OVER, 1775-1850.

Surname	First name & Title	Recorded place of residence	Date	Total £	Legacy £	Biographical notes
Cove	Miss		1831	50.0		
Mayo	Miss		1832	50.0		
Morris	John	Kington	1833	10,000.0	10,000.0	Woolstapler from Kington. Former High Sheriff of Radnorshire.
Russell	Reverend Canon		1833	200.0		
James	John	Leominster	1834	133.0	133.0	
Smithsend	E.		1834	100.0	100.0	
Griffeth	L.D.		1835	100.0	100.0	
Lilly	Jane		1835	100.0	100.0	
Sirrell	Jonathan		1835	50.0	50.0	
Cooke	Joseph	Walford	1836	100.0		
Edwards	Moses		1838	50.0		
Clarke	Mary	Hereford	1837	500.0	500.0	
Picart	Reverend Samuel	Hartlebury	1837	300.0	300.0	
Cooke	Charles	Widemarsh	1837	200.0	200.0	
King	Mrs	Staunton Park	1838	100.0		
Kyrwood	Mrs Anne	Droitwich	1840	800.0	800.0	
Westwood	Miss A.		1842	100.0	100.0	
Hopton	Reverend William Kemerton		1842	90.0	90.0	
Sier	James		1844	900.0	900.0	
Morris	John	Kington	1844	135.0	135.0	Dividends paid by Executors.
Carless	Walter		1844	101.0	101.0	
Thomas	Right Reverend	Bishop of Hereford	1844	100.0		
Money	Sir James Kyrle		1844	90.0	90.0	
Lovesay	Richard		1844	40.0		
Hopkins	S.		1845	100.0	100.0	
Miles	P.S.		1846	200.0	200.0	
Bateman	Lord	Shobdon	1847	100.0	100.0	
Chawick	Elias	Puddlestone Court	1847	63.0		
Holloway	Charles		1848	300.0	300.0	
Griffiths	John	Hereford	1848	180.0	180.0	
Grocers	of Hereford		1848	20.0		
St John	Reverend H.	Dinmore House	1850	20.0	20.0	
Walker	John	Holmer	1850	20.0		
Jones	R.		1850	20.0		
Total donations of £20 or over from 1774-1850				**33,005.5**	**27,484.0**	**(including £4,125 (legacies £3,630) from women donors)**
					83%	

Sources:

Hereford Journal from 1774-1775

Hereford Infirmary Annual Reports 1785, 1788, 1791, 1799-1850.

HEREFORD INFIRMARY: INCOME & EXPENDITURE 1785-1850

	1785 £'000	1788 £'000	1791 £'000	1799 £'000	1800 £'000	1801 £'000	1802 £'000	1803 £'000	1804 £'000	1805 £'000	1806 £'000	1807 £'000	1808 £'000	1809 £'000	1810 £'000	1811 £'000	1812 £'000	1813 £'000	1814 £'000
Ordinary Income																			
Subscriptions	602.75	546	528	423	404	416	312	394	358	295	440	349	453	455	434	554	539	514	588
Dividends & Interest	41.25	25.25	37.25	45	46	646	382	318	318	318	318	385	353	351	351	250	540	350	480
Other	35.25	62.25	79.5	37	39.6	44.65	38	56	67	31.2	33	653	24	29	54	546	55	94	48
Total Ordinary Income	**679.25**	**633.5**	**644.75**	**505**	**489.6**	**1106.65**	**732**	**768**	**743**	**644.2**	**791**	**1387**	**830**	**835**	**839**	**1350**	**1134**	**958**	**1116**
Ordinary Expenditure																			
Foodstuffs	276.5	281.5	340.75	254	379.5	484.5	365.5	402.75	346.75	422	501.5	458.25	390.25	421.25	451	534	503.25	602.75	568.5
Household items	60	67.75	70.25	56.5	59.75	60	65.5	69.25	80.25	94	91.75	102.5	82.25	84.75	107.25	82.75	104.75	86	86.75
Medical Expenses	176.25	112.75	129.5	47.75	157.75	87.75	82.25	192.75	157.75	77.25	100	164.25	129	53	110	99.25	118.5	129.5	99.5
Property Expenses	49.25	41.25	71.5	47.75	64.75	29	44.25	52.25	75.25	30.5	58	164.5	98	49.25	150	136.5	72.25	196	99.75
Salaries & Wages	85.75	89	85.25	123.5	104.25	96.5	107.75	120.5	138.25	134.25	161.5	155.25	125.25	141.5	140.5	164.75	177.75	178.5	200.25
Other costs	32.75	46.75	17.25	20.25	30.75	36	47.25	47.5	44.75	63	23.5	21.75	17.75	21.5	32	36	55	44.75	35
Total Ordinary Expenses	**680.5**	**639**	**714.5**	**549.75**	**796.75**	**793.75**	**712.5**	**885**	**843**	**821**	**936.25**	**1066.5**	**842.5**	**771.25**	**990.75**	**1053.25**	**1031.5**	**1237.5**	**1089.75**
Surplus / (Deficit)	(1.25)	(5.50)	(69.75)	(44.75)	(307.15)	**312.90**	**19.50**	(117.00)	(100.00)	(176.80)	(145.25)	**320.50**	(12.50)	**63.75**	(151.75)	**296.75**	**102.50**	(279.50)	**26.25**

	1815 £'000	1816 £'000	1817 £'000	1818 £'000	1819 £'000	1820 £'000	1821 £'000	1822 £'000	1823 £'000	1824 £'000	1825 £'000	1826 £'000	1827 £'000	1828 £'000	1829 £'000	1830 £'000	1831 £'000	1832 £'000	1833 £'000
Ordinary Income																			
Subscriptions	436	507	536	465	648	654	671	632	615	607	643	659	643	654	664	655	660	646	645
Dividends & Interest	420	380	524	624	550	550	550	580	545	537	560	580	530	589	713	601	585	866	667
Other	86	104	52	88	95	76	102	166	98	158	110	120	200	307	121	326	109	249	106
Total Ordinary Income	**942**	**991**	**1112**	**1177**	**1293**	**1280**	**1323**	**1378**	**1258**	**1302**	**1313**	**1359**	**1373**	**1550**	**1498**	**1582**	**1354**	**1761**	**1418**
Ordinary Expenditure																			
Foodstuffs	483	431.25	491.25	632.75	692.75	621.75	586.5	509.75	399.75	499.75	582	573	596	609.6	525.5	604.25	592.5	587	535.5
Household items	85.75	96.25	76.75	109.5	102.75	111.25	107	101.25	98	92.5	120.25	112.25	107.25	92	77	86.75	83.5	79.25	77
Medical Expenses	104.25	113.25	105.75	114.5	151	139.75	155.5	168.75	167	196.5	188.75	137.5	207.75	145.25	144.5	170	186.75	169.75	190
Property Expenses	142	103	127	109.5	125.75	121.25	89.25	86	90	171.25	148.75	105	149.25	322.75	282	90.75	142	138	113.25
Salaries & Wages	198.75	209.5	213.5	232.25	220.5	217.25	184.75	205	230	217.75	220.75	231.5	238	231.5	276	261.5	251.25	236	232
Other costs	33.75	39.25	40.75	49	56	76.75	68.75	49	54.75	42.75	70.5	89.25	68.5	76.95	55	51.25	71.5	72.75	67.5
Total Ordinary Expenses	**1047.5**	**992.5**	**1055**	**1247.5**	**1348.75**	**1288**	**1191.75**	**1119.75**	**1039.5**	**1220.5**	**1331**	**1248.5**	**1366.75**	**1478.05**	**1360**	**1264.5**	**1327.5**	**1282.75**	**1215.25**
Surplus / (Deficit)	(105.50)	(1.50)	**57.00**	(70.50)	(55.75)	(8.00)	**131.25**	**258.25**	**218.50**	**81.50**	(18.00)	**110.50**	**6.25**	**71.95**	**138.00**	**317.50**	**26.50**	**478.25**	**202.75**

	1834 £'000	1835 £'000	1836 £'000	1837 £'000	1838 £'000	1839 £'000	1840 £'000	1841 £'000	1842 £'000	1843 £'000	1844 £'000	1845 £'000	1846 £'000	1847 £'000	1848 £'000	1849 £'000	1850 £'000
Ordinary Income																	
Subscriptions	638	618	626	599	581	602	571	555	595	592	612	612	619	619	599	625	624
Dividends & Interest	877	899	997	950	975	984	1001	1013	1013	966	1039	964	1034	1028	1157	1053	1054
Other	292	99	158	77	76	212	72	207	50	125	68	218	102	121	69	105	82
Total Ordinary Income	**1807**	**1616**	**1781**	**1626**	**1632**	**1798**	**1644**	**1775**	**1658**	**1683**	**1719**	**1794**	**1755**	**1766**	**1825**	**1783**	**1760**
Ordinary Expenditure																	
Foodstuffs	558	581.75	566.75	681.75	673	725.75	821	650.75	756	763	753	817.25	811.25	851.5	932.25	882.5	747.25
Household items	79.75	87	94.5	90.75	94	101.5	98.25	111.5	103	100	101.5	114	114.25	130.75	122.75	126.5	112.25
Medical Expenses	194	187.25	216.5	201.25	232	189.25	231.25	256	208	235.5	212	250.5	251	202.25	222.25	269.25	221.75
Property Expenses	992.5	321	210	241.75	251.5	294.5	203.25	169	178.25	213	311	390.75	281.5	175.25	246.5	158.5	213.25
Salaries & Wages	240.75	275.25	251.75	250.75	272	282.75	287.25	290	281.75	258.5	266	272.5	292	289.25	303.5	315.5	322
Other costs	82	71	107.5	121	96.75	123	109.5	87.25	122.75	115.5	128.75	97.5	84.75	75	73.25	77	82.25
Total Ordinary Expenses	**2147**	**1523.25**	**1447**	**1587.25**	**1619.25**	**1716.75**	**1750.5**	**1764.5**	**1649.75**	**1685.5**	**1772.25**	**1942.5**	**1834.75**	**1724**	**1900.5**	**1829.25**	**1698.75**
Surplus / (Deficit)	(340.00)	**92.75**	**334.00**	**38.75**	**12.75**	**81.25**	(125.50)	**10.50**	**8.25**	(101.50)	(53.25)	(148.00)	(78.75)	**42.00**	(75.50)	(45.75)	**61.25**

Source: Hereford Infirmary Annual Reports 1785, 1788, 1791, 1799-1850.

MEDICAL PERSONNEL AT HEREFORD INFIRMARY 1775-1850

Name	Qualification	Date appointed	Years of service	Member of City Council	Notes
HONORARY SURGEONS					
Thomas Cam	L.S.A.	1776	18	Yes	Took Edward Trotman as apprentice, 27/8/1778.
Richard Hardwicke	L.S.A. Apprenticed to John Holme, Surgeon of Bishops Frome for 7 years for £31 on 8/7/1825	1776	18	Yes, Mayor 1787	Took John Powell as apprentice for 5 years for £100, 15/7/1788.
William Cam	L.S.A.	1776	18		
Thomas Cam jnr.	L.S.A.	1794	6		
Thomas Cotes	L.S.A., M.D.	1794	23		
Samuel Cam	L.S.A.	1800	38		
John Griffiths senior	L.S.A., M.R.C.S.	1817	20	Yes	3 June 1795, Took Thomas Thompson as apprentice for 5 years for £80, 3/6/1795, Thomas Chapman for 5 years for £150, 3/1/1797 and James Price for 5 years for £150, 16/11/1799.
John Griffiths junior	L.S.A., M.R.C.S.	1837	2		
Charles Lingen	L.S.A., M.R.C.S., F.R.C.S.,M.D.				
Francis Braithwaite	M.R.C.S.	1839	14		
Thomas Cam	D.L., J.P. F.R.C.S.	1839	28		
HONORARY PHYSICIANS					
John Cam	M.A.,M.D. Cambridge, also a surgeon	1776	16	Yes, Mayor 1774	
Francis Campbell	M.D. Glasgow	1776	12+8	Yes, Mayor 1763	
Thomas Blount	MD. Apprenticed to Thomas Sanders, apothecary, of Sturbridge, Worcs, on 24 February 1729 for 7 years for £42.	1792	28		
George Symonds	M.D.	1788	8		
Samuel Hughes	M.D. Edinburgh	1799	25	Yes	
John Bleek-Lye	M.D.	1820	44	Yes	
Mainswete Walrond	M.D.	1825	13		
William Gilliland	M.D.	1838	28		Superintendent of the private lunatic asylum 1835-1854.
PAID APOTHECARIES AND HOUSE SURGEONS					
Aycrigg		1775-c1785	10		
Blackfield		c.1793			
Gamery		1793-1795	2		
Reece		1795-1797	2		
Williams		1797-1805	8		
Tully		1805-1842	37		
Waudby		1843 onwards			

APPENDIX 8

HEREFORD INFIRMARY- SUMMARY OF PATIENTS TREATED 1775-1850

	1776-1788	1799	1800	1801	1802	1803	1804	1805	1806	1807	1808	1809	1810
INPATIENTS													
In at 25 March		30	20	24	21	22	22	24	28	31	26	20	24
Admitted in year	1,859	129	163	145	144	163	145	162	186	179	163	176	199
Treated in Year	1,859	159	183	169	165	185	167	186	214	210	189	196	223
Cured	992	97	97	105	103	108	97	113	125	73	87	86	110
Relieved	85	13	24	21	22	26	21	16	19	55	44	52	33
Discharged for misbehaviour	46	2	3	0	0	0	3	3	2	3	0	1	2
Discharged at own request	40	1	1	1	2	5	2	4	0	3	2	0	0
Improper	12					2	1	1	1	2	0	0	0
Incurable	16	2	0	3	2	4	2	3	1	0	0	5	0
Dead	86	5	5	3	3	4	4	3	4	6	5	0	4
Made outpatients	552	19	29	15	11	14	13	15	31	42	31	28	48
	1,829	139	159	148	143	163	143	158	183	184	169	172	197
In at 25 March	30	20	24	21	22	22	24	28	31	26	20	24	26
Treated in Year	1,859	159	183	169	165	185	167	186	214	210	189	196	223
Death rate	5%	4%	3%	2%	2%	2%	3%	2%	2%	3%	3%	0%	2%
% cured or relieved	59%	79%	76%	85%	87%	82%	83%	82%	79%	70%	78%	80%	73%
% made outpatients	30%	14%	18%	10%	8%	9%	9%	9%	17%	23%	18%	16%	24%
OUTPATIENTS													
In at 25 March		66	30	37	30	23	24	23	20	25	32	36	29
Admitted in year	3,249	149	173	155	119	160	163	174	212	223	238	208	276
Treated in Year	3,249	215	203	192	149	183	187	197	232	248	270	244	305
Cured	2,071	156	138	140	108	137	135	144	163	169	185	166	207
Relieved	140	20	11	9	14	11	11	17	20	25	24	33	41
Non attendance	684	1	3	2	0	0	0	0	0	0	0	0	0
Dead	112												
Inpatients	176	8	14	11	4	11	18	16	24	22	25	16	21
	3,183	185	166	162	126	159	164	177	207	216	234	215	269
Remaining	66	30	37	30	23	24	23	20	25	32	36	29	36
Treated in Year	3,249	215	203	192	149	183	187	197	232	248	270	244	305
% cured or relieved	69%	95%	90%	92%	97%	93%	89%	91%	88%	90%	89%	93%	92%
% made inpatients	6%	4%	8%	7%	3%	7%	11%	9%	12%	10%	11%	7%	8%
% non attenders	21%	1%	2%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%
% dead	4%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Ratio of outpatients to inpatients	1.7	1.4	1.1	1.1	0.9	1.0	1.1	1.1	1.1	1.2	1.4	1.2	1.4

	1811	1812	1813	1814	1815	1816	1817	1818	1819	1820	1821	1822	1823
INPATIENTS													
In at 25/3	26	29	27	36	31	32	30	40	39	41	49	48	50
Admitted in year	195	189	189	176	188	181	217	255	244	283	243	266	276
Treated in Year	221	218	216	212	219	213	247	295	283	324	292	314	326
Cured	91	88	92	90	87	70	89	131	89	98	105	112	123
Relieved	25	27	28	22	12	10	46	61	8	15	19	10	0
Discharged for misbehaviour	1	3	0	0	0	1	2	1	0	2	0	0	0
Discharged at own request	1	0	0	2	1	1	1	0	1	1	1	0	1
Improper	0	0	0	1	1	0	0	2	1	1	0	0	0
Incurable	2	1	0	0	1	1	0	0	0	0	0	0	0
Dead	2	7	3	2	3	8	10	14	5	9	12	2	9
Made outpatients	70	65	57	64	82	92	59	47	138	149	107	140	147
	192	191	180	181	187	183	207	256	242	275	244	264	280
Remaining	29	27	36	31	32	30	40	39	41	49	48	50	46
Treated in Year	221	218	216	212	219	213	247	295	283	324	292	314	326
Death rate	1%	4%	2%	1%	2%	4%	5%	5%	2%	3%	5%	1%	3%
% cured or relieved	60%	60%	67%	62%	53%	44%	65%	75%	40%	41%	51%	46%	44%
% made outpatients	36%	34%	32%	35%	44%	50%	29%	18%	57%	54%	44%	53%	53%
OUTPATIENTS													
In at 25 March	36	40	38	45	49	51	55	60	65	70	78	137	141
Admitted in year	253	236	225	250	276	309	301	338	381	425	453	468	450
Treated in Year	289	276	263	295	325	360	356	398	446	495	531	605	591
Cured	198	186	160	171	180	194	185	193	215	237	190	247	261
Relieved	35	38	40	63	84	103	105	130	149	158	175	187	175
Non attendance	0	0	0	0	0	0	0	0	0	0	0	0	0
Dead													
Inpatients	16	14	18	12	10	8	6	10	12	22	29	30	10
	249	238	218	246	274	305	296	333	376	417	394	464	446
Remaining	40	38	45	49	51	55	60	65	70	78	137	141	145
Treated in Year	289	276	263	295	325	360	356	398	446	495	531	605	591
% cured or relieved	94%	94%	92%	95%	96%	97%	98%	97%	97%	95%	93%	94%	98%
% made inpatients	6%	6%	8%	5%	4%	3%	2%	3%	3%	5%	7%	6%	2%
% non attenders	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
% dead	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
% inpatients	43%	44%	45%	42%	40%	37%	41%	43%	39%	40%	35%	34%	36%
% outpatients	57%	56%	55%	58%	60%	63%	59%	57%	61%	60%	65%	66%	64%
Ratio of outpatients to inpatients	1.3	1.3	1.2	1.4	1.5	1.7	1.4	1.3	1.6	1.5	1.8	1.9	1.8

APPENDIX 8

HEREFORD INFIRMARY - SUMMARY OF PATIENTS TREATED 1775-1850

	1824	1825	1826	1827	1828	1829	1830	1831	1832	1833	1834	1835	1836	1837
INPATIENTS														
In at 25 March	46	51	48	49	33	35	47	49	50	46	48	50	60	60
Admitted in year	287	285	281	304	325	300	377	385	382	392	408	436	438	472
Treated in Year	333	336	329	353	358	335	424	434	432	438	456	486	498	532
Cured	118	125	103	110	71	67	87	96	98	102	115	124	149	192
Relieved	3	9	8	8	6	7	3	10	4	7	0	20	25	14
Discharged for misbehaviour	0	1	0	0	1	0	1	0	0	0	0	1	0	0
Discharged at own request	2	4	3	1	3	1	0	1	0	2	1	0	0	1
Improper	0	0	0	1	0	1	0	1	0	0	0	0	0	0
Incurable	0	2	0	0	1	0	0	0	0	0	0	0	0	0
Dead	10	7	11	15	15	11	13	19	17	15	21	19	24	27
Made outpatients	149	140	155	185	226	201	271	257	267	264	269	262	240	237
	282	288	280	320	323	288	375	384	386	390	406	426	438	471
Remaining	51	48	49	33	35	47	49	50	46	48	50	60	60	61
Treated in Year	333	336	329	353	358	335	424	434	432	438	456	486	498	532
Death rate	4%	2%	4%	5%	5%	4%	3%	5%	4%	4%	5%	4%	5%	6%
% cured or relieved	43%	47%	40%	37%	24%	26%	24%	28%	26%	28%	28%	34%	40%	44%
% made outpatients	53%	49%	55%	58%	70%	70%	72%	67%	69%	68%	66%	62%	55%	50%
OUTPATIENTS														
In at 25 March	145	157	177	132	117	152	168	215	223	238	244	266	289	260
Admitted in year	478	496	360	381	539	538	597	690	685	774	794	798	698	619
Treated in Year	623	653	537	513	656	690	765	905	908	1012	1038	1064	987	879
Cured	288	296	277	285	370	389	403	473	464	526	518	420	280	112
Relieved	162	171	115	97	111	119	127	185	188	194	168	170	140	80
Non attendance	0	0	0	0	0	0	0	0	0	20	50	140	277	420
Dead														
Inpatients	16	9	13	14	23	14	20	24	18	28	36	45	30	17
	466	476	405	396	504	522	550	682	670	768	772	775	727	629
Remaining	157	177	132	117	152	168	215	223	238	244	266	289	260	250
Treated in Year	623	653	537	513	656	690	765	905	908	1012	1038	1064	987	879
% cured or relieved	97%	98%	97%	96%	95%	97%	96%	96%	97%	94%	89%	76%	58%	31%
% made inpatients	3%	2%	3%	4%	5%	3%	4%	4%	3%	4%	5%	6%	4%	3%
% non attenders	0%	0%	0%	0%	0%	0%	0%	0%	0%	3%	6%	18%	38%	67%
% dead	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
% inpatients	35%	34%	38%	41%	35%	33%	36%	32%	32%	30%	31%	31%	34%	38%
% outpatients	65%	66%	62%	59%	65%	67%	64%	68%	68%	70%	69%	69%	66%	62%
Ratio of outpatients to inpatients	1.9	1.9	1.6	1.5	1.8	2.1	1.8	2.1	2.1	2.3	2.3	2.2	2.0	1.7

	1838	1839	1840	1841	1842	1843	1844	1845	1846	1847	1848	1849	1850	Total
INPATIENTS														
In at 25 March	61	60	60	65	65	51	70	66	63	61	67	63	67	
Admitted in year	512	547	590	578	521	506	541	545	556	531	547	571	585	18,917
Treated in Year	573	607	650	643	586	557	611	611	619	592	614	634	652	18,917
Cured	196	207	206	227	239	229	203	226	243	225	252	245	268	7,981
Relieved	9	9	15	21	16	14	20	15	16	25	37	26	49	1,110
Discharged for misbehaviour	0	1	1	2	0	1	3	0	1	0	2	0	3	93
Discharged at own request	1	2	2	6	3	14	20	21	24	7	14	10	10	224
Improper	0	2	1	0	0	0	2	0	0	0	0	1	0	34
Incurable	0	0	0	0	0	1	2	1	0	0	0	3	2	55
Dead	34	30	33	27	35	22	19	31	34	30	8	18	13	776
Made outpatients	273	296	327	295	242	206	276	254	240	238	238	264	241	8,578
	513	547	585	578	535	487	545	548	558	525	551	567	586	18,851
Remaining	60	60	65	65	51	70	66	63	61	67	63	67	66	66
Treated in Year	573	607	650	643	586	557	611	611	619	592	614	634	652	18,917
Death rate	7%	5%	6%	5%	7%	5%	3%	6%	6%	6%	1%	3%	2%	4%
% cured or relieved	40%	39%	38%	43%	48%	50%	41%	44%	46%	48%	52%	48%	54%	48%
% made outpatients	53%	54%	56%	51%	45%	42%	51%	46%	43%	45%	43%	47%	41%	46%
OUTPATIENTS														
In at 25 March	250	340	399	378	361	346	394	347	310	263	251	238	257	
Admitted in year	634	597	513	507	493	598	467	486	497	570	651	655	643	25,622
Treated in Year	884	937	912	885	854	944	861	833	807	833	902	893	900	25,622
Cured	148	114	111	108	94	110	100	120	97	135	190	210	254	13,428
Relieved	40	30	11	9	15	21	19	27	30	58	70	60	41	4,276
Non attendance	334	360	349	344	358	370	350	340	380	350	370	340	336	6,178
Dead			33	28	22	17	20	20	25	29	22	18	20	366
Inpatients	22	34	30	35	19	32	25	16	12	10	12	8	4	1,129
	544	538	534	524	508	550	514	523	544	582	664	636	655	25,377
Remaining	340	399	378	361	346	394	347	310	263	251	238	257	245	245
Treated in Year	884	937	912	885	854	944	861	833	807	833	902	893	900	25,622
% cured or relieved	35%	27%	23%	22%	21%	24%	23%	28%	23%	33%	39%	42%	45%	70%
% made inpatients	4%	6%	6%	7%	4%	6%	5%	3%	2%	2%	2%	1%	1%	4%
% non attenders	61%	67%	65%	66%	70%	67%	68%	65%	70%	60%	56%	53%	51%	24%
% dead	0%	0%	6%	5%	4%	3%	4%	4%	5%	5%	3%	3%	3%	1%
Ratio of outpatients to inpatients	1.5	1.5	1.4	1.4	1.5	1.7	1.4	1.4	1.3	1.4	1.5	1.4	1.4	1.4

Source: Annual Reports

APPENDIX 8

HEREFORD INFIRMARY- SUMMARY OF PATIENTS TREATED 1775-1850

	1776-1788	1799-1810	1811-1820	1821-1830	1831-1840	1841-1850	Total
INPATIENTS							
in at 25/3		30	26	49	49	65	
Admitted in year	1,859	1,954	2,117	2,944	4,562	5,481	18,917
	1,859	1,984	2,143	2,993	4,611	5,546	18,917
Cured	992	1,201	925	1,021	1,485	2,357	7,981
Relieved	85	346	254	73	113	239	1,110
Discharged for misbehaviour	46	19	10	3	3	12	93
Discharged at own request	40	21	8	16	10	129	224
Improper	12	7	6	2	4	3	34
Incurable	16	22	5	3	0	9	55
Dead	86	46	63	105	239	237	776
Made outpatients	552	296	823	1,721	2,692	2,494	8,578
	1,829	1,958	2,094	2,944	4,546	5,480	18,851
Remaining	30	26	49	49	65	66	66
	1,859	1,984	2,448	2,519	2,615	2,725	18,917
Death rate	5%	2%	3%	4%	5%	4%	4%
% cured or relieved	59%	79%	56%	37%	35%	47%	48%
% made outpatients	30%	15%	39%	58%	59%	46%	46%

	1776-1788	1799-1810	1811-1820	1821-1830	1831-1840	1841-1850	Total
OUTPATIENTS							
in at 25/3		66	36	78	215	378	
Admitted in year	3,249	2,250	2,994	4,760	6,802	5,567	25,622
	3,249	2,316	3,030	4,838	7,017	5,945	25,622
Cured	2,071	1,848	1,919	3,006	3,166	1,418	13,428
Relieved	140	236	905	1,439	1,206	350	4,276
Non attendance	684	6	0	0	1,950	3,538	6,178
Dead	112	0	0	0	33	221	366
Inpatients	176	190	128	178	284	173	1,129
	3,183	2,280	2,952	4,623	6,639	5,700	25,377
Remaining	66	36	78	215	378	245	245
	3,249	2,316	3,030	4,838	7,017	5,945	25,622
% cured or relieved	69%	91%	96%	96%	48%	31%	70%
% made inpatients	5%	8%	4%	4%	4%	3%	4%
% non attenders	21%	0%	0%	0%	0%	62%	24%
% dead	4%	0%	0%	0%	4%	4%	1%
Ratio of outpatients to inpatients	1.7	1.2	1.2	1.9	2.7	2.2	1.4
Number of years	12	11	10	10	10	10	63
Average inpatients per year	156	180	214	299	461	555	
Average outpatients per year	271	211	303	484	702	595	

Herefordshire patients admitted to the Joint Counties Asylum from December 1851 to January 1853

Total patients

Union	Total	sex male	sex female	where living previously asylum	where living previously other	Name of Asylum Hereford	Whitchurch	Droitwich	Birmingham	Shrewsbury	Bristol	Gloucester	Gaol	Workhouse	Home/ Not known
Bromyard	4	1	3	2	2			1			1				2
County Hereford	3	2	1	3				3							
Dore Union	8	1	7	4	4	2	2						1	2	1
Hereford Union	18	7	11	9	9	4	3			1		1		2	7
Hereford Union	5	0	5	5		5									
Kington	3	1	2	0	3										3
Ledbury	11	8	3	10	1	1	8	1							1
Leominster	10	5	5	7	1	1			4	2					3
Ross	8	5	3	7	1	4	3								1
Weobley	5	2	3	2	3	1	1								3
Other	3	3	0	3		3									
Total	**78**	**35**	**43**	**52**	**24**	**21**	**17**	**5**	**4**	**3**	**1**	**1**	**1**	**4**	**19**
		45%	55%	67%	31%										

Male Patients

Union	Total	male		where living previously asylum	where living previously other	Analysis of asylums Hereford	Whitchurch	Droitwich	Birmingham	Shrewsbury	Bristol	Gloucester	Gaol	Workhouse	Home/ Non known
Bromyard	4	1		0	1										1
County Hereford	3	2		2	0			2							
Dore Union	8	1		0	1								1		
Hereford Union	18	7		4	3	2				1		1		1	2
Hereford Union	5	0		0											
Kington	3	1		0	1										1
Ledbury	11	8		7	1	1	5	1							1
Leominster	10	5		4	1	1	1		2						1
Ross	8	5		4	1	2	2								1
Weobley	5	2		0	2										2
Other	3	3		3		3									
Total	**78**	**35**		**24**	**11**	**9**	**8**	**3**	**2**	**1**	**0**	**1**	**1**	**1**	**9**
				69%	31%										

Female Patients

Union	Total	sex	female	where living previously asylum	where living previously other	Analysis of asylums Hereford	Whitchurch	Droitwich	Birmingham	Shrewsbury	Bristol	Gloucester	Gaol	Workhouse	Home/ Non known
Bromyard	4		3	2	1			1			1				1
County Hereford	3		1	1				1							
Dore Union	8		7	4	3	2	2							1	2
Hereford Union	18		11	5	6	2	3							1	5
Hereford Union	5		5	5		5									
Kington	3		2	0	2										2
Ledbury	11		3	3				3							
Leominster	10		5	3	2				2	1					2
Ross	8		3	3		2	1								
Weobley	5		3	2	1	1	1								1
Other	3		0												
Total	**78**		**43**	**28**	**15**	**12**	**10**	**2**	**2**	**1**	**1**	**0**	**0**	**2**	**13**
				65%	35%										

APPENDIX 10

Report from Ledbury Board of Health to the Central Board of Health – November 1831.

Report of Congreve Selwyn, Surgeon to the Ledbury Infirmary-

' This has been an unhealthy season with us, as the Dispensary books show.

25 March 1830 to 23 November 1830 - Patients	817
25 March 1831 to 23 November 1831 – Patients	1006
Increase	269

Fever cases since March 1831 are 171, still under treatment 20, deaths among fever patients, 4.

The fever is of the typhus character and in some instances is of a very severe form, but it has, generally speaking, been found among the Poor, in close, confined, and unhealthy situations, in the neighbourhood of pig sties, ditches and wherever there appeared to have been a want of cleanliness.
The very active exertions now being taken by the Board of Health established here for the removal of everything which may be deemed a nuisance in the Town or its suburbs will, there is no doubt, tend to the health of the inhabitants, and remove some of the causes of fever.

The above sent to the Central Board with associated notes.

' Our population, amounting to 3,852 persons, is almost entirely agricultural, and that nearly 3,000 of them live in the Town in small houses, and very confined situations, where there are only surface drains and no outlet for filth – and where many of the families keep pigs.
Under such circumstances it is wonderful we have not been more unhealthy than the report will show, but from the measures now in progress we shall greatly improve the health of the Poor by obliging them to remove their pigsties and other nuisances. Unfortunately there is no summary powers to do this but we have ordered indictments to be pursued against some of the most considerable, which it is trusted will alarm others, but an indictment to remove a nuisance is a tedious process and very expensive, which falling upon a day labourer, will only reduce him and his family to the parish, already overburdened with the poor.
It is generally to be lamented that we have no summary law to remove nuisances by imposing a fine of 20s for every day it shall continue after being presented on oath to the magistrate in Petty Session, or before two magistrates. The only custom here is to present the most obvious nuisances when the Steward of the manor stands notice to remove it which is seldom done and the same process is repeated next year and is in fact perpetuated.'

John Biddulph, Magistrate and Chairman, Board of Health.

BIBLIOGRAPHY

The title of printed sources is shown in italics

List of abbreviations used in the Bibliography
TWNFC Transactions of the Woolhope Naturalists' Field Club

PRIMARY SOURCES

Hereford Library

Manuscript sources
Marriage settlement and deed of separation of Charles Howard, Earl of Surrey and Frances Fitzroy Scudamore, O91.92

R. J. Powell, 'History of the corporation of the city of Hereford, 1500 to the present day', (manuscript). LC 352.02

Printed sources
Hereford Corporation- inquiry into the existing state of municipal corporations in England and Wales (Hereford, 1833)

Hereford sanitary improvements- report of T. Curley to the mayor, aldermen and town council of the city of Hereford (Hereford, 1854)

Rules of Hereford Benevolent Society for the relief of the sick poor (1815)

Rules and orders for the government of the General Infirmary at Hereford (1775)

Rules for the government of the Lunatic Asylum in Hereford (1799)

Rules of a lying-in society for the benefit of poor married women, established at Leominster (1818)

Three Addresses to the Inhabitants of the County of Hereford, in favour of the establishment of a PUBLICK INFIRMARY in or near the City of Hereford (1774)

Herefordshire Record Office

Manuscript sources
Commissions of the peace, Q/JC,

Diary of John Biddulph, G2/IV/J

Diocesan call books including oaths of midwives and surgeons, HD 5

Hereford Board of Health, 1831-1832, BH 37/1-5

Hereford General Infirmary minutes of Governors' meetings

Jarvis Charity records, BC 29

Ledbury overseers and Board of Health, 1831-1832, B 092/61

Letter from Thomas Talbot to Thomas Harley, Oct. 1774, F37/240

Lunacy and asylum records, Q/AL/1-199

New Poor Law Union minutes, K42

Papers of Dr Martin Dunne, F 76/IV/72

Papers of Ann Pateshall, A 95/AP

Papers of John Scudamore Lechemere Pateshall, A 95/J

Printed sources
Hereford General Infirmary *Annual Reports,* S 60

An alphabetical list of the Poll (Hereford, 1774), BC 79/Z6/3

Gwent Record Office
Joint Counties Asylum records, D 3202.24

Joint Counties Asylum, admission registers 1851-1859, D3202.30/1

Joint Counties Asylum Case book, 1850-c.1860, D757.43

First Annual Report of the Joint Lunatic Asylum for the Counties of Monmouth, Hereford, Brecon, Radnor and the City of Hereford, D 910.7

Statement in favour of dissolution of the present union, D 910.9

Newport Library
Joint Counties Asylum, *Statistical Tables of Lunatics and Idiots 1864*

Joint Counties Asylum, *Annual Reports, 1851-1864*

Private records
Ledger Book of Delabere Walker of Bromyard. I am grateful to Mrs Walker for access.

Hereford General Infirmary *Annual Report,* 1785 and 1788. I am grateful to Charles Renton for access.

Herefordshire Medical Association minute book. I am grateful to Dr John Ross for access.

Leominster Moravian records. I am grateful to Basil and Vera Macleavy for access.

GOVERNMENT PUBLICATIONS

Census of England and Wales, Population Tables for the years 1801-1851.

E. Clark, *The Reports of the commissioners in England and Wales relating to the County of Hereford, 1819-1837 (London, 1837)*

House of Commons, Select Committee on Hereford Lunatic Asylum (London, 1839)

T.W. Rammel, *Report to the General Board of Health on a preliminary inquiry into the sewerage, drainage and supply of water, and the sanitary condition of the inhabitants of the city of Hereford* (London, 1853)

NEWSPAPERS

Hereford Journal

Hereford Times

MEDICAL AND TRADE DIRECTORIES

S. Foart Simmons, *The medical register for the year 1783* (London, 1783)

Lascelles 1851 gazateer of Herefordshire (Birmingham, 1851)

Pigott's directory of Herefordshire (London, 1822, 1830, 1831,1835)

Provincial medical directory (London, 1848)

Provincial medical directory (London, 1851)

Robins directory of Herefordshire (London, 1837)

Robson's commercial directory of London and the Western Counties (London, 1840)

Slater's directory (London, 1850)

The universal British directory (London, 1792)

CONTEMPORARY PUBLICATIONS

CLARK, J., *General view of the agriculture of the county of Herefordshire* (London, 1794)

COBBETT, W., *Rural rides* (reprinted London, 1940)

DUNCUMBE, J., *Collections towards the history and antiquities of the county of Hereford* (London, 1804)

DUNCUMB, J., *General view of the agriculture of the county of Hereford* (London, 1805)

GILPIN, W., *Observations on the River Wye and several parts of south Wales* (London, 1782)

HUTCHINSON, J., *Herefordshire biographies* (Hereford, 1840)

PARRY, R., *History of Kington* (Kington, 1845),

PAYNE KNIGHT, R., *The landscape: A didactic poem* (London, 1794)

PRICE, U., *Essays on the picturesque* (London, 1794)

REES, W. J., *The Hereford guide* (Hereford, 1827)

ROBINSON, C. J., *Castles of Herefordshire and their lords* (London, 1869)

ROBINSON, C. J., *A history of the mansions and manors of Herefordshire* (London, 1872)

WILLIAMS, J., *The Leominster Guide* (Leominster, 1808)

PUBLISHED SECONDARY SOURCES

ANDREW, D. T., *Philanthropy and police: London charity in the eighteenth century* (Princeton, 1989)

ANDREWS, J., BRIGGS, A., PORTER, R., TUCKER, P. and WADDINGTON, K, *The history of Bethlem* (London, 1992)

AYLMER, G. and TILLER, J. (eds), *Hereford Cathedral: a history* (London, 2000)

BAILEY, A., 'An account of the founding of the first Gloucestershire County Asylum, now Horton Road Hospital, Gloucester, 1792-1823', *Bristol and Gloucestershire Archaeological Society Transactions,* 40 (1971) pp. 178-191

BARRY, J. and JONES, C. (eds), *Medicine and charity before the welfare state* (London, 1991)

BARTLETT, P., *The Poor Law of lunacy: the administration of pauper lunatics in mid-nineteenth century England* (London, 1999)

BLAINEY, J. D., 'Dr Martin Dunne of Ludlow, 1740-1814', *TWNFC,* 36 (1971), pp. 271-283.

BLICK, D., *The Hereford and Gloucester canal* (Oxford, 1994)

BORSAY, A., *Medicine and charity in Georgian Bath: a social history of the General Infirmary, c. 1739-1830* (Aldershot, 1999)

BORSAY, A., ' "Persons of honour and reputation": the voluntary hospital in an age of corruption', *Medical History,* 35 (1991), pp. 203-210

BORSAY, P., *The English urban renaissance: culture and society in the provincial town, 1660-1760* (Oxford, 1989)

BRIGGS, A., 'Cholera and society in the nineteenth century', *Past & Present,* 19 (1961), pp. 76-96

BRUNDAGE, A., *The English Poor Laws, 1700-1930* (Basingstoke, 2002)

BRUNDAGE, A., 'Private charity and the 1834 Poor Law', in D. T. Critchlow and C. H. Parker (eds), *With us always: a history of private charity and public welfare* (London, 1998), pp. 99-119

BYNUM, W. F. and PORTER, R. (eds), Medical fringe and medical orthodoxy, *1750-1850* (London, 1987)

BYNUM, W. F. and PORTER, R. (eds), *William Hunter and the eighteenth-century medical world* (Cambridge, 1985)

CHERRY, S., 'The role of a provincial hospital: The Norfolk and Norwich Hospital, 1771-1880', *Population Studies,* 26 (1972), pp. 291-306

COHEN, I., 'The non-tidal Wye and its navigation', *TWNFC,* 35 (1956), pp. 83-101

COLLINS, W., *Modern Hereford* (Hereford, 1911)

COLLINS, W., *A short history of Hereford* (Hereford, 1912)

COOTER, R., (ed.), *Studies in the history of alternative medicine* (Basingstoke, 1988)

CORFIELD, P. J., *The impact of English towns, 1700-1800* (Oxford, 1982)

CREIGHTON, C., *A history of epidemics in Britain, Vol. 2.* (London, 1965)

CROSSKEY, P. H., 'Ledger book, 1821-1823, of Mr Delabere Walker, surgeon and physician of Bromyard', *TWNFC,* 40 (1971), pp. 277-279

DANIELS, S. and C. Watkins (eds), *The picturesque landscape: visions of Georgian Herefordshire* (Nottingham, 1994)

DANIELS, S. and C. Watkins, 'A well-connected landscape: Uvedale Price at Foxley', in Daniels and Watkins (eds), *Picturesque landscape,* pp. 40-44

DAUNTON, M. (ed.), *Charity, self-interest and welfare in the English past* (London, 1996)

DAUNTON, M., Introduction in Daunton (ed.), *Charity, self-interest and welfare*, pp.1-22

DAVIDOFF, L. and HALL, C., *Family fortunes: men and women of the English middle class, 1780-1850* (London, 1987)

DIGBY, A., *Madness, morality and medicine: a study of the York Retreat, 1796-1914* (Cambridge, 1985)

DIGBY, A., *Making a medical living: doctors and patients in the English market for medicine, 1720-1911* (Cambridge, 1994)

DIGBY, A., *Pauper palaces* (London, 1978)

DONNISON, J., *Midwives and medical men: a history of inter-professional rivalries and women's rights* (London, 1977)

DUREY, M., 'Medical elites, the general practitioner and patient power in Britain during the cholera epidemic of 1831-2', in INKSTER, I. and MORRELL, J., *Metropolis and Province: science in British culture, 1780-1850* (London, 1983), pp. 257-278.

DUREY, M., *The return of the plague, British society and the cholera, 1831-2* (Dublin, 1979)

ELLIOTT, N., *Dore workhouse in Victorian times* (Hereford, 1984)

FISSELL, M. E., *Patients, power and the poor in eighteenth-century Bristol* (Cambridge, 1991)

FISSELL, M. E., 'Readers, texts and contexts: vernacular medical works in early modern England', in Porter (ed.), *Popularisation of Medicine*, pp. 72-96

FLINN, M. W., 'Medical services under the New Poor Law', in Fraser (ed.), *The New Poor Law in the nineteenth century* (London, 1976), pp. 45-66

FORBES, T. R., 'The regulation of English midwives in the sixteenth and seventeenth centuries', *Medical History,* 8 (1964), pp. 235-244

FORSYTHE, B., MELLING, J. and ADAIR, R., 'The New Poor Law, and the county pauper lunatic asylum', *Social History of Medicine*, 9 (1996), pp. 335-355

FOUCAULT, M., *Madness and civilisation: a history of insanity in the Age of Reason* (London, 1971)

FRASER, D. (ed.), *The New Poor Law in the nineteenth century* (London, 1976)

FRENCH, R., and WEAR, A. (eds), *British medicine in an age of reform* (London, 1991)

GORSKY, M., 'The growth and distribution of English friendly societies in the early nineteenth century', *Economic History Review,* 51 (1998), pp. 489-511

GORSKY, M., *Patterns of philanthropy: charity and society in nineteenth-century Bristol* (London, 1999)

GOSDEN, P. H. J. H., *The friendly societies in England, 1815-1875* (Manchester, 1961)

GOSDEN, P. H. J. H., *Self-help: voluntary associations in the nineteenth century* (London, 1973)

GRANSHAW, L. and PORTER, R. (eds), *The hospital in history* (London, 1989)

GRUNDY, J. E., 'Population movements in nineteenth century Herefordshire', *TWNFC,* 48 (1986), pp. 488-500.

HADFIELD, C., *The canals of south Wales and the border* (Cardiff, 1960)

HAMLIN, C., 'Chemistry, medicine, and the legitimisation of English spas, 1740-1840', in Porter (ed.), *Medical history of waters and spas,* pp. 67-81

HARLEY, D., 'Provincial midwives in England: Lancashire and Cheshire, 1660-1760', in Marland, (ed.), *Art of Midwifery*, pp. 27-48

HILLABY, J., *The book of Ledbury: an essay in interpretation* (Birmingham, 1982)

HILLABY, J., *Ledbury, a medieval borough* (Logaston, 1997)

HODGKINSON, R. G., 'Poor Law medical officers of England, 1834-1871', *Journal of the History of Medicine,* 11 (1956), pp. 299-338

HODGKINSON, R. G., *The origins of the National Health Service: the medical services of the New Poor Law, 1834-1871* (London, 1967)

HOLMES, G. S., *Augustan England: professions, state and society, 1680-1730* (London, 1982)

HOWIE, W. B., 'The administration of an eighteenth-century provincial hospital: The Royal Salop Infirmary, 1747-1830', *Medical History,* 5 (1961), pp. 34-55

HUGHES, P. and HURLEY, H., *The story of Ross-on-Wye* (Logaston, 1999)

HURLEY, H., 'The forgotten Man of Ross: James Wallace Richard Hall, 1799-1860', *TWNFC*, 45 (1985), pp. 305-310

INNES, J., 'The 'mixed economy of welfare' in early modern England: assessments of the options from Hale to Malthus (c.1683-1803)', in Daunton (ed.), *Charity, self-interest and welfare*, pp. 139-180

JENKINS, R., 'Industries in Herefordshire in bygone times', *TWNFC, 22* (1938), pp.103-118

JONES, E. L., *Agriculture and the Industrial Revolution* (Oxford, 1974)

JONES, G. P., 'Cholera in Wales', *National Library of Wales Journal*, 10 (1958), pp 281-300

JONES, K., *Asylums and after: a revised history of the mental health services: from the early eighteenth century to the 1990's* (London, 1993)

JORDANOVA, L., 'The social construction of medical knowledge', *Social History of Medicine,* 8 (1995), pp. 361-381

LANDAU, N., *The justices of the peace, 1679-1760* (London, 1984)

LANE, J., ''The doctor scolds me': the diaries and correspondence of patients in eighteenth century England', in Porter (ed.), *Patients and practitioners,* pp. 205-248

LANE, J., 'The medical practitioners of provincial England in 1783', *Medical History,* 28 (1984), pp. 353-371

LANE, J., 'The provincial practitioner and his services to the poor, 1750-1800', *The Society for the Social History of Medicine,* 28 (1981), pp. 10-13

LANE, J., 'The role of apprenticeship in eighteenth-century medical education in England', in Bynum and Porter (eds), *William Hunter,* pp. 57-104

LANE, J., *A social history of medicine: health, healing and disease in England, 1750-1950,* (London, 2001)

LANE, J., *Worcester Infirmary in the eighteenth century* (Worcester, 1992)

LANGFORD, A. W. 'The history of Hereford General Hospital', *TWNFC,* 36 (1959), pp. 149-160

LANGFORD, A. W., 'Some Herefordshire medical history', *TWNFC,* 36 (1958) pp. 56-66

LANGFORD, P., *Public life and the propertied Englishman, 1689-1798* (Oxford, 1989)

LAWRENCE, S. C., 'Private enterprise and public interests: medical education and the Apothecaries' Act, 1780-1825', in French and Wear (eds), *British medicine in an Age of Reform*, pp. 45-73

LEWIS, J., *Three into one, the Three Counties Agricultural Society, 1797-1997* (London, 1997)

LOUDON, I. S. L., 'A doctor's cashbook, 1828-1831', *Medical History,* 27 (1983), pp. 249-268

LOUDON, I. S. L., 'The origin of the general practitioner', *Journal of the Royal College of General Practitioners'* (1983), pp.13-19

LOUDON, I. S. L., 'The origins and growth of the dispensary movement in England', *Bulletin of the History of Medicine,* 55 (1981), pp. 323-342

LOUDON, I. S. L., *Medical care and the general practitioner, 1750-1850* (Oxford, 1986)

LOUDON, I. S. L., 'Medical practitioners 1750-1850 and the period of medical reform in Britain', in Wear (ed.), *Medicine in society*, pp. 219-247

LOUDON, I. S. L., 'The nature of provincial medical practice in eighteenth-century England', *Medical History,* 29 (1985), pp. 1-32

LOUDON, I. S. L., 'The vile race of quacks with which this country is infected,' in Bynum and Porter (eds), *Medical fringe and medical orthodoxy,* pp.106-128

MACALPINE, I. and HUNTER, R., *George III and the mad-business* (London, 1969)

McCORD, N., 'The Poor Law and philanthropy' in FRASER (ed.), *New Poor Law*

McGREW, R. E., 'The first cholera epidemic and social history', *Bulletin of the History of Medicine*, 34 (1960), pp. 61-73

MARLAND, H. (ed.), *The art of midwifery: early modern midwives in Europe* (London, 1993)

MARLAND, H., 'Early nineteenth-century medical activity: the Huddersfield case', *Journal of Regional Studies,* 6 (1985), pp. 37-48

MARLAND, H., 'The medical activities of mid-nineteenth century chemists', *Medical History,* 31 (1987), pp. 415-439

MARLAND, H. and SWAN, P., 'Medical practice in the West Riding of Yorkshire from nineteenth-century census data' in *Essays in regional and local history in honour of Eric M. Sigsworth* (Hull, 1992), pp. 73-98

MARLAND, H., *Medicine and society in Wakefield and Huddersfield, 1780-1870* (Cambridge, 1987)

MELLING, J., 'Accommodating madness: new research in the social history of insanity and institutions', in Melling and Forsythe (eds), *Insanity, institutions and society,* pp. 1-30.

MELLING, J. and FORSYTHE, B. (eds), *Insanity, institutions and society, 1800-1914* (London, 1999)

MICHAEL, P., *Care and treatment of the mentally ill in North Wales, 1800-2000* (Cardiff, 2003)

MINGAY, G. E., *Land and society in England, 1750-1980* (London, 1994)

MITCHELL, B. R. and DEANE, P., *Abstract of British historical statistics* (Cambridge, 1962)

MITCHELL, D. J., 'Hereford in the Age of Reform, 1832-56', *TWNFC*, 44 (1982), pp. 91-114

MOIR, E., *The justice of the peace* (London, 1969)

MORGAN, F. C., 'Friendly societies in Herefordshire', *TWNFC,* 32 (1948), pp.183-211

MORRILL, S. A., 'Poor Law in Hereford, 1836-1851', *TWNFC,* 41 (1974), pp. 239-252.

MORRIS, R. J., *Cholera 1832: the social response to an epidemic* (London, 1976)

MORRIS, R. J., 'Voluntary societies and British urban elites, 1780-1850: an analysis', *Historical Journal,* 26:I (1983), pp. 95-118

NAMIER, L. B and BROOKE, J., *The history of Parliament: the House of Commons, 1754-1790* (London, 1964)

O'DONNELL, J., 'John Venn and the Hereford Society for Aiding the Industrious', *TWNFC*, 46 (1990), pp. 498-516

O'GORMAN, F., *Voters, patrons and parties: the unreformed electoral system of Hanoverian England* (London, 1989)

OWEN, D., *English philanthropy, 1660-1960* (London, 1965)

PANTALL, R., *George Jarvis (1704-1793) and his notorious charity* (Leominster, 1993)

PARRY-JONES, W. L., *The trade in lunacy: a study of private madhouses in England in the eighteenth and nineteenth centuries* (London, 1972)

PELLING, M., *Cholera, fever and English medicine, 1825-1865* (Oxford, 1978)

PICKSTONE, J. V., 'Dearth, dirt and fever epidemics: rewriting the history of British public health, 1750-1850', in Ranger and Slack (eds), *Epidemics and ideas,* pp.125-148

PICKSTONE, J. V., *Medicine and industrial society: a history of hospital development in Manchester and its region, 1752-1946* (Manchester, 1985)

PICKSTONE, J. V., 'Medicine in industrial Britain: the uses of local studies', *Social History of Medicine,* 2 (1989), pp. 197-203

PICKSTONE, J. V. and BUTLER, S. V. F., 'The politics of medicine in Manchester, 1780-1792: hospital reform and public health services in the early industrial city', *Medical History,* 28 (1984), pp. 227-249

PORTER, D., *Health, civilisation and the state* (London, 1999)

PORTER, R., *Health for sale: quackery in England, 1650-1850* (Manchester, 1989)

PORTER, R., 'The gift relation: philanthropy and provincial hospitals in eighteenth-century England', in Granshaw and Porter (eds), *The hospital in history,* pp.147-178

PORTER, R., 'Laymen, doctors and medical knowledge in the eighteenth century: The evidence of the *Gentleman's Magazine'*, in Porter (ed.), *Patients and Practitioners*, pp. 283-314

PORTER, R. (ed.), *The medical history of waters and spas* (London, 1990)

PORTER, R., *Mind forg'd manacles: a history of madness in England from the Restoration to the Regency* (London, 1987)

PORTER, R. (ed.), *Patients and practitioners: lay perceptions of medicine in pre-industrial society* (Cambridge, 1985)

PORTER, R. and PORTER, D., *Patients' progress: doctors and doctoring in eighteenth-century England* (Oxford, 1989)

PORTER, R. (ed.), *The popularisation of medicine, 1650*-1850 (London, 1992)

PROCHASKA, F. K., *Women and philanthropy in nineteenth-century England* (Oxford, 1980)

PROCHASKA, F. K., 'Philanthropy,' in THOMPSON, F. M. L. (ed.), *The Cambridge social history of Britain, 1750-1950* (Cambridge, 1990), pp. 357-393

RANGER, T. and SLACK, P. (eds), *Epidemics and ideas: essays on the historical perception of pestilence* (Cambridge, 1992)

REEVES, N. C., *The town in the Marches: A history of Leominster and its environs* (Leominster, 1973)

RENTON, C., *The story of Herefordshire's hospitals* (Logaston, 1999)

RISSE, G. B., 'Medicine in the age of Enlightenment', in Wear, (ed.), *Medicine in Society,* pp. 149-195

ROBERTS, G., *The shaping of modern Hereford* (Logaston, 2001)

ROSS, J., 'Hereford and cholera- why did we escape it', *Journal of the Royal College of Physicians of London,* 24 (1990), pp. 238-241

SCULL, A. T., *The most solitary of afflictions: madness and society in Britain, 1700-1900* (London, 1993)

SCULL, A., MACKENZIE, C. and HERVEY, N., *Masters of bedlam: the transformation of the mad-doctoring trade* (Princeton, 1996)

SHAW, W., *The Three Choirs Festival* (London, 1954)

SINCLAIR, J. B. and FENN, R. W. D., *The border janus: A new Kington history* (Kington, 1995)

SHOWALTER, E., *The female malady: women, madness and English culture, 1830-1980* (London, 1987)

SMITH, G., 'Prescribing the rules of health: self-help and advice in the late eighteenth century', in Porter (ed.), *Patients and practitioners*, pp. 249-282

SMITH, L. D., *Cure, comfort and safe custody: public lunatic asylums in early nineteenth-century England* (London, 1999)

STOCKINGER, V. R. (ed.), *The rivers Wye and Lugg navigation: a documentary history, 1555-1951* (Logaston, 1996)

THORNE, R.G., *The history of Parliament: the House of Commons, 1790-1820* (London, 1986)

THOMAS, K., *Religion and the decline of magic: studies in popular beliefs in sixteenth- and seventeenth-century England* (London, 1987)

THOMPSON, F. M. L. (ed.), *The Cambridge social history of Britain, 1750-1950* (Cambridge, 1990)

TOMLINSON, H., 'From restoration to reform, 1660-1832', in Aylmer and Tiller (eds), *Hereford Cathedral*, pp.109-155

WADDINGTON, K., *Charity and the London hospitals, 1850-1898* (London, 2000)

WALKER, C. W., 'Henry Graves Bull', *TWNFC,* 36 (1958), pp. 66-75

WALLIS, P. J. and WALLIS, R. V., *Eighteenth-century medics (subscriptions, licences, apprenticeships* (Newcastle-upon-Tyne, 1988)

WEAR, A., (ed.), *Medicine in society: historical essays* (Cambridge, 1992)

WHITEHEAD, D., 'The architectural history of the Cathedral since the Reformation', in Aylmer and Tiller (eds), *Hereford Cathedral*, pp. 255-275

WILLIAMS, P., *Bromyard, minster, manor and the town* (Leominster, 1987)

WILLIAMS, R., 'Reflections on a doctor's day book', *Transactions of the Radnorshire Society*, 35 (1976), pp. 5-9.

WILLIAMS, W. R. *Herefordshire members, 1213-1896* (Brecon, 1896)

WILSON, A., 'Conflict, consensus and charity: politics and the provincial voluntary hospitals in the eighteenth century', *English Historical Review*, 111 (1996), pp. 599-619

WILSON, A., *The making of man-midwifery: childbirth in England, 1660-1770* (Cambridge, 1995)

WILSON, P., 'Acquiring surgical know-how: occupational and lay instruction in early eighteenth-century London', in Porter (ed.), *Popularisation of medicine,* pp. 42-71

WOHL, A. S. *Endangered lives: public health in Victorian Britain* (London, 1983)

WOODWARD, J., *To do the sick no harm: a study of the British voluntary hospital to 1875* (London, 1974)

UNPUBLISHED THESES

BERRY, A., 'Patronage, funding and the hospital patient, c. 1750-1815: three English regional case studies' (unpublished doctoral thesis, University of Oxford, 1995)