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The Provision of Health Care Under the Scottish Poor Law: Urban Central Scotland in the Late Nineteenth Century[1]

John Stewart

This article examines the provision of health care by Scottish Poor Law authorities in urban areas in central Scotland in the latter part of the nineteenth century. It utilises material from a number of towns and cities, and places this in the appropriate national context. The historiography of the Scottish Poor Law is also discussed. The article has two overarching aims. First, it seeks to contribute to our understanding of the Poor Law in Scotland, and especially its medical services, which is still a rather neglected field of study. Second, it highlights the problems involved in engaging with Poor Law records while also drawing attention to the richness, or potential richness, of the material to be found therein. The piece concludes by urging the need for further research in this area so that a more nuanced picture of the Scottish Poor Law may be arrived at than presently exists.

This article builds on recent work on the operation of the Scottish Poor Law, and particularly its medical services, in urban areas.[2] It also incorporates material drawn from a range of archives and record offices across central Scotland and from printed primary sources. For readers of this journal it is especially important to point out some of the problems facing historians of social welfare in nineteenth- and twentieth-century Scotland, both urban and rural. First, surviving archival material often affords only very patchy coverage.

[1] This article is based on a paper given to the SRA Conference in Perth, November 2016. I am grateful for the comments it elicited, for the Editor's invitation to submit a revised version, and for the helpful comments of an anonymous referee for this journal. Initial research was carried out with the support of a grant from the Carnegie Trust for the Universities of Scotland.

[2] See, for example, A. Gestrich and J. Stewart, 'Unemployment and Poor Relief in the West of Scotland, 1870–1900', in (ed.) S. King and J. Stewart, *Welfare Peripheries: The Development of Welfare States in Nineteenth and Twentieth Century Europe* (Bern, 2007), 125–48; J. Stewart, 'The Provision and Control of Medical Relief: Urban Central Scotland in the Late Nineteenth Century', in (ed.) M. Freeman, E. Gordon and K. Maglen, *Medicine, Law and Public Policy in Scotland, c.1850–1990: Essays Presented to Anne Crowther* (Dundee, 2011), 10–26; D. Sutton, 'Charity Dispensaries, Medical Education and Domiciliary Medical Care for the Poor in Edinburgh and Glasgow, *c.*1870–1914', in (ed.) Freeman *et al.*, *Medicine, Law and Public Policy in Scotland*, 27–48; D. Sutton, 'The Public–Private Interface of Domiciliary Medical Care for the Poor in Scotland, *c.*1875–1911' (unpublished PhD thesis, University of Glasgow, 2009).

This is particularly true of the Scottish Poor Law in the nineteenth and early twentieth centuries since the units of administration were in many cases highly localised and often, thereby, very small. It is also the case that a lot of welfare material has simply been destroyed by local authority administrators anxious to find space for more up-to-date records. And, of course, there is in Scotland the particularly acute issue of social welfare in remote areas. Some years ago Stephanie Blackden made an important start to describing and analysing provision in the Highlands and Islands while more recently scholars such as Annie Tindley and Pat Whatley have further added to our body of knowledge in this particular respect.[3] Nonetheless, rural Scotland remains a challenge for historians of Poor Law medical services, although in general terms it seems clear that outside major urban areas provision was, at best, limited.

Two further points: first, a certain amount of diligence and persistence is often required to track down Poor Law records. So, for instance, those pertaining to Greenock are to be found not in Greenock, but in Glasgow. And for Stirling, relevant archival material is in some cases located not in local authority records, where one would expect to find them, but in a deposit by a local solicitor. Such records as do survive at a local level and which can be accessed are often unused or under-used. On the other hand, correspondence with the central authorities, held at the National Records of Scotland (NRS), is often a rich resource for those seeking information on particular localities. Second, anyone embarking on Scottish welfare history will find that even now it is not well served in the secondary literature for reasons that almost certainly reflect the focus of historians of Scotland on other, apparently more exciting, research themes. The situation has to some extent begun to change but the field nonetheless remains an open one.[4]

[3] S. Blackden, 'The Board of Supervision and the Scottish Parochial Medical Service, 1845–95', *Medical History*, 30, no. 2 (1986), 145–72; idem, 'From Physicians' Enquiry to Dewar Report: A Survey of Medical Services in the West Highlands and Islands of Scotland, 1852–1912', Parts I and II, *Proceedings of the Royal College of Physicians of Edinburgh*, 28 (1998), 51–66, 207–17; A. Tindley, '"Actual Pinching and Suffering": Estate Responses to Poverty in Sutherland, 1845–86', *Scottish Historical Review*, 90, no. 2 (2011), 236–56; P. Whatley, 'The Development of Medical Services in the Highlands and Islands of Scotland, 1843–1936' (unpublished PhD thesis, University of Dundee, 2014); P. Whatley, '"A Full State Medical Service": The Development of Medical Services in the Highlands and Islands, 1845–1936', in (ed.) E. W. Cameron and A. Tindley, *Dr Lachlan Grant of Ballachulish, 1871–1945* (Edinburgh, 2015), 23–36.

[4] One of the best accounts of social welfare in Scotland prior to 1914 remains A. Crowther's 'Poverty, Health and Welfare', in (ed.) W. H. Fraser and R. J. Morris, *People and Society in Scotland: Volume II, 1830–1914* (Edinburgh, 1990), 265–89. See also A. Paterson, 'The Poor Law in Nineteenth-Century Scotland', in (ed.) D. Fraser, *The New Poor Law in the Nineteenth Century* (Basingstoke, 1976), 171–93. For a case study of health-care provision in Glasgow, see S. Blackden, 'The Poor Law and Health: A Survey of Parochial Medical Aid in Glasgow, 1845–1900', in (ed.) T. C. Smout, *The Search for Wealth and Stability: Essays*

This article thus has two principal aims. First, it seeks to illustrate the nature of Poor Law medical provision using material pertaining to major urban centres in central Scotland to give a broad overview of the services available (and not available). A number of common themes emerge although the diversity of policy and practice is also emphasised. Second, it seeks to encourage research and publication by other scholars by suggesting both the need for more investigation of Poor Law medical services while demonstrating the potential richness of, especially, local archival holdings.

So what can we say about Poor Law medical relief in the last part of the nineteenth century in urban Scotland? Some background first. If you fell ill in the latter part of the nineteenth century in Scotland your access to treatment depended primarily on your socio-economic status but your age, gender and place of dwelling might also have important parts to play. If you were well off, you could purchase medical services or, increasingly, insurance. Or if you were a member of a skilled trades union, for instance, such organisations would often operate a form of sickness insurance so that the services of a doctor or hospital admission could be obtained.[5] These various insurance schemes were the model for the 1911 National Insurance Act which introduced state-supported sickness benefits for the first time. Another avenue which might be open to you was to use the facilities, especially the outpatient facilities, of what were called voluntary hospitals. These were institutions such as the royal infirmaries in Glasgow and Edinburgh whose income derived from charitable and voluntary donations and from subscriptions. The most eminent of the voluntary hospitals, the Glasgow and Edinburgh royal infirmaries being notable cases in point, were also, in close association with the universities, teaching hospitals where medical students learned their trade.[6]

But if you could not access any of these services then in all likelihood your only resort was to the medical care provided under the terms of the reformed Scottish Poor Law. You would thus become one of the sick poor, or pauper sick. And if you happened to die while in the care of the Poor Law authorities, your body might find itself being used in Scotland's medical schools. In Leith in 1905, for instance, it was agreed to 'grant the request by Professor Cunningham, Edinburgh University, for bodies of unclaimed paupers for use in the training of students in anatomy and surgery'.[7] The practice of selling corpses to medical schools by Poor Law authorities had been formally established by the Anatomy

in Economic and Social History Presented to M. W. Flinn (London, 1979), 243–62. On the Poor Law prior to reform, see R. Mitchison, *The Old Poor Law in Scotland: The Experience of Poverty, 1574–1845* (Edinburgh, 2000).

5 For an account of such schemes, which utilises some Scottish sources, see J. C. Riley, *Sick, Not Dead: The Health of British Workingmen during the Mortality Decline* (Baltimore, 1997).

6 See M. A. Crowther and M. W. Dupree, *Medical Lives in the Age of Surgical Revolution* (Cambridge, 2007) which devotes considerable attention to both Edinburgh and Glasgow.

7 Edinburgh City Archives (hereafter ECA), SL 21/210, Minutes of Leith Parish Council, 9 January 1905.

Act of 1832, passed in the wake of the Burke and Hare scandal in Edinburgh and much loathed and feared by the poor themselves.[8]

So more specifically, what did the Scottish Poor Law look like after reform in the mid-1840s, reform which had been prompted in large measure by the distress experienced in one of the urban locations that feature in this study, Paisley?[9] Under the terms of the 1845 Act the administration of poor relief shifted to local, elected bodies. These went under various names, so in what follows they are simply referred to as 'the local authority' (or, occasionally, 'parish'). The Act also required, for the first time, that such bodies provide for the sick poor. As noted, there was a high level of disaggregation in the Scottish Poor Law with a large number of local authorities administering the system, particularly when compared with England and Wales.[10] Although these Scottish bodies might combine, for example, to build institutions such as poorhouses (as in 'Combination Poorhouse'), or later, hospitals, nonetheless this highly localised system meant that it was, in principle, acutely sensitive to local opinion. This was important not least because the source of revenue for these local authorities was a form of local taxation – the poor rates. Ratepayers and local authority officials were, as we shall see, keen to keep such taxes as low as possible and this could be a constraint on any expansion of local medical services beyond the bare minimum.

A further difference with the system in England and Wales was that in Scotland relief was not available to the able-bodied – the disqualification rule. This explains the variation in nomenclature since south of the border inmates of workhouses were, as the name would suggest, required to work if fit to do so. In principle, this was not the case in Scotland. Leaving aside its inherent harshness given the volatile nature of the late-nineteenth-century labour market with its frequent spasms of widespread unemployment, the disqualification rule also had medical implications in that it frequently placed on doctors the responsibility of deciding whether or not an individual was fit to work – if so, no relief could legally be given. Understandably, this led to a certain amount of criticism from doctors themselves who pointed out that if the able-bodied were not relieved then they would soon become disabled because of the impact of malnourishment. As Dr Hugh Thomson told a gathering of the medical profession in 1876, there was 'no doubt' that 'the principle of the Poor Law in Scotland is to do for the poor as little as possible'. Acknowledging that any scheme would have its pitfalls, he nonetheless concluded that the 'community should specially charge themselves with the care of the sick poor, commensurate with existing wants'.[11]

It is worth noting that some local authorities likewise publicly questioned the merits of the disqualification rule and its underlying philosophy. In 1876

8 R. Richardson, *Death, Dissection and the Destitute*, 2nd edn (London, 2001).

9 T. C. Smout, 'The Strange Intervention of Edward Twistleton: Paisley in Depression, 1841–3', in (ed.) Smout, *Search for Wealth and Stability*, 218–42.

10 See A. Brundage, *The English Poor Laws, 1700–1930* (Basingstoke, 2002).

11 Quoted in *The Glasgow Medical Journal*, 5, no. 7 (April 1876), 273.

Glasgow's City Parish medical committee engaged in a long discussion – partly inspired by a report by Glasgow's reforming medical officer of health, James Russell – on poor law medical relief. 'No political economist', the committee argued, 'has ever maintained that it is to be desired that sickness alone should be permitted to drive the sick into the region of pauperism'.[12] But for its supporters, disqualification simply recognised the 'spirit of self-reliance … characteristic of Scotch character' and legally this attitude prevailed, criticisms and complaints notwithstanding.[13]

Partly as a result of the rule, Poor Law relief in Scotland was overwhelmingly outdoor relief – that is, received in the claimant's home. Depending on where such claimants lived, this might also include medical relief. Occupants of the poorhouse were thus those who were, for whatever reason, unable to look after themselves. As noted, the able-bodied, however impoverished, could not be admitted. So in some of the larger institutions, what were effectively hospital wards were set aside for the sick and these might in time develop into separate hospitals. It was, moreover, a requirement of all poorhouses that a medical officer be employed.

The previous point notwithstanding, yet another difference with England and Wales existed. There were relatively few poorhouses in Scotland so, whereas south of the border Poor Law hospitals often had their origins in workhouses, there were in reality fewer opportunities for such a development in Scotland. But, as we shall see, some of the larger local authorities were nonetheless innovative in hospital building and refurbishment. One final general point: at the national level, responsibility for the Poor Law was held by a body which, again in the interests of clarity, is simply referred to in what follows as the 'central authority'. Whatever name is used, this body was stretched in terms of staff numbers and the amount of scrutiny it could give to local authorities was limited. And it is notable that only after reorganisation in the 1890s did it actually have a medically qualified member. As the Secretary of State for Scotland, Sir George Trevelyan, rather defensively noted during the appropriate parliamentary debate, it was 'high time that on a body which superintends the public health in Scotland a representative of medical and sanitary science should find a place'.[14]

What, then, actually happened with respect to Poor Law medical care in the latter part of the nineteenth century? One very obvious consequence of

[12] Glasgow City Archives, Mitchell Library, Glasgow (hereafter GCA), D-HEW 1/5/3, Minutes of the Medical Committee, City Parish, 1 May 1876. On Russell, see E. Robertson, *Glasgow's Doctor: James Burn Russell, 1837–1904* (East Linton, 1998).

[13] *Report by the Committee Appointed in November, 1885, by the Lord Provost and Magistrates of Glasgow to Deal with the Relief of the Unemployed in the City, and to Administer the Relief Fund during the Winter of 1885–6* (Glasgow, ?1886), 4 (Mitchell Library, Glasgow, Miscellaneous Pamphlets, Reference MP 14.906).

[14] British Parliamentary Papers (hereafter BPP), Parliamentary Debates, Fourth Series, XXII, 27 April 1894, col.1616.

the provisions of the 1845 Act was that expenditure on medical relief went up more than tenfold between 1846 and 1900. From the point of view of the individual recipient of medical relief, this meant that whereas in 1846 less than one shilling was expended per pauper relieved, by 1900 this had risen to almost eleven shillings.[15]

We can get a sense of what such apparent advances had been made at local level from an official enquiry into Scotland's Poor Law medical services early in the twentieth century. On a positive note, the Clerk to the Parish of Glasgow, who was also its Inspector of the Poor, told the enquiry that, in his view, the 'improvements in the general administration of medical relief to the sick poor at present being carried out in the parish of Glasgow' were in 'advance of anything yet attempted in Scotland'. As evidence, he cited the building of two district hospitals 'for acute and immediate causes of illness'; a 50-bed ward for 'advice and treatment of alleged causes of insanity'; a general hospital dealing with the chronic sick, the disabled and children, which also had 'specially-equipped wards for consumptive cases'; and the retention and renovation of Barnhill Poorhouse to deal with 'the care of the ordinary poor, including the vagrant class'.[16] Of course this official was hardly going to run down his own city and its Poor Law medical provision, but even so this was a fairly impressive catalogue of achievement which suggests that Glasgow saw itself as in the vanguard of health care for the sick poor.[17]

The actual report of the committee, though, painted a rather less rosy picture when it was published in 1904. Among its many recommendations for improvement, it stated that in poorhouses the sick should be 'accommodated (1) in rooms apart from those for the other inmates, and (2) where practicable, in a building detached from the poorhouse proper'. What this meant was that while such conditions might prevail in Glasgow, they clearly did not in other parts of the country. Similarly, it was suggested that in poorhouses accommodation should be improved by increasing the space available per bed and by 'providing sufficient beds to accommodate inmates requiring hospital treatment'. Again, the clear implication is that the number of beds, and the space they occupied and thereby the degree of privacy enjoyed by patients, was inadequate in parts of Scotland. Turning to outdoor relief, the report suggested that the 'appointment of medical officers should be required by statute' and that the central authority should have greater control over the provision of medical relief at parish level. So, once more it is evident that some parishes were not employing medical officers and were not legally required to do so,

15 BPP 1904, XXXIII, *Report of the Departmental Committee on Poor Law Medical Relief (Scotland), II: Minutes of Evidence, Cd.2022*, Appendix LVI.

16 Ibid., 59, Q.1963.

17 This should also be placed in the broader context of Glasgow as a 'progressive' city when it came to public action: H. Fraser, 'Municipal Socialism and Social Policy', in (ed.) R. J. Morris and R. Rodger, *The Victorian City: A Reader in British Urban History, 1820–1914* (London, 1993), 258–80.

their more general obligation to take care of the sick poor notwithstanding. The second issue, the suggested need for more central control, is witness to an ongoing struggle between local authorities and the central authority.[18]

Part, although not all, of this was about money. In broad terms, the central authority wanted improved services while the local authorities, albeit in some cases receptive to this idea, were nonetheless aware that they were directly accountable to their local taxpayers. This was not, in fact, the whole story because in 1848 a Medical Relief Grant had been set up, controlled by the central authority. The purpose of this grant was to provide for medical officers' salaries and, later, to improve the quality of nursing. Local authorities had to meet certain eligibility criteria and there was a constant campaign by them to raise the level of the Grant and, thereby, the volume of money available. This too contributed to the tensions between central and local bodies characteristic of the period with which this article deals.[19]

A few years later another official report of 1909 pointed to further problems with medical relief under the Scottish Poor Law. So, for instance, over one-third of poorhouses had no trained nurses, with pauper inmates themselves taking on this role. Such practice was, in fact, very common and in this respect the report noted, 'Scotland is greatly behind England and Ireland, where pauper nursing was prohibited' in the late 1890s. The report also suggested that medical relief, at least in the large Scottish towns, was probably adequate but that in part this was due to the existence of medical charities and to services provided for free by private practitioners. The public sector was, in other words, being crucially supplemented by voluntary agencies and individual philanthropy. And it was also noted that although medical relief carried no legal stigma, unlike other forms of Poor Law relief, nonetheless its very association with the Poor Law deterred 'self-respecting poor persons from applying, and that owing to this delay some cases have become incurable'.[20] So despite the purported aims of the 1845 Act it is apparent that some 50 years later Poor Law medical relief was still patchy and in certain places blatantly inadequate. So what do we find when we go down to more specific localities? What follows is highly selective while seeking to give some idea in broad terms of how local authorities dealt with the vexed and challenging issue of medical relief.

St Ninian's was a parish adjacent to Stirling and was partly rural, partly industrial. In 1881 its local authority agreed to subscribe the sum of two guineas to the Stirling Royal Infirmary. This was a tactic commonly employed by local authorities, the idea being that voluntary hospitals such as Stirling Royal would then admit sick paupers in need of hospital treatment. This though did not

[18] BPP 1904, XXXIII, *Report of the Departmental Committee on Poor Law Medical Relief (Scotland), I, Cd.2008*, 97–100.

[19] See Stewart, 'The Provision and Control', *passim*.

[20] BPP 1909, XXXIII, *Royal Commission on the Poor Laws and Relief of Distress: Report on Scotland, Cd.4922*, 148, 152.

work out, for two years later the Infirmary informed the local authority that henceforth it would charge that body one shilling and sixpence per day for any pauper admitted. St Ninian's immediately withdrew its subscription, intimating that it would not take any responsibility for paupers admitted to the Infirmary without its explicit consent.[21] A similar decision, although the reasons in this instance are less clear, was taken by the local authority in Edinburgh when, on the recommendation of its medical committee, it declined to subscribe to the Edinburgh Royal Maternity Hospital.[22] So here we have examples of co-operation, or lack of co-operation, between the public and voluntary sectors, an issue which was to plague health-care provision until the advent of the National Health Service.

As noted, there were tensions throughout the period between the central and the local authorities. In 1885 the Lanark authority was forcefully urged by the central authority to enable the building of a fever hospital and not least to isolate potential sufferers from cholera. This was eventually, but reluctantly, agreed and a site for the proposed hospital duly identified. But the issue rumbled on for several years with ongoing disagreements about who exactly was going to pay for the new building.[23] Although its significance was beginning to decline by the late nineteenth century, cholera was one of the major killers in nineteenth-century Britain, and Lanark's reluctance to act suggests financial rather than medical priorities.[24]

The employment of properly trained nurses was another area of conflict. Paisley's Abbey parish was reprimanded by a visiting officer from the central authority who had noted that there were just over 100 'sick and bedridden persons' in the poorhouse. He therefore found it 'surprising' that the local authority had not responded to a circular from the central authority 'by engaging at least five trained nurses'. The Abbey poorhouse committee, by contrast, found this suggestion 'impracticable' as it felt that 'there is not sufficient employment from the nature of the sick and infirm to engage the attention of an additional Staff of Nurses'. Crucially, the 'expense upon the Ratepayers they consider not justifiable'.[25] A further instance then of local accountability

[21] Stirling Council Archives (hereafter SCA), XA 2/1/3, Minutes of the Statutory Half Yearly Meeting of St Ninian's Parochial Board, 13 June 1881 and Minutes of the Ordinary Monthly Meeting of the General Committee of St Ninian's Parochial Board, 30 April 1883.

[22] ECA, SL 8/1/7, Minutes of a Meeting of the Edinburgh Parochial Board, 21 July 1873.

[23] GCA, CO1/46/3, Minutes of the Statutory Half Yearly Meeting of the Parochial Board of Lanark, 5 February 1885; Minutes of an Adjourned Meeting of the Parochial Board of Lanark, 1 September 1885; Minutes of the Annual Meeting of the Parochial Board of Lanark, 3 November 1887.

[24] On cholera, for a recent analysis and guide to the literature, see P. K. Gilbert, *Cholera and Nation: Doctoring the Social Body in Victorian England* (New York, 2008).

[25] Paisley Central Library: Reference and Local Studies Library (hereafter PCL), B.57 7/10, Abbey Parochial Board Poorhouse Committee Minute Book, 1879–86, Minutes, 1

and a local authority's reluctance thereby to raise taxes. Paisley as a town was clearly resistant to inspectors' recommendations in such areas. In 1878, two years before the unsuccessful cajoling of Abbey Parish, neighbouring Paisley Parish had itself received an inspector's report which noted of its poorhouse that the 'sick and bedridden inmates are numerous', and so the appointment of 'a highly trained nurse to superintend the Hospital' and to instruct trainees 'would be a commendable measure in the interests of the whole parish'. But in the ensuing discussion on the poorhouse committee it was suggested that the existing nursing provision was adequate and thus 'it was agreed meantime not to disturb the existing arrangements'.[26]

Nurses, or the lack of them or their limitations, were not the only type of staffing problem. In 1872 a committee of the City Parish in Glasgow noted the case of a Dr Forbes, who was accused of being 'irregular in attendance and remiss in his duties' towards the sick poor. It was agreed that he should be removed from office although he was also given the choice to resign, which he duly did.[27] This is but one example of the considerable powers local authorities held over their medical staff. The latter were often employed on a yearly basis, subject to renewal, and cases of doctors being summarily dismissed are not unknown. Many of these doctors held other posts, but being a Poor Law medical officer, and especially a resident poorhouse doctor, was to be on a very low rung of the medical hierarchy and thereby relatively powerless. Given the production line that was Scottish medical schools, training as they did more doctors than were required in Scotland itself, local authorities were, however, generally not short of applicants for the posts.

Salaries too were decided locally, although central authority approval was required for any alteration. Dr Moorhouse, medical officer to the Stirling Combination Poorhouse, applied for a salary raise in 1909. The local authority made enquiries as to what was paid to those in poorhouses of a similar size to Stirling's, this being usual practice in such cases, and it was accordingly agreed to raise Moorhouse's annual remuneration by £10, to £70.[28] And as noted earlier, doctors were under pressure to ensure that the able-bodied did not receive relief. The 1904 report suggested that on admission to a poorhouse inmates should be classified 'as regards their physical condition and capacity for work', and that better arrangements 'should be made for the discharge of inmates that may have become able-bodied'.[29]

June and 29 June 1880.

26 PCL, B.57 7/30, Paisley Parochial Board Committee Minute Book, 1875–84, Minutes of the Poorhouse Committee, 16 April 1878.

27 GCA, D-HEW 1/5/2, City Parish, Glasgow: Minute Book of the Sanitary Committee, No. 2. Minutes of the Medical and Sanitary Committee, 23 October and 29 October 1872.

28 SCA, Hill and Robb, Solicitors, Deposit, Minutes of a Meeting of the House Committee, 22 July 1909.

29 BPP 1904, XXXIII, *Report on Poor Law Medical Relief (Scotland)*, I, 98.

Life for patients in poorhouse wards was often far from comfortable, as the official reports cited earlier would suggest, and sometimes compounded by neglect. A subcommittee was set up in Greenock in the mid-1880s to investigate complaints about the neglect of pauper hospital patients. The matron was found guilty of not acknowledging the proper role of one of her nurses, refusing to co-operate in this matter with her superior and, of most immediate consequence for the inmates, 'failing to have a sufficient supply of bed and body clothing in the Infirmary store for the Infirmary patients'. To its credit, the local authority appears to have acted quickly on this issue, seeking help from the central authority to sort out the matter.[30] A complainant to the central authority, meanwhile, claimed that while in Govan Combination Poorhouse he had been placed with the ordinary inmates despite his need for hospital treatment. He had consequently left the poorhouse so as to be treated at the Western Infirmary.[31] Such complaints were not uncommon, suggesting a willingness on the part of at least some of the pauper sick to dispute their treatment.

One particular challenge which local authorities faced, and one shared with Poor Law systems throughout the United Kingdom, was the rapid rise in the number of those classified as 'pauper lunatics'. The Monifieth local authority noted in the mid-1890s that over 20 per cent of its paupers were 'lunatics' and that lunacy was 'becoming an increasingly heavy burden'.[32] Nor was this inexpensive. The Leith authority recorded in 1896/97 that its total expenditure on poor relief had been just over £14,500, of which the single largest item, at just over £4,000, had been 'Lunacy Provision'.[33]

So to summarise so far, what we have seen is evidence of the problems faced in the provision of medical relief under the terms of the Scottish Poor Law. There were issues over staffing, over patient care and, as far as the central authority was concerned, over the lack or inadequacy of provision in some parts of the country with, as has been suggested, remote rural areas suffering particularly badly although there were clearly issues in urban areas as well. Financial restraint often lay behind these problems. And, of course, the system was meant to be basic and not necessarily very sophisticated. As is often the case in welfare history, it might be correctly inferred that poor people received

30 GCA, CO2/22/4, Minutes of the Greenock Poorhouse Committee – Sub-Committee on Neglect of Infirmary Patients, 30 January 1885 and Minutes of a Special Meeting of the Committee of Management, 10 February 1885.

31 NRS, HH 23/20, Minutes of the Board of Supervision for the Relief of the Poor in Scotland, 4 February 1885.

32 Dundee City Archives (hereafter DCA), P/D/4/1/1/(3), Minutes of a Joint Meeting of Parochial Board and Town Council, Monifieth, 9 May 1895.

33 ECA, SL 21/2/1, Leith Parish Council, Minutes of Law and Finance Committee, 1 July 1897, Table of Income and Expenditure. On the issue of lunacy and the Poor Law in nineteenth-century Scotland, see L. Farquharson, 'A "Scottish Poor Law of Lunacy"?: Poor Law, Lunacy Law and Scotland's Parochial Asylums', *History of Psychiatry*, 28, no. 1 (2017), 15–28.

a poor service. But this is not necessarily the whole story. We saw earlier that expenditure on Poor Law medical services increased consistently over the latter part of the century. We have also seen that in Glasgow claims were made about significant improvements in, especially, hospital accommodation. So were there any further examples of improvement and innovation? Again, these examples are selective but they do illustrate certain key points.

The Edinburgh local authority, although not always in the vanguard of progress, nonetheless made coherent attempts to improve its poorhouse medical facilities. In 1888 a specially appointed committee reported that positive changes had already been achieved but it also made six points which it felt would reap further benefit. These included the proposal that a 'thoroughly qualified nurse should be appointed as Head Nurse', and in view of the importance of 'having nurses thoroughly qualified, as well as of good character and kindly disposition, and in order that the fullest enquiry may be made in regard to them', then all applicants should be fully investigated and personally interviewed before any appointment was made to a nursing post. These moves were in response, it has to be said, from circulars from the central authority but it is clear that they were taken seriously. The committee's recommendations were subsequently approved.[34]

In Dundee, meanwhile, pressure from both the central authority and from overcrowding in the city's poorhouses led to the building of The New Hospital in the early 1890s. It was acknowledged that the decision to go ahead with this project had been delayed because of concerns, on behalf of the ratepayers, about large-scale expenditure. But it had become apparent that any further delay might have 'very serious consequences'. Building commenced in spring 1891 with the first patients being admitted on Christmas Day, 1893. When completed, the hospital had beds for 320 patients as well as accommodation for the resident medical officer, sixteen nurses and two other members of staff. The local authority was clearly proud of its achievement, and although it has to be taken into account that the following statements came from an interested party, they are nonetheless revealing about what this particular Poor Law body thought it was doing. The hospital was, the latter had been led to believe, 'quite unique in Scotland, both as regards its Architectural arrangement, and the equipment of the wards'. From the point of view of the authority itself, the:

> splendid buildings are fulfilling in an admirable manner the humane purpose for which they were designed, and the indoor sick poor of the Combination are now being treated under conditions which are, we venture to think, creditable alike to the Parochial Board and the community at large.[35]

[34] ECA, SL 8/1/9, Minutes of a Sub-Committee of the Medical Committee of the Parochial Board of Edinburgh, 13 March 1888; and Minutes of the House Committee, 21 March 1888.

[35] DCA, P/D/1/19, Minutes of a Statutory Meeting of the Parochial Board of the Dundee Combination, 14 August 1894, Appendix 1.

The last point, about the hospital being a credit to the 'community at large', is noteworthy. From a modern perspective it is tempting to see the medical provision of the Scottish Poor Law in the nineteenth century as cruel, squalid and underresourced, and there is plenty of evidence for such a standpoint. On the other hand, the case of The New Hospital in Dundee also suggests that a form of civic pride could be taken in welfare institutions and that this was backed up by financial investment. Dundee, it seems to be saying, is a city that looks after its sick poor.

As suggested, this has been a snapshot of certain aspects of the medical services of the Scottish Poor Law in the late nineteenth century. Nonetheless, certain points are clear. First, the sort of treatment a sick pauper might receive was dependent primarily on where they lived, and the level of commitment shown by their local authority. In certain urban areas, local authorities went beyond the provision of a basic minimum and displayed a sense of civic pride in doing so, particularly with respect to large-scale projects such as hospitals. These very public buildings, it was clearly felt, said something positive about local authorities, their humanity and their commitment to the pauper sick. Second, and by contrast, sensitivities about the reaction of ratepayers might inhibit local action even in the face of pressure from the central authority which had in any event highly limited powers of enforcement and in most circumstances had to rely on persuasion and cajoling. The resistance by some authorities to the provision of properly trained nurses is an especially striking case in point. The very structure of the Scottish Poor Law, meanwhile, meant that the able-bodied were denied relief which might have saved money, but also could and did lead to unnecessary deprivation and ill health.

Third, until now the issues outlined in the previous point have tended to dominate our perceptions of the working of the Scottish Poor Law from the time of its reform in 1845 onwards. The widely held view that the system was cruel and heartless is not necessarily unjustified and, as suggested earlier, it can undoubtedly be seen in large parts of the country as being a poor welfare service for poor people. But as repeatedly noted, coverage varied over Scotland as a whole with some places performing in a significantly more supportive way than others. And this leads to the final point, a further call for more research on the Scottish Poor Law in general and its medical provision in particular. It was suggested at the outset that not all records which might have survived have done so. There are, nonetheless, both printed sources and local (and indeed national) archival materials that remain unexploited or under-exploited, and which provide a rich resource for historians of Scottish welfare and thereby of Scottish society more broadly.