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THE POOR MAN'S DOCTOR: THE RISE AND FALL OF THE DISPENSARY SYSTEM IN ULSTER

by

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SOME years ago when about to enter the new Holywood Arches Health Centre, I became interested in the origins of general practice in East Belfast.

The earliest name I could discover in the street directories of the last century was that of Doctor James Murray. He had been appointed by the Grand Jury of Down in 1839 to a small dispensary at Bridge End, having received degrees in surgery and medicine from the University of Glasgow and obtained further experience as a temporary physician in the Belfast Fever and Cholera Hospital. Here he lived and practised until his death on the 2nd of February 1862. His original contract had enjoined him to be present at the dispensary for two hours each day to attend to the needs of the sick poor among a population who numbered approximately six thousand. Since no other medical name appeared in the streets of East Belfast until after Doctor Murray's demise I was struck by the endurance of this dispensary doctor.

Why did James Murray and many like him decide to practise among the poorest members of the community, ravaged by smallpox, cholera, dysentery, fever and blindness in addition to all the minor disorders which we see today? Even more interesting was the spirit of philanthropy (or was it ultimate financial gain?) which led landlords, merchants and grand juries to create the first dispensaries throughout Ireland, albeit in a haphazard manner, more than two centuries ago.

I soon realized that if poverty was the *raison d'être* of the dispensary patient a sizeable proportion of my own practice would have fulfilled the requirement and I

would have been a dispensary doctor with possibly a small number of private patients to make life economically tolerable. And yet I knew nothing about the dispensary system since the arrival of the National Health Service had replaced it, along with virtually all other forms of general practice, in the year in which I commenced my medical studies at Queen's. Subsequently as junior house officers we were amused by odd comments from senior colleagues who had recently laboured under the system and were glad to be rid of it, along with boards of guardians, relieving officers and white and red tickets. It was difficult to believe that they were referring to an important sector of an Irish health service which was more advanced than in England and one of the most advanced in Western Europe in the first half of the 19th Century according to at least one historian addressing a local medical audience as recently as 1968.²

The principle of a doctor providing constant medical care to people in the same geographical area for a lengthy period of time, which tends to occur only in these islands and is largely based on the old dispensary system, was one of several other reasons which further excited my interest. I would like therefore to share with you some of the information through which I have been able to catch a glimpse of dispensary medical practice especially in relation to this province. Perhaps it may even have lessons for us today.

EARLY MEDICAL CARE IN IRELAND

The concept of professional medical care and its availability to those in need was nothing new to the native Irish. They had well established rules for the treatment of sick persons in the prechristian era, which was codified in the Brehan Laws. Each practising physician was required to register his credentials and if he was not registered he must give notice of the fact before attempting to treat a patient. Special attention was paid to the care of the aged to ensure that this section of society received all necessary care. In the tenth century A.D. hereditary physicians held sway. Only membership of a medical family entitled a person to the necessary training, there being no medical schools as yet in Ireland. The height of one's ambition was to be appointed physician to a chieftain and those who achieved such status often wrote medical manuals in Latin for the benefit of their less privileged colleagues. The poor and the destitute could go to the nearby monasteries where the monks provided medical care in addition to hospitality until their dissolution under Henry VIII. Such measures however were no antidote to the upsurge of disease which inevitably followed repeated English conquests of the island, each of which created further poverty and malnutrition amongst the local inhabitants.

EARLY RELIEF OF POVERTY

Irish society was not blind to the relationship between poverty and disease and attempted in various ways to relieve the plight of the poor. The Church, in addition to providing medical care, also gave alms to the needy and encouraged its members to do likewise with the proviso that such donations should be given wisely. Needless to say, the numerous beggars at large were only too willing to assist the donors to obtain the blessings of salvation which might be expected to follow such generous action. They made use of prevalent religious and superstitious beliefs by well judged use of the Poor Man's Curse and the Poor Man's Blessing.

Alas, much of the early legislation designed to alleviate poverty tended to persecute the poor rather than relieve them. Thus an Act of 1541 late in the reign of Henry VIII directed how the Aged and Poor and Impotent Persons, compelled to live by alms, should be organised, and rogues and vagabonds punished. In 1612 the Attorney General for Ireland, Sir John Davies, showed more concern for Irish feelings. He criticised particularly landlord absenteeism and the custom of Coyne and Livery which allowed English soldiers to confiscate a farmer's entire profit for the year, with the inevitable result that he could not afford to till his land the following year and was made idle. By 1634 the problem of vagrancy was such that each county was ordered to provide at least one House of Correction for the punishment of rogues, vagabonds and sturdy beggars and other lewd and idle persons. Rebellion followed with eleven years of confiscation and slaughter. Hordes of beggars now roamed the country-side intruding into every house and carrying infection and pestilence to the occupants. Various attempts to enact legislation to provide for the poor in Ireland came to nothing but eventually in 1703 the first Work House was created in Dublin. (In 1721 the death penalty was brought in for vagabonds who broke jail or were at large without lawful cause).

Years later Jonathan Swift the celebrated Dean of St. Patrick's (the author of Gulliver's Travels) addressed his readers on the topic of Irish poverty in the brilliant and biting satire "A Modest Proposal for Preventing the Children of Ireland from Being a Burden to their Parents or Country and for Making them Beneficial to the Public." In this essay the "final solution" ironically proposed was that surplus children at the age of one year should be slaughtered and sold as food. He added drily "I grant that this food will be somewhat dear, and therefore very proper for landlords, who, as they have already devoured most of the parents, seem to have the best title to the children." In 1724 he initiated a campaign to stimulate the consciences of society's leaders. He argued that in a situation where half the population supported themselves by begging only trade could create the jobs to incite people to labour. Begging was the result of many causes—laziness, unemployment, enormous rents for cabins and potato plots, early marriages and the ruin of agriculture. Finally in 1737 because of the failure of the Dublin Work House to give adequate relief to the poor, he introduced a scheme to alleviate the needs of his own district. The poor were badged and received relief in accordance with their needs. The result was judged to be most effective morally. Subsequent legislation recommended the creation of houses of industry in each county and town but these largely failed due to lack of voluntary subscriptions.

A series of House of Commons Committees surveyed the scene in the early nineteenth century. Ultimately a Royal Commission was appointed in 1833 to enquire into the condition of the poorer classes in Ireland and the various institutions already established by law for their relief, and also to ascertain what further remedial measures appeared necessary to alleviate the condition of the Irish poor or any portion of them. After three years of investigation and deliberation it formulated proposals which were forward looking and enlightened, but likely to prove expensive. Unfortunately the English Prime Minister, Lord John Russell, was not pleased with the report. (One finding of local interest was the fact that the counties of Ulster demonstrated less poverty but had a similar degree of destitution with the rest of Ireland). The end result was the Poor Law Act of 1838, creating the

union system of poor relief administered by local boards of guardians, based on the model of the English poor law system.

MEDICAL RELIEF

The need for drastic state involvement in health care for the poor was less compelling. An important step had already been taken in 1765 when the Irish Parliament passed a bill enabling grand juries to provide funds for the provision of infirmaries in each county. About the same time the first tentative steps in the provision of primary care in the form of dispensaries were being taken by some of the landed gentry for the benefit of their tenants and retainers. Their efforts may have been inspired by similar developments in England with which they would still have had strong ties. The English dispensary system had developed from a reaction on the part of apothecaries and some concerned physicians like John Lettson to the neglect of the poor by physicians in the previous century and was intended to produce "Charitable Institutions where medicines were dispensed and medical advice given free gratis or for a small charge."³

While the purpose of the dispensaries in the two countries was the same their fates were different. In England the total number of charitable dispensaries at the beginning of the 19th Century was only thirty eight, sixteen of them being centred in London; although more were created, they fought a losing battle with the externs of the increasingly prestigious hospitals. In Ireland there does not appear to have been such rivalry. Furthermore charitable dispensaries were encouraged by an Act of 1805 which allowed grand juries to contribute sums equal to the amount of donations and subscriptions. Thus existing dispensaries might find their income doubled and new dispensaries were encouraged to such an extent that by 1833 they numbered 452. The movement spread from the large estates to the towns with such local examples as Belfast (1792), Coleraine (1797), Cushendall and Ballygawley. Here the initial impetus came from groups of professional and businessmen driven often by their religious convictions to seek out and help those less fortunate than themselves. For example, in Coleraine⁴ thirty such people including the Mayor, James Thomson, and nine clergymen set out to collect money for the creation of a "Charitable Association for the relief of the Sick Poor" with an appeal to their townspeople preceded by four carefully chosen religious texts and couched in the following terms:

"It is a melancholy truth that however deplorable the state of street-beggars may appear, they are not in general the most necessitous. Back streets and lanes exhibit spectacles much more affecting. There the wretched inhabitants are often found languishing under adversity, poverty and sickness, many of whom were once respectable members of society but are now reduced by sickness, and by an honest shame withheld from seeking relief, often forgotten by their relations or having none who can assist them, destitute of friends; and to complete their misery, perhaps without the comforts of true religion which affords the greatest consolation in the day of distress. How pitiable then must their situation be!

These being incontestable facts, a few friends of suffering humanity have for the present formed themselves into a society, each contributing monthly according to his ability; which institution they lay before and beg the assistance of the charitable public."

It was usual for each dispensary to be managed by a committee whose members might be known as governors and which was responsible for obtaining the necessary funds, appointing and paying the medical officer and sometimes an apothecary and providing them with premises from which to practise. Contributors were entitled to nominate suitable destitute persons in need of medical attention and medicine, usually in proportion to their annual contribution to the funds of the dispensary. The medical officer was expected to attend at the dispensary at pre-arranged times to see patients who could come out, and visit at home those who were too ill to do so. He was expected to furnish the committee with an annual report containing itemised details of all expenditure incurred, the number of patients presenting, with or without a summary of the medical conditions treated, and the outcome of his treatment.

From the few records available there seems to have been no shortage of applicants for the posts of medical officer. Either a physician already practising privately in the district would offer his services or a newcomer might be appointed with the expectation of part-time private practice. This dual role could be important in rural districts where the population was thinly dispersed.

From the letters of the Reverend John Moore, the trustee of the Annesley Estate in Castlewella,⁵ it is evident that when Lady Annesley (acting in place of the late Earl) and the governors of the dispensary were considering the appointment of a successor to the retiring medical superintendent, Dr. Hunter, in 1840, they looked for "a person capable of attending to the rich as well as the poor." They had obviously received good attention because the record also stated that it was their "intention to present an address as a substantial mark of their regard because Dr. Hunter (had) been for eighteen years in the laborious situation as Dispensary Doctor (there)." Mr. Moore was already in receipt of a tentative application from a Mr. Falloon who was enquiring about local dispensaries, with a special interest in Newcastle. In his intriguing reply Mr. Moore praises Newcastle but hints at the possibility of a vacancy in Castlewella where "we have a very good dispensary and the doctor is at present on leave of absence for some months; it has been spoken of that his return here is uncertain." Lest he might appear to be offering the post to Mr. Falloon he is careful to state, "I am in no way bound or pledged to anyone should he resign; my own vote as well as those with whom I am connected here will I hope be given to the most deserving candidate."

Another example of good private management was illustrated by the rules of the Government of the Schools and Dispensaries instituted and supported by the Fishmongers Company of London in their estate in the County of Londonderry. These were printed in a booklet in 1828 and the dispensary rules were twelve in number. Two dispensaries were to be provided, one each for the Northern and Southern districts of the estate administered by separate boards. Two surgeons duly qualified as full surgeons in the Army were to be appointed with an annual salary of £100.00 each, to attend their respective dispensaries for two hours each morning and afterwards visit such patients as were unable to attend. Complaints against the medical officer could result in his dismissal if seven members agreed, the company's agent later receiving a full statement of the grounds on which they proceeded. The patients must produce to the medical officer a certificate signed by a member of the board and must have a fixed place of abode on the company's estate or be a servant or a tenant thereon.

DEFECTS OF CHARITABLE DISPENSARIES

It was inevitable that in a system, based on such a large group of heterogeneous voluntary committees, some of these occasionally found themselves in difficulty in the realms of management and finance. Thus within two years of its creation the minutes of the Ballygawley Dispensary record that the governors and subscribers were unable to pay their surgeon Dr. Wilson when through the dishonesty of the late county treasurer no grant was received from the grand jury.⁶ These grants although recommended and usually given following the Act of 1805 were not obligatory until 1836. They depended on priorities as assessed by the twenty four jurors, who were usually leading landowners or their agents appointed by the sheriff of each county to assist the judges in circuit and administer the local government of the county when they met at the assizes. They made contributions to numerous charities including the county hospitals from the fines imposed by the courts.⁷ Some of the committees were lazy. Thus minutes of the Rathfriland Dispensary in 1821 record that following a period of slackness due to inertia on the part of both the committee and the medical officer, the members resolved to meet four times in each year.

The death of a benevolent estate owner could cause financial difficulties for the dispensary created by him or his predecessors and others in neighbouring estates. For example, in 1839 following the death of Lord Annesley his trustee found himself in difficulty over the funding of the dispensaries in Castlewellan and Rathfriland.⁵ Although the latter was financed by the Meade Estate the two estates provided reciprocal care for tenant workers straddling their boundary. Thus he wrote to his counterpart, apologising for the inability of the Annesley Estate to contribute to either Castlewellan or Rathfriland dispensary but "hoping that when the affairs of the estate were settled these two desirable institutions would be supported by the present Lord as did his father." He concluded, "Whenever your tenants here apply to me I give recommendations to the dispensary in Castlewellan the same as to Lord Annesley's tenants and hope you will be so kind as to do so by those of the Annesley property who apply to you at Rathfriland".

Notwithstanding these isolated criticisms the voluntary dispensaries worked well and were commended by various committees of enquiry. Their large number, however, concealed the fact that there were many areas in Ireland where no such facility existed, which did not go unnoticed during the turmoil of the famine and the periodic epidemics which swept the island.

THE BELFAST DISPENSARY

No consideration of the early voluntary system would be complete without a passing reference to the first dispensary in Belfast. In 1792 a group of concerned people, led by Dr. James McDonnell, along with Charles Brett and Henry Joy from the Belfast Charitable Society, published a prospectus detailing the aims of the dispensary and inviting subscriptions. As soon as subscriptions amounted to fifty pounds the subscribers would be able to nominate an apothecary, two surgeons and two physicians. This small sum was immediately subscribed. The medical staff were appointed comprising two attending physicians, Doctors McDonnell and White, two attending surgeons Messrs. Fuller and McClelland and two consulting physicians Doctors Halliday and Mattear. They later examined candidates for the post of apothecary and in the ensuing ballot Mr. Hull was successful. He was required to

reside at the dispensary, to compound and dispense the medicine prescribed, to maintain a register of the patients, to keep the current accounts and not to absent himself one whole day and night without the sanction of the committee. For this service he received the annual salary of £40.00. The medical appointments were honorary and would subsequently be made by ballot of the paid-up subscribers. Patients could only be seen on the recommendations of the subscriber whose quota depended on the size of his subscription, the minimum of half a guinea per annum entitling him to have one patient on the books at a time. Recommendatory letters were to be sent to the dispensary before 10.00 a.m.

Malcolm reflected that "It was not to be expected that the significant sum called for would be sufficient to institute these varied plans though to the honour of the profession, be it ever remembered, that body upon which rested the entire success of every part of the scheme warmly co-operated to carry out the entire undertaking regardless of all trouble and the sacrifice of valuable time. It is also pleasing to observe with what unanimity the leading merchants and professional men laboured for the common good and how partners of all ranks and of all political and religious creeds acted in harmony and mutual goodwill."

At its initial premises consisting of a house with six beds for fever patients in Factory Row, later Berry Street, the dispensary became very popular. During the first four years of its operation out of 2,406 patients who received medical and surgical advice and medicine, 1,740 were pronounced cured, 336 relieved, 50 dismissed as incurable and 280 either died or made no report.⁸ The cost per patient was four shillings and four pence, which compared favourably with returns from the Public Dispensary in London for the year 1792 where the comparable figure was five shillings and one penny.³

Frequent outbreaks of fever and an expanding population demanded the creation of more accommodation. This was accomplished by moving the dispensary and fever hospital to two houses on West Street beside Smithfield Market and later in 1817 to the new hospital in Frederick Street, the future Belfast General Hospital. The dispensary functioned at the back of the hospital, preserving the unity of identity between the general medical care of the poor in the community and the more specialised medical and surgical facilities developing within the hospital. The same year saw the onslaught of a particularly virulent form of typhus which stretched the resources of the new hospital to its limits. The incalculable value of the dispensary at this time was referred to in the Belfast General and Commercial Directory of 1819 as "proving of the utmost importance to the industrial classes of society," who together with the poor bore the brunt of the epidemic.

When it was ultimately incorporated in the poor law system it had served its purpose nobly. Its medical attendants had included many names associated with the Belfast Medical School, since from 1832 it had been a requirement that any doctor wishing to become a visiting physician or surgeon to the hospital, must have served at least three years as a dispensary attendant. It had also become an important source of patients for the teaching of medical students who had the privilege of seeing the early stages of illness, as they do today in the teaching practices associated with Professor Irwin's Department of General Practice.

THE MEDICAL CHARITIES ACT (1851)

The epoch of the charitable dispensary was rapidly coming to an end. The Poor Law Relief Act of 1838 had provided machinery for the relief of poverty throughout the country by the creation of unions which were administered by boards of guardians, responsible to the central authority of the Poor Law Commissioners. A union district was composed of a manageable number of electoral divisions and each board of guardians consisted of elected and ex-officio members, the latter drawn from local justices of the peace, assistant barristers and clergymen. If it was inefficient it could be dissolved by the Commissioners, who could appoint paid officials instead.

Relief which was funded from the local rates was provided only within the workhouses at the discretion of the guardians lest any poor person, however destitute, should think that it was his statutory right. Preference was given to the aged, the infirm, the handicapped and children, with priority to those within the union boundary. The workhouses were built (to a standard design) with amazing rapidity throughout the one hundred and thirty unions and even as soon as 1842 there were 37 workhouses, containing 115,000 inmates.

This scheme formed the basis of the poor laws in Northern Ireland until 1948. It was not yet considered necessary to include medical relief within its scope, largely because of the extensive network of county infirmaries and fever hospitals and the 452 charitable dispensaries already in existence. The next decade was to test it to the full. Escalating distress due to crop failures punctuated by sporadic outbreaks of cholera and typhus culminated in the famine of 1846 to 1847. Although the northern counties suffered less than other areas, probably because the people here included not only the potato, but oatmeal in their staple diet, the rest of the country was less fortunate. It was necessary to supplement many of the workhouses with additional accommodation which was often deficient in sanitation, thus adding to the effects of poor nutrition and resulting in a high mortality rate among the inmates and officers. By 1851 the population of Ireland had fallen from an expected nine million persons to six and a half million. Following these events the need for more uniform medical care in the community was clamant. The same problem in England had been dealt with according to the Poor Relief Amendment Act which empowered the unions to provide both poor relief and medical relief, by appointing doctors to see patients in the workhouses or in their homes.⁹ Thus to obtain treatment the patient had to be declared a pauper, or alternatively pawn his goods for the five shillings consultation fee or do neither.

The Irish Poor Law system managed to avoid this ignominy. In 1851 the Medical Charities Act was passed to provide for the better distribution, support and management of medical charities in Ireland.¹⁰ It provided a complete machinery for domiciliary medicine throughout the country, by extending the relief hitherto only available in workhouses, county infirmaries and the charitable dispensaries, to all who needed it.

The top tier of the administration was already in existence in the form of the Poor Law Commission, which was strengthened by the addition of two more commissioners; one of these was to be a physician or surgeon of not less than ten years' standing with the title of Medical Commissioner. The Commissioners were to appoint as many inspectors as the Treasury would allow, who must be physicians or

surgeons of not less than seven years' standing to assist in the carrying out of the Act. Neither the Medical Commissioners nor the inspectors could continue to practise in any professional capacity.

The boards of guardians provided the second tier. They were instructed to divide their unions into dispensary districts commensurate with local geography and population needs. The cost of all medical relief afforded within each dispensary district, together with all the salaries and charges incidental to the same, would be charged on the poor rates of the appropriate electoral division. The Commission set the standards of qualification and the number of the officers to be appointed to the service of each dispensary district and the number of persons comprising the committee of management of the district.

The District Dispensary Committee provided the third tier of management. Its size was determined by the Commission according to the needs of the district and it was elected by the guardians from owners or occupiers of property in the district along with any local guardians and it held office until after the next annual election of guardians when the new committee was appointed. The guardians were also responsible for providing premises from which the medical officer could practise and in which the management committee could meet, as well as medicines and medical appliances for the needs of eligible patients. The committee on the other hand appointed the medical officer whose qualifications were determined by the Commissioners who could remove him if the grounds were sufficient and direct the committee to appoint a replacement, or appoint one directly if it failed to do so.

A person's entitlement to treatment depended on the issue of a ticket by a member of the dispensary committee, a relieving officer, or the warden of an electoral division included in the district, directing the medical officer to provide him with medicine and advice (in that order) or attend him at home. A home visit was meant to be a rarity, obtainable only with a red ticket; such calls were not popular, partly because of the risk encountered by the relieving officer and doctor when entering the filthy environment of the patient. A ticket could be cancelled by a majority of the committee at its next meeting if they thought the holder was not a fit object for dispensary relief.

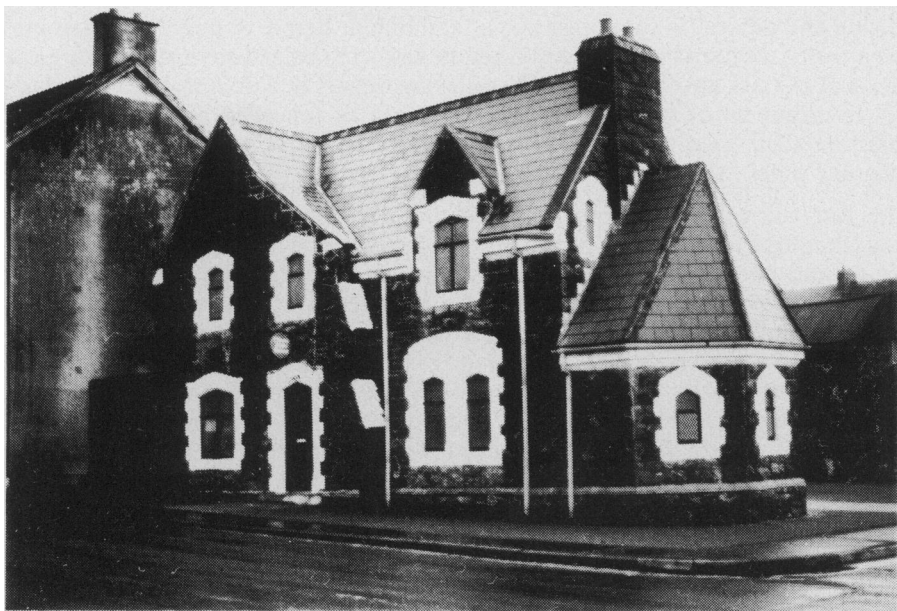
The Act laid other statutory unpaid duties on the medical officer, such as the vaccination against smallpox of anyone in the district who requested it. He had to examine and certify dangerous lunatics who were brought before justices of the peace and provide medical care for the inmates of bridewells and houses of correction, and these duties were considered in fixing his salary. Standards were to be maintained by the right of inspectors to visit dispensaries at any time and attend the meetings of boards of guardians and dispensary committees in which they could take part but not vote. The incorporation of the existing charitable dispensaries under the new system was to be completed by the appointment of existing medical officers to the new districts provided they were approved by the Commissioners.

Thus began a new chapter in the medical care of the numerous poor in Ireland. It drew much of its inspiration from the best examples of voluntary dispensary care already in existence. Above all it did not reduce the patient to the status of a pauper since the dispensaries were usually separate from the workhouses and managed by their own committees.

Subsequent alterations in legislation included the abolition in 1872 of the Poor Law Commission which was replaced by the Local Government Board with broadly the same powers. In 1878 the Public Health Act added the status of district medical officer of health to the role of the dispensary medical officer, with an additional salary of five, ten or in rare cases thirty pounds per year. Within the Local Government (Ireland Act) of 1898 the boards of guardians ceased to be rating and public health authorities. The dispensary committees were also abolished and their power and duties transferred to the boards of guardians. The close contact between the local committee and the doctor, chosen carefully by them since they would be dependent on him for attendance on them and their families, thus ceased to exist, leaving the doctor to the mercy of the boards of guardians who were more likely to be influenced in their decisions by political or religious motives. On the other hand many dispensary committees had ceased to function through the neglect of their honorary officers, seldom meeting unless an appointment was to be made. Following the creation of Northern Ireland in 1920 the control exerted by the Local Government Board was transferred to the Ministry of Home Affairs.

LOCAL ORGANISATION

Like most far reaching pieces of legislation the 1851 Act took time to settle down. At the beginning the unions must have depended heavily on existing dispensaries and their medical personnel, filling the gaps as needs grew and finance became available. Twenty five years later the twenty eight union districts of the six counties, which were later to become Northern Ireland, were responsible for fully functioning dispensaries in one hundred and ninety two districts.¹¹ The number of medical



The "Old Dispensary" in Mount Street, Ballymena, built in the 1860s.

officers employed was one hundred and sixty two with usually one to each district. Large districts notably in Belfast might have several stations with more than one medical officer per station, whereas over sparsely populated districts, one medical officer might look after several stations. Greyabbey, for example, had one medical officer for three stations. In 1875 most of the medical officers received £100 per year for their services, some more, some less. Thus the doctor in Armagh received £150 because he also served the prison and the asylum, whereas his colleagues in Caledon received only £60.

ADMINISTRATION—CHOLERA EPIDEMIC OF 1853-1854

The administrative structure of the new system was soon tested. At the meeting of the British Association in Belfast in 1852, Malcolm had read a paper predicting the probability of a third outbreak of Asiatic cholera in the British Isles, based on his observations of the poor sanitary state of Belfast. Rural sanitation was no better. A report of the Honourable Irish Society in 1836 describes the conditions under which many of the peasants on its estates were living, as follows: "It is now too common for the parents and children of both sexes, even adults with other individuals composing the family, to huddle together in one room or hovel, and it not infrequently happens that to these are added the pigs, poultry and other animals; in the outside, immediately at the threshold of the door a space is hollowed out to receive filth of every description, called mixings, which is applied for manuring the ground for potatoes, and disgusting as this appears to the sight, the stench arising from these fermentations of their putrescent matter is still made obnoxious and offensive and must necessarily be most injurious to the health of the inhabitants."¹²

Malcolm's prophecy was fulfilled when cholera appeared among immigrants on board ships in Belfast Lough in 1853. It spread throughout Ireland during the following year. The fact that it was considered less severe than previous outbreaks may be due to the early diagnosis and management of cases by dispensary medical officers among the most vulnerable members of the community, and the prompt notification of cases to the Poor Law Commissioners.

Throughout the year medical inspectors were busy in Ulster, following up requests from the Commissioners to visit affected union districts, reporting the results of their discussions with dispensary medical officers and recommending appropriate measures to prevent further outbreaks.¹³ One of them, Dr. Alexander Knox, featured in the investigation of outbreaks as far apart as Londonderry, Portaferry, Armagh, Ballylesson and Portglenone, in addition to his routine inspections of dispensaries under his control.

Some of the newly appointed dispensary medical officers were unaware of their obligation to notify the Commissioners. Dr. Miller in the Ahoghill Dispensary commences his letter to these gentlemen: "I beg to inform you that a case of cholera has occurred in this district which I was not aware it was my duty to report to you until I read your instructions on the subject today in the Annual Report for last year. I therefore hasten to report to you the symptoms of this case, hoping as no other case has since occurred that the omission will not be deemed by you as serious neglect of duty." In Ballynure we find Dr. Knox reprimanding the dispensary medical officer for not reporting six cases among his private patients, the excuse being that no case had occurred recently in his dispensary practice.

The correspondence between the medical officers, commissioners and inspectors suggests that the medical officers took their responsibilities seriously, displaying fine clinical detail and home care of the highest order. The following extract is from a letter from Dr. Filson of the Portaferry Dispensary District to the Commissioners.

“I wrote to you yesterday with regard to a case of Cholera which I was called on to attend and now submit for your information the following particulars: Phelix Smith, aged fifty years, a labourer, and inhabitant of Portaferry, had been at work on Friday and Saturday last in the town, and seemed in his usual health. His family, six in number, had all been in good health and still are so. On Sunday morning he was attacked with purging, which continued severe all day; evacuations watery and whitish; great thirst, but not much pain; vomited for the first time about nine o'clock on Sunday evening, and continued to do so at short intervals during the night; bowels purged at same time; great thirst, which he appeased by drinking large quantities of cold water, and which was rejected, mixed with whitish flacculent matter; unable to leave the bed when purged; had no medicines of any kind, and made no application for advice till ten o'clock on Monday morning. When visited, found him labouring under the symptoms above detailed; examined the evacuations, and found them rice-water like; pulse small, and about 100, tongue pallid and moist, skin of face dusky, features sharp, tip of nose cold, praecordial oppression, great debility, and no urine voided during the night; whispering sound of voice, so characteristic of the disease; no cramps or spasms.

Immediately gave him two pills, each containing one gr. opium and two camphor, and half an hour after a draught containing aromatic confection, spirit ammon, and camphorated mixture, tins and jars containing hot water to the stomach and extremities, additional blankets, and for drink, whiskey largely diluted with cold water, in small quantities. The pills and draught were retained on the stomach.”

Dr. Filson visited the patient every hour during the day and returned the next morning at six o'clock, when he was able to report:

“He has continued easy and free from any unfavourable symptoms during the night; towards morning, voided about half a pint of urine; did not see it. He feels languid; pulse 80, and weak; tongue clean, thirst abated; skin comfortably warm; voice resumed its usual character; has taken a cup of bread and water; ordered a pill containing three grains calomel and half grain opium.

One o'clock;—Has had one motion from the bowels, tinged with bile. The rest of the family, six in number, are at present all well. The house in which they reside is very small, and not sufficient accommodation for so large a family. The Dispensary Committee have afforded me every assistance in their power. I have the honour to be your obedient servant,
Alex. B. Filson.”

MORBIDITY

Details of the large range of illness seen and treated by the dispensary doctor can rarely be found. According to his terms of service he kept a treatment register and made an annual report to the management committee of the charitable dispensary or

the subsequent union dispensary. Few of the registers seem to have survived but those available for Belfast and Ballygawley suggest that their main function was to provide statistics of the numbers treated and the cost of items of service, culminating in the cost per patient.

Annual reports should provide fuller details of morbidity but they are even more difficult to locate especially where the committee was careless and the doctor did not submit a report. However, in 1850, in his penultimate report before the Rathfriland Dispensary was transferred to union control the medical officer, Mr. Samuel Swann, MRCS, LAH, gives some insight into the problems in his district when he states:

“Independent of the diseases which are generally the most frequent at this institution and which may be called the staple diseases of Irish Dispensaries namely — fever, rheumatism, dyspepsia, cutaneous affections, diarrhoea, dysentery, pulmonary and bronchial inflammations, there are but few others which deserve any particular notice. There is not more than the usual amount of fever and the cases were usually of a mild type.”

Referring to his success in vaccinating people against small pox he remarks:

“I feel happy in being able to state that the prejudice being entertained by some against vaccination is fast giving way and I trust that before many years are gone by that the disease will only be known by name in Great Britain.”

The following year Dr. Phillips, in the Ballygawley Dispensary,⁶ reported to his committee that he attended 1466 patients during the year, of whom 1092 were cured, 211 relieved and 42 died. He had 2 cases of anthrax, 5 of smallpox, 83 of fever which in Tyrone meant either typhoid or typhus, 9 of scarlet fever, 30 with measles, 12 with whooping cough. 40 wounds were dressed, acquired mostly in the fighting fairs, 73 operations were performed because there was no hospital and 241 children vaccinated.

These figures can be compared with those for the Cushendall Dispensary during the 2 years from 1832-34 in which 863 cases of extraordinary variety were treated.¹⁴ The 33 commonest disorders are listed in Table 1 with 10 or more examples of each. 60 less frequent disorders also feature in the report of which 26 appear in Table 2.

Most of them can be found in any general practitioner's surgery today. Some we no longer thankfully see, like typhus, scrophula, dolor post partum and ophthalmia. Some of the names no longer exist, like opstipatic, rubeola, pyrosis. Otilis, anaserea and cynariche are probably mis-spellings of otitis, anasarca and cyananche. The latter was an upper respiratory infection especially common during periods of famine.¹⁵ While no valid comparison can be made with morbidity in general practice to-day some apparent differences are striking, for example, the low incidence of heart disease (1.3 per cent), the relative preponderance of pleurisy (3.7 per cent) over bronchitis (2.3 per cent) and the low incidence of rheumatism (1 per cent). The smaller number of patients treated in the Cushendall district, 863 cases in 2 years, compared with Ballygawley, 1466 in one year, may have been due to numerical differences in population but a more potent factor may have been the health and longevity of the people of the Glens. Thus James Boyle's memoir of 1835 observed that in the previous two years two persons had died, “one at the age of 105 and the other 100 years; in the old churchyard in one grave were buried a grandfather, his

TABLE 1
Cushendall Dispensary 1832-4
Problems in 10 or more patients

Vaccination	76	Lumbago	14
Vermes	56	Rubeola	14
Dyspepsia	40	Odontalgia	14
Typhus	37	Asthma	13
Pleuritus	29	Leg Ulcers	13
Psoriasis	24	Accouchment	12
Abscess	21	Pyrosis	12
Ophthalmia	20	Dolor Postpartum	12
Sprains	20	Dysentery	10
Scrophula	20	Dislocations	10
Catarrhus	18	Debilitas	10
Bronchites	18	Fractures	10
Hepatitis	18	Phlegm	10
Opstipatic	18	Palpitation and Heart	
Burns and Scalds	16	Disease	10
Vertigo	15	Ringworm	10
Diarrhoea	15	Wounds	10
TOTAL PATIENTS 863		TOTAL PROBLEMS 93	

TABLE 2
Cushendall Dispensary 1832-4
Further Diagnoses

Rheumatism	9	Pertussis	5
Menorrhagia	7	Pneumonia	5
Otilis	7	Syphilis	5
Cephalgia	6	Splenitis	5
Cynariche Tonsilaris	6	Whitlow	5
Parotidea	6	Ascites	4
Haemorrhoids	6	Entiritis	4
Hernia	6	Gonorrhoea	4
Neuralgia	6	Inflammation from	
Hysteria	6	Laceration	4
Anaserea	5	Sciatica	4
Colics	5	Tinea Capitis	4
Nephritis	5	Diseases of Urinary Organs	4

son and grandson whose united ages amounted to 284 years." Several persons aged 90 were then living in the parish.

As always there were some who found time for research in the midst of their dispensary duties. Dr. Forbes, while Dispensary Doctor in Penzance, was one of the

first physicians to use Laennec's stethoscope in England, producing several publications on the subject. In Londonderry Dr. Cuthbert in the Glendermott Dispensary investigated the effects of Caisson Disease among divers involved in the building of the new bridge over the Foyle.¹⁷

MEDICAL GRIEVANCES

Our profession has never taken kindly to direction from the agencies of government. The good will of people like McDonnell who not only served the dispensaries but in some cases created them seems to have declined somewhat after the introduction of the Medical Charities Bill. The Irish Medical Association founded 12 years earlier in 1839 had foreseen the dangers of central direction inherent in the Bill but failed to involve itself in the necessary negotiations to secure reasonable terms for the profession.¹⁸ This inertia may have been due to the advancing age of its President Richard Carmichael and his subsequent death in 1849. Although the medical attendants of the fever hospitals and the dispensaries formed their own organisation in 1849 it was already too late for them to be effective in removing many of the faults inherent in the Bill. The Irish Medical Association subsequently worked actively to improve the lot of the dispensary medical officer. In 1863 when the average salary was between £50 and £70 per annum they were campaigning for a minimum salary of £100. Pension rights were also demanded culminating in the first Superannuation Act passed in 1865.

When the Public Health Act of 1878 gave the poorly paid title of district medical officer to the dispensary medical officer but failed to define these duties clearly, the Association stressed the need for adequate remuneration for the work which was intended to carry considerable responsibility; on this occasion it was not successful. O'Connell in his presidential address to this Society,¹⁹ described the dilemma facing the dispensary medical officer whose salary for both duties was merely a retaining fee, forcing him to secure a paying practice according to local conditions. Since the unfortunate doctor could find himself obliged to prosecute offenders against the Public Health Act who were his most affluent private patients, it is little wonder that the public health needs of the community were often ignored.

Hopes for a better deal were raised by the appointment of a Vice-Regal Commission in 1906 to advise on poor law reform in Ireland, which ultimately recommended the establishment of a state medical service. This and other progressive suggestions were, however, shelved when a Royal Commission on the Poor Law, dealing with both Great Britain and Ireland, was appointed before the Vice-Regal Commission could submit its report.

Although the medical officers had been apprehensive when the dispensary committees were disbanded and their functions taken over by the boards of guardians in 1898, the Local Government Body exerted firm control and increasingly ensured that the guardians gave more realistic salaries to their medical officers. It also minimised the abuse by guardians and wardens in the issue of tickets to people who were able to pay the very moderate fees charged to lower paid workers. By comparison the failure of the Ministry of Home Affairs in Northern Ireland to act as firmly when it assumed the powers of the Local Government led to considerable dissatisfaction amongst local medical officers in Ulster.

Although a Departmental Commission on Local Government Administration reported in 1927 that the dispensary system was functioning soundly and should be retained,²⁰ its usefulness was gradually coming to an end in Northern Ireland.

Lyle writing in the Ulster Medical Journal in 1937 described vividly the frustration and disillusionment of the Poor Law Doctor.²¹

“He is on duty for twenty four hours a day seven days a week during forty eight to fifty weeks a year and is at the beck and call of every Tom, Dick and Harry who can get a ticket to commandeer his services; it is not difficult to obtain these, seeing that they are on issue by wardens and guardians who are in many cases grocers or publicans and who dispense them as bonuses with quarter pounds of tea or bottles of stout irrespective of the medical needs or financial circumstances of the applicant.”

“Any time which he may have to spare from his official duties is necessarily taken up with the attempt to earn a living for himself and his family by private practice, his official salary leaving but little margin after his necessary professional expenses are defrayed.”

Like the general practitioners today, he found that his workload had steadily increased, for which he identified several causes. The main factor was the gradual elimination of the small farmer, who had employed no labour outside his own family, all of whom paid for their treatment, and his replacement by the larger farmer whose employees were all poor law patients. The original Act of Parliament had not defined a poor person and yet the dispensary doctor was obliged to attend free of charge all poor persons, an obligation which was not lost on many who were above the poverty line. Yet another cause was the reversal in ratio of requests for home visits to consultations at the dispensary. Earlier reports to the Local Government Body indicated a ratio of one to two, whereas at least two thirds of Lyle’s consultations were home visits, often requested at night. Like O’Connell he also found that his public health duties resulted in the loss of private patients when he drew attention to the unsanitary state of their property, and cited some of the guardians as the worst offenders.

CONCLUSION

Such comments were not merely the complaints of a disgruntled poor law medical officer, jealous of his colleagues in the Free State who appeared to have been treated more fairly by the prevailing system. As society progressed the dispensary system had become an anachronism. A potent factor was the eventual implementation in 1930 of Lloyd George’s National Insurance Act,²² providing most of the less affluent workers with a doctor of their choice in return for a small insurance contribution which gave the doctor a more realistic income for his services. The logical consequences was an extension of this scheme to the dependents of all insured persons and other poor persons, who would have free choice of doctor, in return for which the doctor would be paid a realistic capitation fee and receive compensation for loss of office and be relieved of his duties as district medical officer of health. The dispensary system was incorporated into such a scheme with the advent of the National Health Service in 1948.

Few will have regretted its passing. To the doctor, administration by the Northern Ireland General Health Services Board must have seemed pleasurable compared

with some of the boards of guardians while the patient was no longer required to prove his entitlement to treatment. Perhaps most significantly, in the first year of National Health Service approximately 740 general practitioners decided to provide general medical services under the scheme compared with a total of 160 dispensary medical officers in post at the changeover. In the same year 96 per cent of the population had registered with doctors of their choice.²³

Although dispensary physicians like Dr. Murray might find little in contemporary general practice to compare with their experience, their achievements must seem to us to have been all the greater. Take for example Dr. William Smyth whose memory is revered by our Society in the stained glass window of our library.²⁴ A person of exceptional courage and strength, he was appointed to the dispensary at Burtonport in 1882, his predecessor having died from typhus which frequently visited Donegal in the autumn. In October 1901 there was another outbreak of typhus affecting a labouring family on the island of Arranmore, one of whom had acquired the infection when harvesting in Scotland. No one would help the family or assist Dr. Smyth to visit them so he rowed the three miles there and back each day, often laden with food and drugs. Eventually he decided that they needed attention in hospital. This involved the purchase of a larger boat, which, although unseaworthy, was sufficient to enable him with the help of a colleague to row his patients to the mainland, where a waiting ambulance conveyed them to the hospital at Glenties. His task completed he set off to enjoy a few days' respite at the Glasgow Fair. Although he believed himself to be immune from typhus, he was already infected and became ill on the journey; he returned home early to have the diagnosis confirmed by his neighbour Dr. Gardiner. The illness progressed rapidly and he died from pneumonia 12 days after the appearance of the first symptoms.

Our Society rightly honoured William Smyth, but perhaps as today only the patients were capable of evaluating the true worth of the dispensary physician. I shall leave it to an editorial in the Irish News of the 20th July, 1937 to speak on their behalf:

"The dispensary medical officer may not have the glamour of the surgeon or the renown of the specialist. He may be one of the forgotten men of medicine, moving obscurely about a country district on an unremitting round of duty, night and day, in fine weather and in foul, his name achieving the accolade of print but once a year, when he applies for his annual holidays to the local board, but ultimately he is the guardian of the health of the people.

These men often lead an arduous life, harassed by circumstances, red tape, ignorance, but on the whole they put a lot more into their work than they ever get out of it, do a lot more than they are ever thanked for, perform wonders in adversity that are forgotten as soon as they are done.

They are the servants of the poor, outposts against disease, indispensable units of our social organisation."

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