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III. THE MEDICAL MISSION AND THE CARE OF THE SICK POOR IN NINETEENTH-CENTURY ENGLAND

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SIDNEY AND BEATRICE WEBB, in their book *The State and the Doctor*, which was submitted in the first instance as a memorandum to the Royal Commission on the Poor Laws in 1909, dismiss the work of the free dispensaries and medical missions in one short paragraph.

> We need not describe the Free Dispensaries and 'Medical Missions' which abound in the slum districts of a few large towns. All the arguments against the gratuitous, indiscriminate, and unconditional medical attendance afforded by the out-patients' departments of the hospitals appear to us to apply, in even greater strength, to the free dispensaries and medical missions; with the added drawbacks, that they are not, as a rule, under responsible and specialised medical supervision, and that they are not able to offer immediate institutional treatment to those of their patients whom they find to require it. The 'Medical Missions', in particular, were stated to be the 'worst of the whole lot... mixing up medicine with religion', and seeking to attract persons to religious services by the bait of 'cheap doctoring'.[1] In our opinion, all these centres for the gratuitous, indiscriminate, and unconditional dispensing of medical advice and medicine, far from meriting encouragement, or offering opportunities for extension, call imperatively—at any rate where they involve the gathering of crowds of sick persons in halls and passages—for systematic inspection and supervision by the local Medical Officer of Health, in order to ensure that they are not actually spreading more disease than they are curing.[2]

It is intended here to give some account of the work of these medical missions and to assess their importance in the nineteenth century and in the future development of medical services for the community.

Two main sources of treatment were available for the sick poor during the nineteenth century—statutory provision made under the Poor Law and later the Public Health authorities, and the various voluntary agencies. Though no statute had, prior to 1834, specifically authorized the supply of medical attendance and medicine at the expense of the poor rates, the 1834 commissioners found that a system of medical relief had everywhere grown up under which the sick were attended and supplied with physic by the 'parish doctor'. They continued this practice of outdoor relief, and only in the sixth decade of the century began to make specific arrangements for indoor care. The years 1862–65 were marked by growing public alarm with regard to the spread of infectious disease and by much sickness among the poor, so that the

[1] Quoted from the *Royal Commission on the Poor Laws, 1909*, appendix, Vol. III, Qs. 33,690, 33,691.
[2] S. and B. Webb, *The State and the Doctor* (1910), pp. 134–5.

workhouses in London and the large towns became overcrowded with sick persons and it became apparent that the existing arrangements were by no means adequate.

The result was the establishment of the Metropolitan Asylums Board in 1867, which built hospitals at first for paupers suffering from infectious diseases, but later admitting all cases recommended, irrespective of the patient's affluence; and the official encouragement of the grouping together of unions throughout the country into 'sick asylums' large enough for the erection of a poor law infirmary. The intention had also been to develop a system of poor law dispensaries for those on 'out-relief' similar to the methods followed in Ireland at that time. Here, as a result of the Medical Relief Charities Act, 1851, any sick 'poor person', not necessarily a pauper, had a right to free medical advice and medicine, and this was not regarded as poor relief. Each union was divided into dispensary districts and the sick poor were directed to the nearest dispensary.[3] G. J. Goschen, the president of the Poor Law Board, in the annual report of the Board of 1869–70 went so far as to suggest that it might be possible 'to extend gratuitous medical relief beyond the actual pauper class',[4] but this was not followed and instead, after 1870, it became the official policy to encourage indoor rather than outdoor relief for the sick and to grant outdoor relief only when indoor was not available. Thus, during the second half of the nineteenth century, and until the last decade when some change in policy is noticeable, there was not any appreciable concern for the restoration to health of the outdoor sick.

Therefore for ailments which did not require institutional treatment, the poor were largely dependent upon voluntary agencies. These included the out-patient departments of the voluntary hospitals where charges were not usually made, but where a 'subscriber's letter' was frequently asked for; the provident associations and dispensaries and the sick clubs of the friendly societies where a small regular subscription was required; and the medical clubs organized by private doctors in the poorer areas, which worked on a similar basis but where in an emergency the doctor would sometimes give gratuitous help. But subscribers' letters were much abused and often hard to come by, and the provident and medical clubs required continuity of subscription which was difficult for the man whose employment was intermittent or who frequently changed his place of residence. The alternative was the medical mission.

In its fully developed form, the medical mission comprised free medical attention at the dispensary, nursing in the home, some care for the general welfare of the patients, a hospital for those needing institutional treatment, and arrangements for convalescence. But more usually:

A well-established medical mission consists of the medical missionary with his trained assistants and nurse, aided by voluntary helpers. The work is carried on at a

[3] Ibid. p. 14, note 2. [4] *22nd Annual Report of the Poor Law Board, 1869–70*, p. lii.

central institution or dispensary, where the patients attend at a specified hour to receive advice and medicine. Day by day when the patients are assembled, the Bible is read, and a short scriptural address is given; and then the patients are taken in detail, examined and prescribed for.... Such of the patients as are too ill to attend at the dispensary, he visits at their own home.... As he goes about among the sick poor of the district, he has further opportunities of finding out their temporal and spiritual wants, and a variety of moral and religious agencies spring up in connection with the dispensary, their number depending upon the amount of voluntary help which the medical missionary is able to command.[5]

As early as 1746 John Wesley is said to have established a free dispensary in England, though the early medical missions were to be found in the foreign field, the first being formed in 1712 when the Society for the Propagation of the Gospel was officially given the duty of caring for both the health and spiritual welfare of two slave plantations in Barbados. The development of nineteenth-century home medical missions can be traced to this foreign missionary work, in particular the Macao Mission Hospital and Canton Dispensary (1828) to which Dr Peter Parker was returning when he paid his fleeting visit to Edinburgh in 1841. Here, in July 1841, at a meeting attended by representatives from the university, the clergy, the medical profession, merchants and bankers, he described the work of the Canton Dispensary, as a result of which it was decided to form the Edinburgh Missionary Association, under the presidency of Dr John Abercrombie, to train medical men for service abroad.[6]

Home medical missionary work began in connexion with the Edinburgh Association when, in 1859, Dr William Burns Thomson was appointed superintendent of their small dispensary at 39 Cowgate, which they used to train their students. His attention had first been drawn to the need for home medical missions when, as a student, he had visited in the Edinburgh gaol. Calling at the home of one of the prisoners, he found illness there and no way of getting the immediate help of a qualified practitioner. This, he discovered, was not unusual in the slums of that city. He drew immediate attention to the fact in 'Medical Missions', a prize essay which he wrote for a competition at the university,[7] and devoted the rest of his life to publicizing the need for home medical missionary work and to helping to start such missions in the heavily populated areas.

The Edinburgh Medical Missionary Association had originally opened similar societies in London, Liverpool and Glasgow in the 1840's to train medical students for the foreign missionary field, but all had closed except the association at Edinburgh which continued under the leadership of Dr John Coldstream. The intention of Dr Burns Thomson, when he became superintendent in 1859, was to use the mission dispensary to train medical students

[5] *Medical Missions at Home and Abroad*, July 1878.
[6] P. L. Garlick, *The Wholeness of Man* (1943), p. 122.
[7] W. Burns Thomson, *Medical Missions* (1854).

for work in Britain as well as abroad. At first this was regarded with suspicion by the leaders of the Edinburgh Medical Missionary Association, who felt that their funds were not designed for that purpose, and for a time Dr Burns Thomson had to use his own dispensary. But the support of Dr James Miller, Professor of Surgery, and that of several others on the academic staff of Edinburgh University persuaded the Association to undertake the training of home medical missionaries.

A hostel, run by Dr Burns Thomson and his wife, was opened near the dispensary for students intending to become medical missionaries. They attended the courses at the university, did some of their laboratory work on the premises under the direction of Dr Thomas Grainger Stewart, a university lecturer in pathology, and gained some practical experience by helping with the medical work of the dispensary. In their free time they were expected to take some part in the Christian activities of the dispensary in order to learn the methods employed by a well-organized mission. Dr Burns Thomson's boast was that during the period of his superintendency not one of the students attached to the Cowgate dispensary was ploughed in a professional examination.[8]

The following is a contemporary description of the Edinburgh Medical Mission when Dr Burns Thomson had become its superintendent.

> It is the hour for the patients gathering. They come dropping in one by one.... Gradually the room fills with sufferers of every age, and under well-nigh every sort of ill. As the patients gather a lady comes in and, sitting down among them, begins reading the Bible.... To many of these poor patients, the word of God is absolutely a new sound.... It is now two o'clock. A thin, worn man enters the room with an active springy step, and his forefinger between the leaves of the Bible. It is Dr Burns Thomson, the superintendent of the Institution.... A short prayer follows the sermon, and then the doctor retires to a separate room, where he sees the patient himself, with the students, several of whom are being trained for the work of medical missions.... A correct register is kept of the name, address, ailment and treatment of every patient. All cases that require it are visited at the patient's home. The necessary medicines are given at the dispensary, and medicines, like the advice, are all free. The number of patients verges on seven thousand for the year.[9]

The work was publicized through the issue of the *Medical Mission Circular* in October 1864, to be followed by the *Medical Missionary Journal* in October 1865 and superseded by *Medical Missions at Home and Abroad* in 1878. At the same time, Dr Burns Thomson, often accompanied by Professor Miller, made frequent tours throughout the country, speaking at gatherings of medical and Christian persons, in particular the Mildmay Conference, which at that time attracted very large numbers from all the Protestant denominations.

The outcome was the formation of medical missions at other provincial

[8] See W. Burns Thomson, *Reminiscences of Medical Missionary Work* (1895).
[9] Ibid. pp. 42–4.

centres; at Liverpool (1866), Aberdeen (1868), Glasgow (1868), Bristol (1871), Manchester (1871), Birmingham (1875), Brighton (1875), Oldham (1875) and Dublin (1890).[10] Connexions with Edinburgh were close in the first instance, the Liverpool Mission being an auxiliary of the Edinburgh Medical Missionary Association;[11] the Aberdeen Mission being started by Dr William Thomson Crabbe, a nephew of Dr Burns Thomson;[12] and the Glasgow Mission being an offshoot of that at Edinburgh.[13] The Manchester Mission was inspired by that at Liverpool,[14] and the Birmingham Mission arose from a visit of Dr Burns Thomson in 1874 which was sponsored by Dr Samuel Berry, the president of the Birmingham Christian Medical Association.[15]

Most of these medical missions had several dispensaries, the Birmingham Mission in particular dividing the poorer parts of the city into four sections with a mission responsible for each. Aberdeen, like Edinburgh, trained students of the Aberdeen University for medical missionary work, and Dublin, with a branch at Limerick, had a mobile clinic which toured the rural districts.[16] In all cases district nurses were attached to the missions, or, as in that of Glasgow, a group of deaconesses; all had bands of voluntary workers to call at the homes of the patients; most possessed a convalescent home; and a few had some arrangements for sleeping patients until they could be accepted at a hospital.

London was later in starting such missions, though again the immediate incentive was supplied by Dr Burns Thomson who delivered a series of lectures on the subject in October 1869. The outcome was the opening of the London Medical Mission in Endell Street, St Giles, in 1871 with Dr George Saunders as superintendent.[17] The extension of such missions in London followed at first two main lines; the one stemming from the Mildmay Institution, with which Dr Burns Thomson was closely connected when he left Edinburgh in 1870; and the other from the London Medical Association (1877), of which Dr Saunders was the first president and which had the full support of Dr William Fairlie Clarke.

Dr Fairlie Clarke did much to encourage medical missions in the metropolitan area. He combined a keen interest in social problems with his medical work and had been the first male workhouse visitor to join Louisa Twining. When the Charity Organization Society was formed in 1869 he became

[10] Detailed accounts of these missions are to be found in the periodicals, *Medical Missions at Home and Abroad* (subsequently cited as *M.M.*) and *The Christian* (subsequently cited as *Chr.*). The following references indicate where these may be found. For a brief account see K. J. Heasman, *Evangelicals in Action* (London: Bles, 1962).

[11] *M.M.* Feb. 1886; *Chr.* 10 March 1870, 4 Feb. 1909.

[12] *M.M.* April 1889.

[13] *M.M.* Jan. 1886; Aug. and Sept. 1888; *Chr.* 11 Nov. 1875, 30 Dec. 1875.

[14] *M.M.* June, 1886, Oct. 1888, Aug. 1889, June 1896, Nov. 1897.

[15] *M.M.* Dec. 1887, Jan. 1889, Feb. 1889, April 1899.

[16] *M.M.* June 1890, June 1896, Aug. and Sept. 1898.

[17] See Louisa Clayton, *The London Medical Mission* (1873) for an account of the St Giles Mission.

honorary secretary of their medical committee to deal with hospital reform, and in a paper read to the society in 1871 suggested that medical missions could well supplement the work of the provident societies by providing medical services for those unable to qualify for provident help. With Dr Saunders, he was instrumental in forming the Medical Prayer Union (1874), from which developed the London Medical Missionary Association. Like the association in Edinburgh, the London Association trained medical students of the London University for missionary work, having a hostel where the students lived and several dispensaries where they received practical instruction.[18]

Among these dispensaries were those at St Giles (1871),[19] Marylebone (1876),[20] Canning Town (1887),[21] St Pancras (1888),[22] Deptford (1889),[23] Islington (1890),[24] Lambeth (1891),[25] and Forest Gate (1898).[26] There was some interchange of doctors with the provincial missions, Dr Laidlaw of the Glasgow Mission being for a time the superintendent of the St Pancras dispensary, and close contact with the St Giles Mission, the Marylebone and Deptford dispensaries both owing their origin to St Giles. In London, prominent churches helped with the welfare side of several of the dispensaries, the Regent's Square Presbyterian Church supplying workers for the St Pancras dispensary, and F. B. Meyer's congregation at Christ Church, Westminster Bridge Road, helping at the Lambeth dispensary.

The medical missions of the Mildmay Institution were first formed on the advice of Dr John Dixon from the Glasgow Mission, who had been invited by the Rev. and Mrs Pennefather, the superintendents of Mildmay, in 1874 to start a medical mission in connexion with their work. This Institution had been started in 1861 at Mildmay Park, North London, to provide a centre for Christian social work. By 1874 it consisted of some twenty missions scattered throughout the metropolis and a mission to the Jews in Whitechapel. Its full-time social workers, many of them deaconesses, all received some training and it was probably the most well organized of the voluntary charitable organizations of the period.[27]

The first of its medical missions was opened in connexion with its existing mission at Bethnal Green, and this became the centre for the most complete medical missionary organization in Britain. A staff of full-time medical assistants were employed and dispensaries opened at Victoria Park in 1876, in

[18] E.A.W., *William Fairlie Clarke* (1885), *passim*.
[19] *M.M.* Aug. 1886, Oct. 1888, June 1891, June 1896.
[20] *Chr.* 1 June 1876, 8 June 1882.
[21] *M.M.* Oct. 1887, Feb. 1895.
[22] *M.M.* Jan. 1889, June 1889, May 1894, Dec. 1894, June 1896.
[23] *M.M.* Nov. 1888, June 1889, June 1891; *Chr.* 10 April 1891, 22 April 1909.
[24] *M.M.* June 1891, May 1896, June 1896; *Chr.* 7 March 1890.
[25] *M.M.* June 1896.
[26] *M.M.* April 1898.
[27] Accounts of the medical missions of the Mildmay Institution are also to be found in H. J. Cooke, *Mildmay, The Story of the First Deaconess Institution* (1893), Ch. IX.

Whitechapel in connexion with their work for the Jews in 1880,[28] in Walworth in 1887,[29] and Old Ford in 1888.[30] These dispensaries had the advantage of a trained nursing staff, many of the deaconesses who served them having taken the course in nursing which had been started by the Institution in 1866, and since they were all run in connexion with one of their existing missions, the services of welfare workers were freely available. They possessed the only medical missionary hospital in this country, which was opened in Turville Street, Bethnal Green, in 1877 with Dr William Gauld as its medical superintendent. From the first it was equipped with wards for men, women and children and had a small maternity wing, patients were accepted without recommendation or subscribers' letters, and priority was given to those from the dispensaries. When the hospital was rebuilt in 1892 it could accommodate 400 patients.[31] In connexion with it was a home for the chronically sick, several convalescent homes and a home for the aged. Thus it represented home medical missionary work at its best and continued to meet the needs of the poor in this way in the early decades of the present century, its hospital and maternity home now forming part of the National Health Service.

The example of these medical missions served to make medical work another of the activities which were undertaken by the numerous voluntary charitable organizations of the later decades of the nineteenth century. Dispensaries were opened in connexion with the social work of most of the Protestant denominations. The Quakers, in 1867, started medical work at the Bedford Institute, near the Ratcliffe Highway, which eventually developed into the North Eastern Hospital for Children;[32] the Whitecross Street Medical Mission was opened the next year in connexion with the work of the Methodists in the City and later formed part of the Leysian Mission;[33] the West London Wesleyan Mission introduced medical work in 1887;[34] the Baptists started the Dorrington Street Medical Mission in 1890;[35] the Congregationalists began medical work at the Robert Browning Settlement in 1896;[36] and the Church Army opened its first free dispensary in 1895.[37] The French Protestant Church in Bayswater also opened two dispensaries in 1878 to serve the foreign community.[38]

The larger of the missions took similar action. The Billingsgate Mission, soon after its foundation in 1875, opened a first-aid post to deal with accidents

[28] *M.M.* Nov. 1885, April 1888.
[29] *M.M.* Oct. 1887.
[30] *M.M.* Dec. 1888, June 1891.
[31] *M.M.* Jan. 1885, Oct. 1888, June 1891, May 1892.
[32] *Annual Report of the Bedford Institute* (1867); *M.M.* Aug. 1890, Oct. 1890.
[33] *The Family Friend*, Aug. 1885.
[34] *Annual Reports of the West London Mission*, 1887, 1891, 1894.
[35] *Baptist Times*, 6 Dec. 1918; D. M. Rose, *Baptist Deaconesses* (1954), pp. 6–7.
[36] W. A. Hammond, *Fifteen Years in the Central City Swarm* (1912), p. 78. This is an account of the work of the Browning Settlement.
[37] *Annual Report of the Church Army* (1895).
[38] *M.M.* Jan. 1883.

in the market.[39] Dr Barnardo's dispensary, in connexion with his East London Mission, was opened in Shadwell in 1878.[40] Mr Fegan, a noted worker among boys in Deptford, introduced medical care in the 1880's,[41] and Thomas Jackson did the same in relation to his Working Lads' Institute in Whitechapel.[42] The Battersea Medical Mission (1882), run as part of Mrs Meredith's Mission in Clapham, is noteworthy for its work among women and children. Its first superintendent, Dr Annie McCall, established the Clapham Maternity Hospital in connexion with it, and here one of the earliest schools of midwifery was started.[43]

Only brief mention can be made of the many independent medical missions which were opened at the time, among them the Free Gospel and Medical Mission in the Mile End Road (1873),[44] St Luke's Medical Mission in Bunhill Row (1889),[45] the Bromley-and-Bow Medical Mission (1891) in connexion with the Harley House Missionary Training College,[46] the Kentish Town Medical Mission (1891),[47] St Paul's Medical Mission, Goswell Road,[48] and the Plumstead Medical Mission, founded as a memorial to General Gordon.[49] There is no way of discovering exactly how many of these missions were in existence in the last decades of the century, but it is probable that they were fairly numerous and of varying degrees of efficiency.

From Britain the conception of home medical missionary work was carried to some other countries. Miss de Broen, when she visited Scotland in 1874, heard of the work of the Edinburgh Mission and introduced similar services at her mission in Belleville, Paris. This is said to have been the only medical mission in France at that time.[50] Dr G. D. Dowkonntt, who had worked for three years at the Liverpool Mission, returned to Philadelphia in 1879 to open a medical mission there, to be followed by one in New York in 1881 and another in Chicago in 1883.[51]

Thus it was that home medical missions in the larger towns became increasingly numerous in the second half of the nineteenth century. Two names are outstanding in their development—those of Dr Burns Thomson and Dr Fairlie Clarke. The larger missions tended to fall into closely linked groups, the provincial ones with Edinburgh as their centre, and those in

[39] Charles Oakey, *Billingsgate from Within* (1933), pp. 3 ff. This is an account of the Billingsgate Christian Mission and Dispensary.
[40] *Chr.* 13 Aug. 1896.
[41] *Chr.* 26 May 1898. See also W. Y. Fullerton, *J. W. C. Fegan*, n.d.
[42] See W. Potter, *Thomas Jackson of Whitechapel* (1929).
[43] See Patricia Davies, *Fifty Years of Midwifery, the Story of Annie McCall* (1950).
[44] *Chr.* 16 Jan. 1873.
[45] *Chr.* 31 Jan. 1890; *M.M.* April 1890.
[46] *M.M.* June 1889, April 1890.
[47] *M.M.* June 1891.
[48] George Saunders, *The Healer-Preacher, Sketches of Medical Mission Work* (1884), appendix. This book also contains accounts of several of the other medical missions.
[49] *Chr.* 25 Jan. 1873.
[50] *M.M.* Oct. 1884.
[51] *M.M.* July 1885.

London in connexion with the London Medical Missionary Association. The Mildmay Medical Missionary Organization stands out as an example of what home medical missionary work could achieve. As a result medical missions came to be regarded as one of the services provided by the voluntary charitable organizations of the period, not only in England, but in some other countries where voluntary charity followed a similar pattern. It was only as the state took over greater responsibility for medical services in this country that these missions gradually closed their doors.

It is now necessary to consider the criticism which was raised in regard to these missions. Those who condemned them outright fall into two groups. A few persons, such as the Webbs, were far ahead of their time in suggesting that many of the anomalies might be avoided if such services were rendered by the state, provided that the state could produce a unified, rate-supported scheme for both the destitute and the sick poor.[52] Others, following the contemporary view that thrift should be encouraged at all cost, preferred a voluntary service, but one organized on provident principles and in the form of a comprehensive scheme of provident dispensaries linked with the voluntary hospitals.[53] This was the view of the majority of the Royal Commission on the Poor Laws, and of most of the members of the Charity Organization Society, though the report of the Royal Commission did find some place for medical missions, particularly in cases where other forms of medical help were not readily available.[54]

But most critics raised one or more of the following points. Many were of the opinion that these missions offered 'indiscriminate and unconditional medical attendance'. Persons who should have claimed the medical services of the Poor Law were deflected to them, and some went to both sources. It is quite apparent that persons qualifying for the state medical attention did attend the medical missions, but this was partly caused by the prevailing system. There was often delay between the issue of a medical order by the relieving officer and the attendance of the 'parish doctor'. There might be a discrepancy in hours between those of the relieving officer and the doctor, or the patient might have to wait some time before his medicine was dispensed. In some cases this could lead to disastrous results, and in most it meant interference with working hours and a consequent loss of wages which could cause much hardship to the very poor. Furthermore, some Boards of Guardians followed a highly restrictive policy, making it necessary for a personal visit, on the part of the relieving officer, to the home of the applicant before a medical order could be granted; and there was always the chance of disenfranchisement if any 'medical extras' were provided which could be regarded as additional to ordinary medical relief. Medical missions did not entirely obviate

[52] Webbs, op. cit. Ch. VI.

[53] See Sir Charles Trevelyan, *Metropolitan Medical Relief*, a paper read at a C.O.S. conference, 17 April 1877.

[54] *Report of the Royal Commission on the Poor Laws, 1909*, Cd. 4499, Part V, para. 105.

such difficulties, but they were usually far more accessible to patients, provided medical help more speedily, and had few restrictive regulations.

It was also said that persons who could pay some small amount were attracted to the free services of the missions. This was undoubtedly true and the medical missions were aware of it, using their voluntary workers to assess the circumstances of the patients and asking for some contribution from those who were in a position to pay. In fact, Dr Burns Thomson took much trouble to ascertain, through his voluntary visitors, the circumstances of every patient who attended the dispensaries more than once, that the 'overlapping of medical charities and feigned illness to obtain "sick comforts" might be avoided'.[55]

A constant criticism was that the medical missions were not 'under responsible and specialized medical supervision'. A glance at the qualifications of those in charge of the better-known missions does not indicate this. In fact it is likely that the standard of qualification was higher than that of many of the district medical officers, and certainly of the sick club doctors in the towns, whose jobs were notoriously for those who had failed elsewhere.

The following table gives some details of the qualifications of doctors in charge of the more important medical missions.[56]

Medical Mission	*Doctors in Charge*	*Qualifications*
Birmingham	Samuel Berry	F.R.C.S.
	W. Thomson Crabbe	F.R.C.S.
Brighton	O. R. Prankard	M.D.; M.R.C.S.
	John N. Winter	M.R.C.S.
Bristol	J. Fountain Elwin	F.R.C.S.
Edinburgh	W. Burns Thomson	F.R.C.S.
	William Browne	F.R.C.S.
	John Pringle	M.D.
Glasgow	R. Laidlaw	M.B.; F.R.C.S.
Liverpool	J. A. Howard	L.R.C.P.
	J. Bond	M.B.; C.M.; L.R.C.S.
	J. A. Owles	M.D.
	D. M. Williams	L.K.Q.C.P.
London	W. Fairlie Clarke	M.D.; F.R.C.S.
St Giles	George Saunders	M.D.; C.B.
	David Rhys Jones	L.F.P.S.; L.M.; L.S.A.
	W. Riddall Bell	M.D.; M.R.C.S.
East London	Dr Barnardo	F.R.C.S.
	Robert Milne	M.D.; C.M.
Marylebone	Robert Chambers	L.R.C.S.
Mildmay	William Gauld	M.D.; C.M.
	William Roberts	M.B.; C.M.; M.R.C.S.; L.S.A.
Mission to Jews	John Dixon	M.B.; C.M.
St Pauls	S. C. Griffiths	M.D.; M.R.C.S.

[55] Burns, *Reminiscences*, op. cit. pp. 66–9.

[56] These qualifications appear in the *Medical Directories* of the period.

Medical Mission	*Doctors in Charge*	*Qualifications*
Manchester	Edward Meacham	M.R.C.S.; L.S.A.
Oldham	A. T. Duncan	L.R.C.P.; L.R.C.S.
Salford	Thomas Raitt	M.D.; C.M.

A fully equipped medical mission would also have the services of a qualified dispenser and of nurses with a training of several months in one of the larger hospitals. In the Edinburgh Mission it was customary for the nurses to work for a short time at the Chalmers Hospital, and at Mildmay the deaconesses received not only a year's training in welfare work but an additional six months in one of the hospitals of the Institution. Few other types of dispensary could make such a boast.[57]

Similarly, it was held that the medical students of the training associations in connexion with the medical missions, such as those at Edinburgh and London, were permitted excessive freedom in dealing with patients. This may have been so, though we know that Dr Burns Thomson in Edinburgh was careful to see that his students always visited with a qualified practitioner.[58]

It was also suggested that doctors at the medical missions regarded their work as subordinate to that of any other practice that they might have. This might well be said of some of the district medical officers in the towns[59] and of the sick club doctors. Where it applied to the doctors at the medical missions, it was usually in the case of the smaller mission which did not employ a doctor full-time. It is unlikely that a doctor employed full-time at one of these missions would undertake such unremunerative work without a sense of dedication.

Another criticism was that the medical missions were not able to offer 'immediate institutional treatment to patients'. In practice this was only possible at the out-patient clinics of the large general hospitals and in those Poor Law districts where there was a Poor Law infirmary. But the Mildmay Institution, with its four large dispensaries in South and East London and the central mission hospital at Bethnal Green, at which cases at the dispensaries had priority, provided the outstanding example of medical missions with immediate institutional treatment for patients. Other medical missions, like most of the dispensaries, had supplies of subscriber's letters to the voluntary hospitals, which were given to the patients requiring hospital treatment, and in addition some, such as those at Canning Town and Kentish Town, provided a few beds for those who were awaiting their turn at the hospital.[60]

A more pertinent attack was the view that the medical missions, particularly the smaller and less well-known ones, tended 'to mix up medicine with religion, and seek to attract persons to religious services by the bait of cheap doctoring'. There is no doubt that sometimes the zeal of evangelization did

[57] Burns, *Reminiscences*, op. cit. p. 182. Cooke, op. cit. p. 50.
[58] Burns, *Reminiscences*, op. cit. p. 51.
[59] Webbs, op. cit. pp. 79–80.
[60] *M.M.* Feb. 1895, June 1891.

outweigh the careful selection of patients, and that religion took precedence over adequate medical care. But this was not the desire of those who first sponsored home medical missions. Dr Burns Thomson trained his students 'to heal and to preach',[61] placing the emphasis in that order, and the view of Dr Saunders, the superintendent of the London Medical Mission, was that:

> a true medical mission is an agency where the best medical skill is applied, by thoroughly qualified practitioners, towards the treatment and cure of disease in every form. Yet this is avowedly and openly as a prelude and introduction for the glad story of the Gospel of salvation which the medical missionary comes to bear.[62]

The accommodation of the medical missions was said to involve 'the gathering of crowds of sick persons in halls and passages' where more disease was spread than was cured. This was no doubt the case with some of the missions, for example the Marylebone Mission, where for two and a half years the hall was used as a waiting room and many of the patients were obliged to stand in passages and on the stairs.[63] On the other hand, the premises of the London Medical Mission consisted of a large and well-ventilated hall for 200 patients, consulting and dispensing rooms, with separate rooms for the secretary, nursing staff, lady workers and the welfare department.[64] This compares well with a description of the average Poor Law dispensary in London, which was:

> usually situated in a poor quarter on the ground floor, occasionally on the first floor, of an old dwelling-house, and is seldom built for, but only adapted to, its purpose. One, contained in an old dwelling-house, was reported on by the Local Government Board inspector in 1899 as 'far from satisfactory', and, as regards accommodation, the waiting room was very cold and cheerless, no painting or white-washing had been done for several years.[65]

Lastly, it was asserted that the medical missions played merely an insignificant part in the medical services for the poor during the period. In actual numbers of attendances this was true. Far more people claimed the services of the District Medical Officer and attended the out-patient departments of the voluntary hospitals, and there were some 927 provident dispensaries in the metropolis alone in 1873.[66] Medical missions were only to be found in some of the larger towns and the rural sick depended almost entirely upon the Poor Law doctor and the medical club. But figures of attendances at the medical missions were not insignificant. Aberdeen was said to see 700 new cases per annum; Glasgow to undertake 35,000 consultations; Bristol had 13,000 consultations and 5000 domiciliary visits; Dublin's mobile clinic attended some 100 persons on each trip; St Giles had 5450 consultations and 1190 domiciliary visits in a year; Bethnal Green

[61] Burns, *Medical Missions*, op. cit. p. 17.
[62] Saunders, op. cit. p. 21.
[63] *M.M.* Oct. 1879.
[64] Saunders, op. cit. p. 108.
[65] *Royal Commission on the Poor Laws*, appendix, Vol. XII, p. 273.
[66] Trevelyan, op. cit. p. 18.

had an average of 80 hospital patients with 7000 visits and 6000 consultations; and the Mildmay Mission to the Jews had 14,000 consultations and 5000 domiciliary visits.[67] Statistics such as these can only give a very general impression, for there are no details as to how they were gathered, and they do not all apply to the same year. But they indicate that quite an appreciable number of the persons in the towns made use of the missions.

It is even more difficult to judge the quality of the services which they rendered. Little indication is given as to the time allowed to each patient, though at the Birmingham Mission it is said that the doctor saw ninety patients per day, and gave each patient an average of five consultations.[68] Some district medical officers, to whom few cases were referred, may have done better than this; others certainly far worse. But it is quite impossible, in this instance, to make any justifiable comparison.

In generalizing upon these criticisms it has to be remembered that the Webbs were writing at the beginning of the twentieth century about conditions which they found then. Many of the points in favour of the medical missions are made about their early days which fall during the last three decades of the nineteenth century. It is, therefore, possible that there could have been some marked deterioration in these missions. But even if this were so, such criticisms cannot be said to be entirely warranted. When they did apply, it was usually to the smaller and independent missions which sprang up when medical missions had become a popular form of charitable enterprise. Furthermore, there is no indication from later records that this was equally true of the older, well-established medical missions which have been described here. What can be said is that these smaller missions became more numerous at the end of the nineteenth century and their inadequacies more apparent, and so gave the impression that they were representative of the home medical missionary movement as a whole.

Dr J. A. Owles, a superintendent of the Liverpool Mission, in his reply to the question 'Are medical missions needful and useful at home?' points to the gaps in the medical services which they attempted to fill.

I believe there is a medical necessity for them; neither hospitals, nor dispensaries, nor parochial medical relief can fully meet the need. A principal officer of a Children's Hospital said to me lately, that they did not want trivial cases, nor the very poor... parish infirmaries are only for destitute persons and they are unpopular. Like the healthy wards of the workhouses, they are a last resource. Parish medical officers are badly paid and over-worked. Often they are struggling for a private practice, or they already possess one; and have neither time nor inclination for more than what is absolutely necessary. Provident dispensaries have lately been advocated and may do much good; but if they were multiplied a hundred times over still

[67] These statistics are taken from the accounts of the missions in *Medical Missions at Home and Abroad*. See previous references.

[68] *M.M.* Jan. 1880.

numbers who are too poor to make the regular payments would be left to medical missions. Moreover, in their lowest stratum they need us to seek them, and almost to compel them to accept advice and medicine. They will not apply until the very last stage of disease, and then only to get a certificate of the cause of death.[69]

It was these two main groups, whose needs were rarely met by other forms of medical care, whom the medical missions sought to help—the very poor, and those who were not seriously ill. Low wages, casual employment or changing residence made it impossible for many to contribute regularly to the provident fund or sick club. Nor would such persons be granted state medical relief in areas where the regulations were applied at all strictly. Their alternative was the small-fee-demanding doctor whom few could afford for any protracted illness, or the medical mission.

Likewise, the great majority of Poor Law cases were those of chronic infirmity. Children were not very frequently to be found on their list, adults rarely except where disease was advanced, and midwifery cases according to the policy of the guardians. It was mainly persons from these categories who were to be found at the medical missions, in particular the children, upon whom special attention was bestowed. The medical missionary was therefore in a far better position to make an early diagnosis than the state medical practitioner.

In the course of their work the medical missions emphasized two aspects of medical care which were overlooked by many boards of guardians—home nursing, and what were called 'medical extras'. As Mrs Webb pointed out in her memorandum to the Royal Commission:

> From the medical standpoint, one of the greatest obstacles to recovery among the sick poor who are treated in their homes is the lack of proper nursing. The district medical officer has no power to order a nurse to be provided. The boards of guardians have power to appoint one or more salaried nurses to visit the sick poor on outdoor relief, but I have not come across any such Poor Law nurses, and I believe that hardly any boards of guardians have made such appointments.[70]

The medical missions always included a nurse on their staff whose duty it was to attend to cases at the dispensary and to follow out the instructions of the doctor in the home of the patient. In fact, the well-organized medical mission consisted of a team of doctor, dispenser, nurses and voluntary workers combining their services for the benefit of the patient.

Similarly, as Mrs Webb also pointed out, 'in the medical attendance of the sick poor, recovery often depends on more than drugs and hygienic advice'.[71] Medical extras, or 'those necessary articles of food or medical or surgical appliances which will conduce to the recovery or improvement of health of the patient',[72] were sometimes supplied by the unions, though quite often they

[69] *M.M.* Oct. 1878.
[70] *R.C. on the Poor Laws, 1909*, appendix, Vol. XII, p. 277.
[71] Ibid. p. 275.
[72] Webbs, op. cit. p. 32.

took the form of additional relief and never reached the sick. They formed, however, an integral part of the provision made by the medical mission. Beef tea, milk, arrowroot, and other food for the sick were supplied from the invalid kitchen on the recommendation of the doctor, coal was provided for a fire for the sick-room, and blankets and other medical necessities were lent for the period of need. Thus medical missions were concerned with the general comfort and well-being of their patients at a time when the usual attitude towards the sick poor was one of grudging relief.

Furthermore, the needs of the family of the patient were taken into consideration by the medical missions, as well as those of the individual. The voluntary workers visited the homes of all who attended the dispensaries, reported on the conditions which they found there and upon the needs of other members of the family, in particular of the children. The women and children were encouraged to attend the social activities of the mission and so brought into contact with its staff, and both the doctor and nurse would visit the home when necessary and in this way often became the counsellor on domestic matters and the friend of the family. This meant that the doctor could base his treatment on his knowledge of home surroundings. It also made it possible for any disability or incipient illness of any member of the family, or even of the neighbours, to be noticed and treated in its early stages. Much of this closely resembled the duties of the district nurse, of the health visitor, and of the other social workers who today try to help in domestic problems.

Similarly, the medical missionary was ahead of his time in taking some account of the mental as well as the physical condition of the patient. In his combination of medical and spiritual help he had some faint realization of the interaction of the state of mind upon the general health of the body. For example, it is said of Dr Crabbe of Birmingham that he made a point of seeing each patient alone, of addressing him by his christian name, and of spending time to talk with him and listen to his difficulties.[73] It cannot be said that these doctors had any real knowledge of psychology or mental processes, and in certain instances their crude methods of preaching the Gospel had deplorable results. But they were the precursors of those who today support spiritual healing and who see in the complementary work of the pastor and the doctor a greater future for medical science.

These home medical missions of the later nineteenth century cannot be passed over as worthless and unworthy of detailed comment. As already noted, they had many deficiencies, probably the most striking being the tendency of the smaller missions to show little discrimination in those whom they treated, to render inadequate services and to supply a mixture of religion and medicine which did little credit to either. But this cannot be said of the

[73] *M.M.* April 1881.

larger missions, particularly of those connected with the Edinburgh or the London Medical Missionary Associations, and with the Mildmay Institution, whose medical missionary hospital and missions provide an outstanding example of home medical missions at their best.

To their credit was the fact that in many cases they supplied services for groups of people who would otherwise have been left without medical attention, and in so doing filled a temporary gap in the medical services which was later provided by the better facilities of the Poor Law and the Public Health services, and by the change in attitude of the authorities towards caring not only for the destitute sick but for those who found it difficult to make any but a small payment.

Had this been all, they would be worthy of note. But they also set a precedent for the co-ordinated services which are provided today by the local health and hospital authorities in their combination of medical services, nursing, welfare facilities and advice in the home; and for the interest which is now taken in the family as the unit for attention. It may be argued that what they achieved in these respects was infinitesimal, but theirs is the first instance in which such an approach was successfully tried and it compares favourably with the contemporary attitude of the poor law authorities.

Furthermore, they emphasized the fact that health depends as much upon the soundness of mind and spirit as upon that of the body. In this they were far in advance of the thought of their time and followed methods which are more familiar to the twentieth than to the nineteenth century.

These missions should therefore receive somewhat more attention from the social historian than they have done in the past.