The union doctor

D. U. BLOOR, MRCGP, DCH
General Practitioner, Stourbridge; Course Organizer, Dudley.

SUMMARY. The appointment, terms of service, and work of the Poor Law medical officer, the union doctor, is described to illustrate one of the roles of the mid-nineteenth century general practitioner. It was this role which laid the foundation of modern general practice.

Introduction

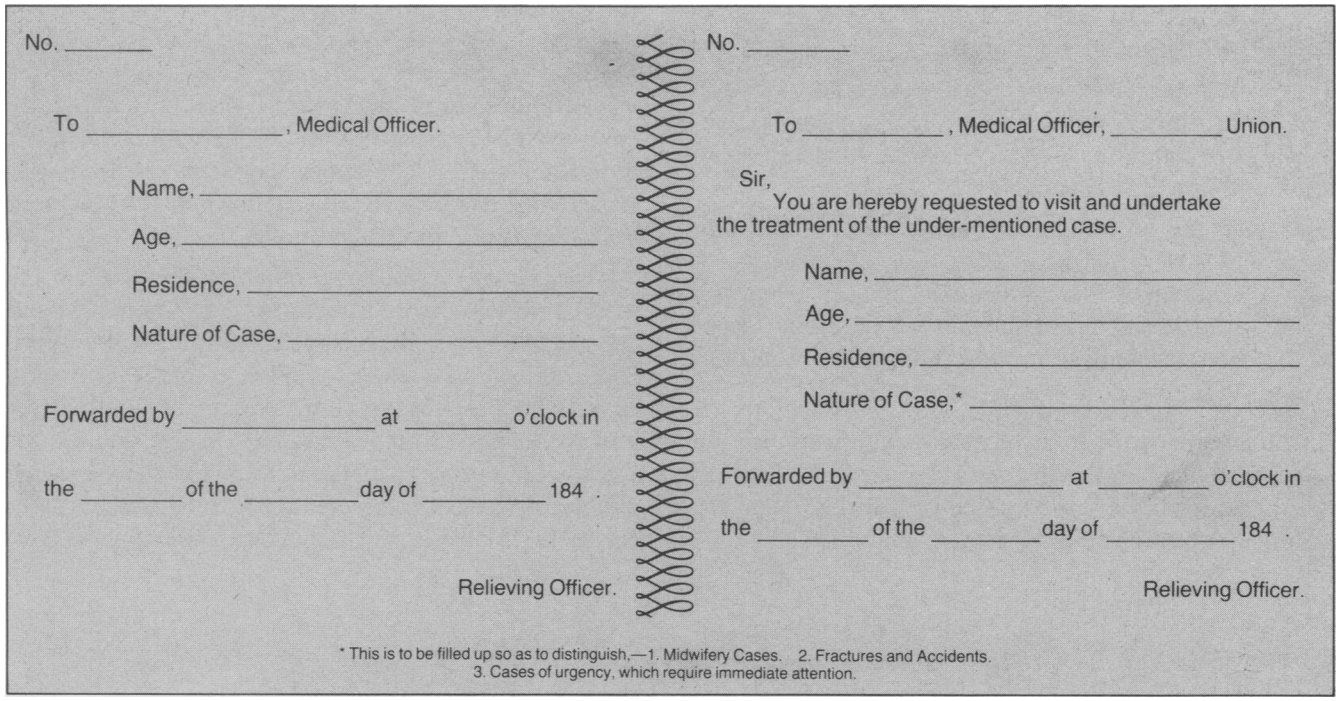
THE census of 1851 showed that half the population was by then living in towns (Trevelyan, 1944). The massive shift of the population from the country to the town had been brought about by the Industrial Revolution and was, at this mid-point of the century, still increasing. The fruits of the revolution were put on show by the Prince Consort in 1851 at the Great Exhibition, while the spoils of the revolution, the social and medical problems, were being identified and solutions were being sought.

The first Public Health Act, 1848 tackled the sanitary problems of urbanization while the most important Factory Act, 1847 made some attempt to tackle the worst evils of the factory system. During all these intensive activities, quietly and unnoticed by historians, leave was granted to introduce a Bill into Parliament which set out the foundations of a Royal College of General Practitioners (McConaghey, 1972). Unfortunately, nothing came of it but the years of bitter struggle to get that far demonstrated the strength and growing influence of a body of medical men who had always been concerned with primary care. What then was general practice like at this focal point in our history?

It was diverse and had many facets, for it was constantly having to adapt to rapidly changing conditions—conditions that many doctors were trying to influence for the better. Most of the working population, and their families if they could afford it, were looked after by a doctor working for a sick club or Friendly Society. Many mining and railway companies ran their own sick clubs and deducted the workers' contributions at source (Bloor, 1978a). Doctors were also employed as certifying surgeons to examine children and young people before they started work in the factories and to enquire into accidents (Thomas, 1948). There were always a few patients who managed to pay the doctor but the hard core of general practice at this time consisted of those who could not afford a doctor or a subscription to a club. They were attended by a doctor employed by the Board of Guardians, usually on a part-time basis and called the 'union doctor'. This doctor could also be doing all the other jobs mentioned above and was in every sense a general practitioner. A better understanding of general practice at this time will, therefore, come from looking at these individual roles.

The Poor Law and the Board of Guardians

The origin of the National Health Service and the Welfare State may be traced to the Poor Law Amendment Act, 1834 which resulted from the findings of the Royal Commission on the workings of the Poor Law (Hodgkinson, 1967). This classic social document was much concerned with the principle of self-help and deterring the able-bodied pauper from seeking help (Checkland and Checkland, 1974). It is surprising to find that this Act makes only two scant references to medical relief, and yet it has formed the foundation of our medical services. Its enactment gave rise not only to the administrative framework of the medical and welfare services but to many other local government services. The parish, a self-contained social unit for many hundreds of years, was inefficient and too small for central administration. Parishes were therefore joined together to form 'unions': the 15,535 parishes in the Report had become 568 unions by 1837. Each union was controlled by a Board of Guardians elected from ratepayers and Justices of the Peace and they usually met once a week. The essence of the new administration was that control was exerted over the Board of Guardians by a central board, the Poor Law Board. They issued the guidelines, directives, and regulations. The Board of Guardians lasted nearly a hundred years until it was abolished by the Local Government Act, 1929. Fortunately, over the years the work of the Poor Law Board and the Board of Guardians was monitored by various select committees and royal commissions and this led to progressive reform. This article is based on


No. _____

To _____, Medical Officer.

Name, _____

Age, _____

Residence, _____

Nature of Case, _____

Forwarded by _____ at _____ o'clock in

the _____ of the _____ day of _____ 184 .

Relieving Officer.

No. _____

To _____, Medical Officer, _____ Union.

Sir,

You are hereby requested to visit and undertake the treatment of the under-mentioned case.

Name, _____

Age, _____

Residence, _____

Nature of Case,* _____

Forwarded by _____ at _____ o'clock in

the _____ of the _____ day of _____ 184 .

Relieving Officer.

* This is to be filled up so as to distinguish,—1. Midwifery Cases. 2. Fractures and Accidents. 3. Cases of urgency, which require immediate attention.

Figure 1. *Form (I): The medical relief order check book. (after Parliamentary Papers, 1854.)*

the evidence taken by the Select Committee on Medical Relief, 1854 (Parliamentary Papers, 1854).

The appointment of a union doctor

The size of a union, in area and population, varied a great deal but the maximum size of 15,000 acres and the same number of people was laid down by a Poor Law Board regulation of 1842. Most unions had their own workhouses and the two most important officers of the Board of Guardians were the 'relieving officer' and the doctor. It was the duty of the relieving officer to assess the social and medical needs of people and advise the Guardians about their eligibility for relief. If he considered they needed relief, he issued an 'order' (Figure 1) in writing which had to be handed to the doctor. Theirs was a difficult, unenviable, and often dangerous job which brought them into contact with dirt, squalor, and infection. During the cholera epidemic of 1847, for example, 27 relieving officers and their assistants in the Liverpool Union died.

Although doctors were selected by the local Board of Guardians their appointment had to be approved by the Poor Law Board and they alone had the power of dismissal. There seemed to be no shortage of applicants despite the low pay (Figure 2). The main inducements seemed to be the chance of making more contacts, increasing private practice, and stopping someone else from getting the job. The doctors could be chosen by several methods. Initially, there was the novel method of the doctor submitting a tender for his services and this of course ensured that the Guardians got the best bargain. This pernicious practice was stopped in 1842 by a Poor Law Board regulation. The job, if advertised, had to state the salary but the only regulation imposed on the Guardians was the notification of an election of a doctor to a union. The appointment was often for life but could also be on an annual basis and the election each year a mere formality. Occasionally, the annual appointment gave the Guardians an opportunity to get rid of a doctor with expensive prescribing habits. Complaints against doctors were, however, uncommon and took the form of a letter written by a gentleman or clergyman to the Poor Law Board. The Board could then ask the local Poor Law inspector to investigate or if medical negligence was involved a local medical man of some eminence could be asked to look into the matter. The Board could then admonish the doctor or ask him to resign, as they did to seven doctors in 1853. Formal dismissal, which was in their power, never occurred.

After the selection of the doctor the clerk of the Guardians would formally notify the Poor Law Board of the appointment on the appropriate form. The doctor had to be a licensed medical man, for this was one of the two scant references to medical relief in the 1834 Act. Any of the following four qualifications were acceptable:

1. A diploma or degree as surgeon from a Royal College or university in England, Scotland, or Ireland, and a degree in medicine from a university in England legally authorized to grant such degree, or both, with a diploma or licence of the Royal College of Physicians of London.

2. A diploma or degree as surgeon from a Royal College or university in England, Scotland, or Ireland,

and a certificate to practise as an apothecary from the Society of Apothecaries of London.

3. A diploma or degree as surgeon from a Royal College or university in England, Scotland, or Ireland, if the applicant had been in actual practice as an apothecary on 1 August 1815.

4. A warrant or commission as surgeon or assistant surgeon in Her Majesty's Navy, or as surgeon, or assistant surgeon, or apothecary in Her Majesty's Army, or as surgeon or assistant surgeon in the service of the Honourable East India Company, dated before 1 August 1826.

The insistence by the Board on these qualifications is, in retrospect, most important, for a standard was being set which led inevitably to the Medical Act 1858 and the setting up of the General Medical Council.

The work of the union doctor

The work of the union doctor involved seeing patients in the workhouse or in their own homes and this could be done by the same doctor or different ones (De Carle Woodcock, 1912). The duties and the necessary paper-work to be done were clearly laid down by the Poor Law Board (Figures 3 and 4; Appendix).

It was usually essential to obtain an order from the relieving officer before a doctor would see a patient and this act itself must have come from utter desperation. Four out of six patients applying for relief would become paupers. Many people would prefer to pawn their worldly goods in order to pay the five shillings for a consultation out of a labourer's wage of nine to ten shillings a week. Others preferred to do neither. John Leigh, the Manchester Union doctor and Registrar of

Figure 2. *'A splendid opening for a young medical man'. (Reproduced by permission of* Punch.*)*

SPLENDID OPENING FOR A YOUNG MEDICAL MAN 1848

Chairman : 'WELL, YOUNG MAN. SO YOU WISH TO BE ENGAGED AS PARISH DOCTOR ?'
Doctor : 'YES, GENTLEMEN, I AM DESIROUS——'
Chairman : 'AH ! EXACTLY. WELL, IT'S UNDERSTOOD THAT YOUR WAGES—SALARY I SHOULD SAY—IS TO BE TWENTY POUNDS PER ANNUM ; AND YOU FIND YOUR OWN TEA AND SUGAR—MEDICINES I MEAN—AND, IN FACT, MAKE YOURSELF GENERALLY USEFUL. IF YOU DO YOUR DUTY, AND CONDUCT YOURSELF PROPERLY, WHY—AH—YOU—AH—— '
[*Punch :* 'WILL PROBABLY BE BOWLED OUT OF YOUR SITUATION BY SOME HUMBUG WHO WILL FILL IT FOR LESS MONEY.']

Births and Deaths, stated that out of 2,179 deaths, 726 had no medical attention at all (Parliamentary Papers, 1854).

Trying to get emergency help was often very difficult, particularly if the relieving officer could not be found. A church warden could give an order and the Poor Law Board was emphatic that a doctor could attend a patient without one and still get paid; but the doctors found from bitter experience that the Guardians did not always pay up and so there was great reluctance to go without an order.

Getting an order was not the end of the problem. Dr Cooper, of the Stowe Union, stated that in his Union a patient might live seven miles from the relieving officer,

(A.) To be filled up by the Medical Officer.

Initials of Medical Officer in attendance on every Case.	Name of the Sick Pauper.	When admitted to Sick Ward.	When Discharged.	Nature of Disease.	Days when Attended.							Males.							Females.							Extras.			State or Termination of the Case, and in the Event of Death, the apparent Cause thereof.
												The No.* of the Dietary on which placed							The No.* of the Dietary on which placed.											
					S.	M.	T.	W.	Th.	F.	Sat.	S.	M.	T.	W.	Th.	F.	Sat.	S.	M.	T.	W.	Th.	F.	Sat.	What ordered	When ordered.	When discontinued.		
					Total No. each Day																									

Figure 3. *Form (P): District medical relief book. (after* Parliamentary Papers, *1854.)*

Figure 4. *Form (Q): The workhouse medical relief book. (after* Parliamentary Papers, *1854.)*

Week ending day of 184 .

Name.	Age.	Residence.	Parish to which Chargeable.	Nature of Disease.	Days when attended, or when Medicines were furnished.*							Necessaries ordered to be given to the Patient.	Present State or Termination of the Case.	Observations.
					S.	M.	T.	W.	Th.	F.	Sat.			

*Attendances at the Patient's own house are to be denoted by the letter (H). Attendances at the Surgery or Medical Officer's residence, by the letter (S). Medicines supplied without seeing the Patient, by the letter (M). Any attendances given by a substitute or other person, instead of the Medical Officer, is to be entered in *red* ink.

the doctor six miles from the patient and seven miles from the relieving officer and so a relative would have to walk 20 miles to get the doctor to the home, and then walk 12 miles next day to collect the medicine.

Medicines

The majority of the union doctors were under contract to supply patients with drugs and this expense element was incorporated in their remuneration. It was commonly stated that because of this the drugs given out were inferior to those issued to private patients and members of sick clubs. This was consistently denied by the doctors and they claimed that they had no hesitation in prescribing recently introduced expensive drugs, such as cod liver oil and quinine.

Most doctors dispensed their own medicines; there were no tablets or injections to be given at the time of the consultation and so a home visit would mean another visit to the surgery or workhouse. This problem was already being tackled in 1850 by the formation of dispensaries in towns and cities, while the rural areas relied, as today, on the dispensing doctor. The city dispensaries were set up by subscription or by the Board of Guardians. In Liverpool, for example, there were two Poor Law dispensaries with a drug store and three subscription dispensaries attached to hospitals.

Perhaps more important than medicines was the attention given to diet and it was within the doctor's power to order 'extras' such as special diets, meat, beer, or porter (Table 1). The Board of Guardians was always extremely cost conscious and the ordering of extras by the doctors led to constant friction. There is no doubt that the doctors were often liberal in their prescribing habits and ordered extras when patients were not ill but merely suffering from malnutrition, knowing that this was against the rules. The Poor Law Board made it clear, however, that doctors were free to prescribe what they considered necessary but unfortunately this had no legal force since the local Board of Guardians controlled the money.

Doctors' pay

There was dissatisfaction with pay and conditions within a few years of the introduction of the union system rather like the period 1948 to 1966, and this led to the formation of many medical associations. The Association of Poor Law Medical Officers had a membership in the middle of the century of about 3,000.

The methods of payment varied from one union to another: a fixed salary, per-case payment only, or extra fees added onto either of these methods or a different rate for the able-bodied pauper or infirm. A sum of £30 was common for workhouse work and £70 if a district was included. If a district involved a great deal of

Table 1. Medical reports for weeks ending June 14 (after *Parliamentary Papers*, 1854).

No. 1 contains 18 Cases, and the following Orders are made:

Intermittent	Mutton.	Inflamed lungs	Mutton.
Cancer	ditto.	Rheumatism	ditto.
Uterine pain	ditto.	Paralysis	ditto.
Debility	ditto.	Intermittent	ditto.

No. 2 contains 14 Cases, and the following Orders:

Diseased bones	Mutton and porter.	Cough	Mutton.
Debility	Mutton.	Fever	ditto.
Pneumonia	ditto.	Pleuro-pneumonia	ditto, and porter.
Cough	ditto.		

No. 3 contains 18 Cases, and the following Orders:

Amenorrhoea	Mutton and porter.	Dropsy	Mutton.
Scrofula	Porter.		

No. 4 contains 79 Cases, and the following Orders:

Old age	Mutton.	Diseased bone	Mutton.
Diseased heart	ditto.	Bronchitis	ditto, and porter.
Cancer	ditto.	Ague	Porter.
Erysipelas	ditto.	Diseased bladder	Mutton and porter.
Convalescent	ditto.	Abscess	Mutton.
Inflamed leg	ditto.	Diseased bones	ditto, and porter.
General debility	ditto.	Diseased knee joint	Mutton.
Old age	ditto.	Diseased lungs	ditto.
Diseased heart	ditto, and porter.		

No. 5 contains five Cases, and the following Orders:

Chronic cough	Mutton.	Abscess	Mutton.
Dyspepsia	Mutton.		

travelling an attendance allowance was sometimes paid, for it would be necessary to keep two horses. Extra fees were usually allowed for maternity cases and for vaccination. The fee for a normal delivery would be 10 shillings and for a difficult confinement £1. Liverpool Union did not allow any extra fees at all. Most doctors had a small amount of private practice which was more lucrative. Dr Cooper, of the Stowe Union, calculated in 1847 that he received £40 for his union work and that this paid at the private rate would come to £302 and, similarly, the £9 for his sick club with 60 members should have realized £24. In other words, he was receiving one eighth as much pay for his union work as for his private work (Parliamentary Papers, 1854).

In the large cities it was common to forbid private work because of the large volume of work and the workhouses were quickly evolving into infirmaries. Various inducements were offered to compensate for this. The Liverpool Union offered a salary of £200 per year with a free house and maintenance. The system of payment was supposed to cope adequately with the massive increase in work during epidemics and particularly those of the cholera epidemics of 1847 and 1853. It was made clear by the Poor Law Board that the local guardians should pay out fees but at the end of the day their parsimonious attitude prevailed.

Conclusion

The picture of the union doctor that emerges from the Select Committee Report, 1854 is not dissimilar to the modern general practitioner. Duties and guidelines were laid down (terms of service), payment by salary (basic practice allowance), attendance allowance (mileage allowance), extras (item of service), per-case payment (capitation fees) and separate fees for midwifery and vaccination: all these are the essence of the Red Book. It was therefore inevitable that there should be lengthy discussions on medical supervision and audit of the Poor Law doctors and equally clear that any such suggestions would be firmly rejected. Despite this, the medical profession and particularly the Society of Apothecaries (Bloor, 1978b) were raising standards and the Poor Law Board was in a unique position to impose standards, and did so. The union doctor worked for a pittance in difficult circumstances and was the lowest in the medical hierarchy but he had by his endeavours, his associations, and his contractual obligations, enabled the modern general practitioner to maintain his role in primary care and to stand as an equal among his medical colleagues.

Appendix

Duties of a medical officer

Art. 205. The following shall be the duties of every medical officer appointed by the guardians, whether he be the medical officer for a workhouse or for a district:

No. 1 To give to the guardians, when required, any reasonable information respecting the case of any pauper who is or has been under his care; to make any such written report relative to any sickness prevalent among the paupers under his care, as the guardians or the commissioners may require of him; and to attend any meeting of the Board of Guardians when requested by them to do so.

No. 2 To give a certificate respecting children whom it is proposed to apprentice in conformity with Articles 59 and 61.

No. 3. To give a certificate under his hand in every case to the guardians, or the relieving officer, or the pauper on whom he is attending, of the sickness of such pauper or other cause of his attendance, when required to do so.

No. 4 In keeping the books prescribed by this order, to employ so far as is practicable, the terms used or recommended in the regulations and statistical nosology issued by the Registrar-general; and also to show when the visit or attendance made or given to any pauper was made or given by any person employed by himself.

Duties of a district medical officer

Art. 206. The following shall be the duties of a District Medical Officer:

No. 1 To attend duly and punctually upon all poor persons requiring medical attention within the district of the Union assigned to him, and according to his agreement to supply the requisite medicines to such persons, whenever he may be lawfully required to furnish such attendance or medicines by a written or printed order of the guardians, or of a relieving officer of the union, or of an overseer.

No. 2 On the exhibition to him of a ticket, according to Art. 76, and on application made on behalf of the party to whom such ticket was given, to afford such medical attendance and medicines as he would be bound to supply if he had received in each case an order from the guardians to afford such attendance and medicines.

No. 3 To inform the relieving officer of any poor person whom he may attend without an order.

No. 4 To make a return to the guardians at each ordinary meeting, in a book prepared according to the form marked (P) hereunto annexed, and to insert therein the date of every attendance, and the other particulars required by such form, in conformity with Art. 205, No. 4.

Provided, however, that the medical officer may, with the consent of the guardians, but not otherwise, make the entries which he is directed to make in such book on detached sheets of paper, according to the same form, and cause the same to be laid before the guardians at every ordinary meeting, instead of such book; and the guardians shall, in that case, cause such sheets to be bound up at the end of the year.

Duties of the medical officer for the workhouse

Art. 207. The following shall be the duties of the medical officer for the workhouse:

No. 1 To attend at the workhouse at the periods fixed by the guardians, and also when sent for by the master or matron.

No. 2 To attend duly and punctually upon all poor persons in the workhouse requiring medical attendance, and according to his agreement to supply the requisite medicines to such persons.

No. 3 To examine the state of the paupers on their admission into the workhouse, and to give the requisite directions to the master, according to Articles 91 and 92.

No. 4 To give directions and make suggestions as to the diet, classification, and treatment of the sick paupers, and paupers of unsound mind, and to report to the guardians any pauper of unsound mind in the workhouse whom he may deem to be dangerous or fit to be sent to a lunatic asylum.

No. 5 To give all necessary instruction as to the diet or treatment of children, and women suckling children and to vaccinate such of the children as may require vaccination.

No. 6 To report in writing to the guardians any defect in the diet, drainage, ventilation, warmth, or other arrangements of the workhouse, or any excess in the number of any class of inmates, which he may deem to be detrimental to the health of the inmates.

No. 7 To report in writing to the guardians any defect which he may observe in the arrangements of the infirmary, and in the performance of their duties by the nurses of the sick.

No. 8 To make a return to the guardians, at each ordinary meeting, in a book prepared according to the Form (Q) hereunto annexed, and to

insert therein the date of every attendance, in conformity with Art. 205 and the other particulars required by such form to be inserted by the medical officer, and to enter in such return the death of every pauper who shall die in the workhouse, together with the apparent cause thereof.

No. 9 To enter in the commencement of such book, according to the Form marked (R), hereunto annexed the proper dietary for the sick paupers in the house, in so many different scales as he shall deem expedient.

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Vocational trainees

Will [vocational trainees] insist on working as members of primary health care teams? Will some of them accept the challenge of inner city areas, or will they leave it to hospitals to take responsibility for primary care in these areas? Will the team be increasingly involved in personal preventive services? Will young doctors be motivated to seek out vulnerable patients; people who most need vaccination, contraceptive advice, cytological screening, child health surveillance? Or will they leave it, as do many of their elders, to clinical medical officers and community nurses deployed by the area health authority?

Will family doctors take a larger part in the training not only of medical undergraduates but also of related professions including nurses and social workers? Will they follow the example of a few pioneers in recording and examining their own performance with a view to improving it, or will they wait for others to thrust some form of audit upon them?

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