## *Public Health Issues and General Practice in the Area of Middlesbrough, 1880-1980*

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## Abstract

The thesis looks at the industrial town of Middlesbrough from 1880-1980. It examines public health issues the town encountered, with particular reference to General Practitioners (GPs), assessing their interactions with the community, local authorities, industry and medical professionals.

The rationale for this study was to evaluate the relationships the GPs formed within the town and how they responded to the changing nature of health in Middlesbrough as the century under investigation progressed. GPs are often overlooked within medical history; therefore, the study provided an opportunity to examine their role over an extended period.

The thesis utilized a previously unused archival resource, the Dr Geoffrey Stout Collection (Teesside Archives, Middlesbrough). Additionally, it analysed Medical Officer of Health reports, local newspapers, medical journals, council minutes and comparable secondary literature sources. Oral history interviews with retired GPs from the area were also collected throughout the project.

The thesis determined that GPs within Middlesbrough had complex relationships with the principle stakeholders of the town, the attitudes of the GPs, especially towards public health, often being in conflict with the town's officials. Middlesbrough's association with industry compromised the community's health; this complicated not only the GPs relationship with the community but, on occasion, caused the town's authorities to delay in their response to outbreaks of disease in order to protect Middlesbrough's industrial paymasters.

This thesis provides a continuous outline of the role of GPs in an industrial town, not only at the height of its success but also during the post-WW2 decline. It presents analysis of the GPs interactions, roles, attitudes, successes and failures. Additionally, it reviews the town's health and the attempts made to combat disease, improve sanitation and reconstruct housing. The study establishes the origin of the town's long-term association with poor health, a topic still pertinent and relevant in modern policy debate.

# 'Public Health Issues and General Practice in the Area of Middlesbrough, 1880-1980'

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## List of Abbreviations

(BMA) British Medical Association

(BMJ) British Medical Journal

(GP/GPs) General Practitioner(s)

(ICI) Imperial Chemical Industries

(IMR) Infant Mortality Rate

(LHA) Local Health Authority

(MDMS) Middlesbrough District Medical Society

(MOH/MOHs) Medical Officer(s) of Health

(NHI) National Health Insurance

(NOH) North Ormesby Hospital

(TB) Tuberculosis

## Statement of Copyright

## Acknowledgements

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## Dedication

This thesis is dedicated to my parents and Shelley, for their unending love and support throughout.

# Introduction

## Overview, Aims and Objectives

The thesis will explore the relationship between the public health issues that have arisen, historically within Teesside, specifically Middlesbrough, from 1880-1980 and the primary factions who dealt with these varying and multifarious concerns. The inquiry will include an analysis of living conditions within the region, looking at housing, poverty and unemployment. The thesis will examine the impact of industry, in regards to pollution, employment, working conditions and changes in the industrial dynamics of the area. It will also examine the types of disease that have affected the region and the health care provision and ideas developed to combat these, at times endemic, illnesses. Finally, the thesis will look at the social conditions of the community and the effects they had upon health. The interrelationship between these areas is extensive; any given section does not allow for a thorough examination without reference to the others. They all have implications upon each other, largely regarding the decisions that the individuals, community and officials made at any given time. The relationship between the factors is particularly evident in the case of infectious diseases such as pulmonary tuberculosis (hereafter, TB), measles, scarlet fever and pneumonia. These diseases were prevalent in the areas of a town where there was poor housing conditions, high unemployment and inadequate diets (within Middlesbrough these included the wards of Newport, St. Hilda's and Cleveland).[1]

The principle stakeholders that require consideration when assessing health within the town of Middlesbrough is the population, industry, the medical profession and local authorities. The latter group comprised of numerous committees and boards covering a wide spectrum of health issues as part of their duties. The interactions between the aforementioned groups are to be examined in terms of their respective relationships and the hierarchy of power within the town. The interactions between these groups were complex,

[1] Katherine Nicholas (1986), *The Social Effects of Unemployment in Teesside*, Manchester University Press, Manchester, p. 84. For details of the wards of Middlesbrough, see *Fig. 1*, Chapter I, p. 42.

and power and influence tended to shift throughout the course of the century. During the greater proportion of the period explored, the community had the least influence over the decisions made, ostensibly in their name. Instead, this was left to the local authorities and their various committees associated with health, alongside the medical profession of the town.

Within the medical profession, the key group to be observed is that of the General Practitioners (hereafter, GP(s)). The study will focus on their experience of public health issues within the town and the wider region, and how they dealt with what arose, and in turn, how this influenced their daily working lives. The primary aim of this is to assess whether the perceived wisdoms of what GPs encountered during the late nineteenth century and much of the twentieth century, such as industrial, environmental and health concerns regarding living and social conditions were what the GPs were confronted with. One of the difficulties in looking at these effects upon health is assessing the impact upon GPs in the area, and subsequently, the GPs influence upon them. General practice records, particularly those pertaining to the first half of the twentieth century, are scarce. Once an individual has been dead for ten years or more, their medical records can be disposed of. Therefore, much of the GPs interaction and role can only be analysed by reviewing the Medical Officer of Health (hereafter, MOH(s)) annual reports to see which diseases they would have been treating and their subsequent reactions to any outbreaks or epidemics. Hospital records can reveal those admitted by referral from GPs to those treated by GPs within the actual hospital.[2] The problem, however, arises with the fact that patient records are not widely accessible.[3] Medical journals and local newspapers can be useful for gaining insight as to what the GPs were doing, as many of them would write articles or letters about issues that were concerning their region and their practice. To this end, chapter IV of the thesis contains a

[2] Only hospital records that contained patient information prior to 1910/11 could have been viewed in open access. As this is not a study of hospital treatment it was identified early in the research process as an unbeneficial source due to the incomplete nature of such records both in terms of the information recorded concerning GPs and the lengthy process of application for access.
[3] Guenter B. Risse and John Harley Warner (1992), 'Reconstructing Clinical Activities: Patient Records in Medical History', *Social History of Medicine*, **5**: pp. 183-205.

small number of oral interviews taken with GPs who practised during the 1950s-1980s. The interviews form a substantial element of the final chapter of the investigation and help illustrate the trends and responses to health by the GPs in a way that no other source of information allows.

The thesis will examine the role of the GP in relation to public health. What did public health mean for GPs? What did they consider public health to be? When one uses the expression "public health", is it another term for preventive medicine, or does it mean the health of the public? In 1920, Charles-Edward Amory Winslow (1877-1957), an American bacteriologist and an expert in the field of public health, defined it as follows,

> 'Public health is the science and the art of preventing disease, prolonging life and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health.'[4]

This definition is still largely applicable to what the aims of public health are today. Therefore, Winslow's explanation can certainly be of help in considering how the GPs of Middlesbrough might have felt about public health from 1880-1980. GPs historical role as "curer" would tend to suggest that their perception of the term applied more towards the health of the public than that of preventive medicine. Was there a reluctance amongst the GPs to become actively involved with public health matters? Was their involvement passive and dependent on issues such as workload, relationships with the MOH and town authorities? The possibility exists that the GPs were not encouraged to be involved in initiatives regarding public health within Middlesbrough. If so, what were the reasons behind such a strategy and who controlled the implementation of public health in the town?

[4] Charles E.A. Winslow (1920), 'The Untilled Fields of Public Health', *Science*, **51**(1306): p. 30.

There is a substantial body of existing work on the history of public health in Britain, particularly within the industrial era. Such histories have often taken the form of generalized reviews of the structure of public health and the implementation of policy.[5] This is particularly evident in work regarding sanitation, especially the critical period after Edwin Chadwick's 1842 publication *Report on the Sanitary Condition of the Labouring Population of Great Britain*.[6] The historians and sociologists who have headed the field in examining public health and medicine have included Dorothy Porter, Jane Lewis and Virginia Berridge.[7] Their publications have tended to observe the developments of public health in Britain over an extended period, with no specification to one geographical area or singular aspect of the subject, such as sanitation, vaccination and screening programmes or responses to disease and epidemics. There have also been much more detailed, focused investigations of the topic, addressing the issues of individual towns and themes, or on occasion, both. An example of one such study that combined both aspects is John Welshman's review of public health in the city of Leicester during the twentieth century.[8] This thesis will maintain its focus on the role of the GP and their involvement in matters of public health rather than relinquishing the emphasis of the study over to the role of the local authorities and the MOH. By necessity, the latter two groups will form a critical element of the thesis. However, the central analysis of their role shall be in relation to their interaction with the GPs.

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[5] Steve Sturdy (ed.) (2002), *Medicine, Health and the Public Sphere in Britain*, *1600-2000*, Routledge, London, and George Rosen (1993), *A History of Public Health* (Introduction by Elizabeth Fee; Biographical Essay and New Bibliography by Edward T. Morman), John Hopkins University Press, Baltimore.

[6] Edwin Chadwick (1965), *Report on the Sanitary Condition of the Labouring Population of Great Britain*, Edinburgh University Press, Edinburgh (original work published 1842) and Christopher Hamlin (1998), *Public Health and Social Justice in the Age of Chadwick: Britain, 1800-1854*, Cambridge University Press, Cambridge.

[7] Dorothy Porter (1994), *The History of Public Health and the Modern State*, Rodopi, Amsterdam, Jane E Lewis (1986), *What Price Community Medicine? : The Philosophy, Practice, and Politics of Public Health Since 1919*, Wheatsheaf Books, Brighton and Virginia Berridge (1999*), Health and Society in Britain since 1939*, Cambridge University Press, Cambridge. Other exemplars include, Anthony S Wohl (1984), *Endangered Lives: Public Health in Victorian Britain*, Methuen, London, Frances B Smith (1979), *The People's Health, 1830 to 1910*, Croom Helm, London and Sally Sheard and Helen Power (eds.) (2000), *Body and City: Histories of Urban Public Health*, Ashgate, Aldershot.

[8] John Welshman (2000), *Municipal Medicine: Public Health in Twentieth-Century Britain*, Peter Lang, Oxford.

GPs have seldom been examined in relation to their involvement in matters of public health; indeed GPs are often consigned to the footnotes of such histories or at best a chapter within a larger volume.[9] In the last twenty years, there have been some publications regarding General Practice and its history within Britain. The most notable being, Irvine Loudon's *Medical Care and the General Practitioner 1750-1850*, Anne Digby's *The Evolution of British General Practice 1850-1948* and finally, the edited volume *General Practice Under the National Health Service, 1948-1997*.[10] Whilst they are thorough, chronological reviews of the field of General Practice and its development, they are generalized with no specificity to a particular geographical location.[11] This is something that this thesis presents, the opportunity to assess the changes within General Practice in a defined location over a period of one hundred years. It traverses two centuries, evaluating the rise and fall of industry within the town and the fall and rise of General Practice in the second half of the era examined.

Anne Digby's study of British general practice was careful to utilise an extensive dataset of GPs from all over the country. This was a conscious attempt to make the study as inclusive as possible rather than exclusive by including GPs from both urban and rural practices.[12] For the purposes of this study of Middlesbrough, it is only the urban GPs data that shall be assessed as the development of urban Middlesbrough provides the most valuable insight into the structure of general practice in a modern, custom-built industrial

[9] The Welshman study is an example of this observation, with only a partial chapter dedicated to the GPs of the city. There are a few examples of work's that have looked at the role doctor's played in relation to public health, however they are not necessarily specific to General Practice. Jeanne L Brand (1965), *Doctors and the State: the British Medical Profession and Government Action in Public Health, 1870-1912*, John Hopkins University Press, Baltimore and Elizabeth Fee and Roy M Acheson (eds.) (1991), *A History of Education in Public Health: Health that Mocks the Doctors' Rules*, Oxford University Press, Oxford.

[10] Irvine Loudon (1986), *Medical Care and the General Practitioner, 1750-1850*, Oxford University Press, Oxford, Anne Digby (1999), *The Evolution of British General Practice 1850-1948*, Oxford University Press, Oxford and Irvine Loudon, John Horder and Charles Webster (eds.) (1998), *General Practice Under the National Health Service, 1948-1997*, Clarendon Press, London. Work largely based on these studies include Irvine Loudon (1984), 'The Concept of the Family Doctor', *Bulletin of the History of Medicine*, **58**: pp. 347-362 and Anne Digby and Nick Bosanquet (1988), 'Doctors and Patients in an Era of National Health Insurance and Private Practice, 1913–1938', *Economic History Review*, **41**: pp. 74-94.

[11] Even the examples that have looked at a particular location have tended to be based around a particular premise. Mark Perry (2000), 'Academic General Practice in Manchester under the Early National Health Service: A Failed Experiment in Social Medicine', *Social History of Medicine*, **13**(1): pp. 111-130 and Martin Powell (2005), 'Coasts and Coalfields: The Geographical Distribution of Doctors in England and Wales in the 1930s', *Social History of Medicine*, **18**(2): pp. 245-263.

[12] Digby, *Evolution of British General Practice*, pp. 4-7.

town. Digby acknowledges the same difficulty that this study also encountered, namely separating GPs from surgeons and subsequently from other specialisms such as public health, especially in the late nineteenth and early twentieth centuries.[13] Specialism was often left to those who predominately practiced in the hospital environment, although there was often reluctance by doctors to abandon general practice entirely. The GPs in question possibly viewed general practice as a lucrative source of income in a town with relatively few practitioners to meet the needs of an increasing population such as Middlesbrough.

Other histories of the profession have tended to focus on general practice in comparison to secondary care (hospital-based medicine), an exceptional example being the work of Frank Honigsbaum in examining the division between primary and secondary care.[14] Medical practitioners have also attempted to write their own histories, journals such as the *British Medical Journal* and the *British Journal of General Practice* have often published editorials or short articles related to the history of GPs.[15] Such accounts tend to be non-specific in their approach, certainly in terms of location and often subject matter. The inclusion of GPs within a study, except for the examples noted, rarely occurs in any consistent, continuous form.

Another area requiring consideration is how much impact medical intervention had upon improving health in the region. This debate still exists within medical history even today. Thomas McKeown famously argued that environment and social improvements had the greater impact on the decline in mortality rates rather than medicine.[16] His work primarily looked at the decline of infectious diseases during the nineteenth century, prior to the introduction of mass immunisation, antitoxins or antibiotics. He argued that improvements in living conditions led to the lower mortality rates, meaning that diseases did not have the

[13] *Ibid*.
[14] Frank Honigsbaum (1979), *The Division in British Medicine : A History of the Separation of General Practice from Hospital Care, 1911 -1968* , St. Martin's Press, New York and Frank Honigsbaum (1980), 'Separation of General Practice', *The Lancet*, **315(8170)**: pp. 716-717.
[15] These are often GPs reminiscing about their time in practice. Denis Pereira Gray (1992), 'History of the Royal College of General Practitioners: The First 40 Years', *British Journal of General Practice*, **42(353)**: pp. 29-35 and Zosia Kmietowicz (2006), 'A Century of General Practice', *British Medical Journal*, **332**: pp. 39-40.
[16] Thomas McKeown (1979), *The Role of Medicine: Dream, Mirage or Nemesis?*, Blackwell, Oxford.

same level of opportunity to spread as previously. This he contended was in combination with improved diet and nutrition, leaving individuals less susceptible to infection and in a better situation to fight it. This is a highly contentious argument, many commentators, such as Simon Szreter, feel it undermines the role of medicine.[17] Particularly as the decline in mortality rates, or so it is disputed, cannot be entirely attributed to the decline in infectious disease. Indeed, medical historians Flurin Condrau and Michael Worboys recently made the case that infectious diseases were never the 'normal' cause of death in the Victorian era and that national epidemic crises were not as widespread in the era as believed, but rather localised.[18] This argument can certainly be borne out by the experience in Middlesbrough in the late nineteenth century. However, the disease to cause Middlesbrough the most concern during this time was pneumonia. The issue of whether the disease could be considered infectious is one that has continued to be debated through until the present day. There has been recent conflicting opinion over the experience of the Victorians regarding epidemics and infectious disease. Graham Mooney highlighted the issue concerning the infectious nature of pneumonia in the Victorian era. He contended that 'a very large portion, if not all, of the deaths ascribed to pneumonia in the Victorian period were infectious.'[19] Condrau and Worboys do not consider pneumonia to be infectious, or to have been considered so by nineteenth-century doctors, as in order for it to be so it had to have been 'directly or indirectly communicable.'[20] One of the aims of the first chapter of this thesis is to address the latter assertion that pneumonia was not considered infectious or communicable by contemporary physicians. Certainly, the experience of those in nineteenth-century Middlesbrough was at odds with this opinion, and the attestations of the town's doctors are there to be seen. Whether this was through frustration from a lack of demonstrable evidence to the contrary,

[17] Simon Szreter (1988), 'The Importance of Social Intervention in Britain's Mortality Decline c. 1850-1914: A Re-interpretation of the Role of Public Health', *Social History of Medicine*, **1**: pp. 1-37.
[18] Flurin Condrau and Michael Worboys (2007), 'Second Opinions: Epidemics and Infections in Nineteenth-Century Britain', *Social History of Medicine*, **20**: pp. 147-148.
[19] Graham Mooney (2007), 'Response: Infectious Diseases and Epidemiological Transition in Victorian Britain? Definitely', *Social History of Medicine*, **20**: p. 599
[20] Flurin Condrau F. and Michael Worboys M. 2009, 'Second Opinions: Final Response Epidemics and Infections in Nineteenth-Century Britain', *Social History of Medicine*, **22**: p. 167.

or an appreciation of the unusual set of variables the disease presented within Middlesbrough is for debate.

The town of Middlesbrough has over the previous decade, come under intense scrutiny from the media, both local and national. This is particularly so in reference to nationwide issues such as obesity, poverty, substance abuse, crime and the long-term health effects that industry can have. Middlesbrough has effectively become the 'gold' standard by which all perceived negative elements within the country can be compared. Declared on a national television programme in 2007 as 'the worst place to live' in Britain, the town has long had to endure a negative image in the public psyche.[21]

The importance behind undertaking such research is what it can provide us with in relation to the health issues we have to address in the region today. There were health concerns specific to the North East of England. These issues still have resonance today, as health provision in the region proves problematic for both the government and the local health authorities. In evaluating how GPs coped with such problems in the past, it may prove beneficial when structuring future health policies and strategies for the North East. In addition, by evaluating the factors that occurred in the past that may have some impact on the communities' health in the future, perhaps we can plan for those eventualities more successfully than previously. Additionally, the thesis will aim to investigate whether the modern day perceptions of the town have any deep-rooted historical basis. Furthermore, it will attempt to determine whether it was the actions of those involved in public health care during the period to be examined that have left Middlesbrough with this most ignominious of reputations.

This thesis, therefore, will argue that GPs were involved in public health matters within Middlesbrough, although this was expressed almost passively at times. Those the

[21] The programme in question was the Channel 4 property show '*Location, Location, Location*' which informed viewers that Middlesbrough had 'critical health levels, double the English average of drug abuse, 8 per cent more smokers than the English average and over a quarter of inhabitants admitted to binge drinking.' Complaints by Middlesbrough Council to the British television watchdog OFCOM (Office of Communications) were subsequently dismissed, thus reinforcing the view that this analysis of the town was indeed correct. http://www.dailymail.co.uk/news/article-1204127/Middlesbrough-really-worst-place-live.html. Accessed on May 23rd 2011.

GPs worked with, especially the MOH, directly influenced the level of association they had with any given public health initiative. The thesis will also contend that the GPs involvement was often hindered by the attitude of the local authorities of the town, observable throughout the period examined. This interference, as the GPs perceived it, led to reluctance amongst the doctors to become engaged with public health concerns in the town. Therefore, the GPs continued to operate as an autonomous group within Middlesbrough and the surrounding area. The thesis will attempt to demonstrate that not only did this strained relationship between the GPs and the local authorities damage chances of public health initiatives being successfully implemented within the town but it also compromised the health of the community. Such theories will be assessed by analysing the Infant Mortality Rate (hereafter, IMR) of the town, reviewing the varying responses to epidemic disease in Middlesbrough and evaluating the success of the planned reconstruction of the town just after WW2.

## Methodology

The main sources used when researching the thesis, other than the historiography of the available secondary literature available on the topic, were those housed at the Teesside Archives in Middlesbrough. Located within these archives is the *Special Collection of Dr Geoffrey Stout*, which includes medical material from the early nineteenth century through until the 1980s.[22] Dr Stout, who had practised as a GP within Middlesbrough from 1957 to 1987, was himself an enthusiastic medical historian, collecting information on all aspects of health within Teesside for several decades prior to his death in 2001.[23] Stout also published numerous articles in local history journals concerning sanitation, disease and the role of the MOH within the region.[24]

[22] Robina Weeds (2003), *A Catalogue to the Medical History Papers of Geoffrey Stout in Teesside Archives*, University of Teesside, Middlesbrough.
[23] David W Pattenden (2001), 'Obituary for the Late Dr Geoffrey Stout', *Cleveland History*, **80**: pp. 2-3.
[24] Geoffrey Stout (1976), 'Floating Hospitals on the Tees', *Cleveland and Teesside Local History Society*, Bulletin **31**; Geoffrey Stout (1981), 'Enteric Fever in the Tees Valley 1890-1891', *Cleveland and Teesside Local History Society*, Bulletin **40**; pp. 30-38; Geoffrey Stout (1986), 'A Ledger Initialled

## Oral History

As already mentioned, the thesis shall make use of interviews, undertaken with retired GPs from Middlesbrough and the surrounding areas. This is a qualitative study by using the narrative of the GPs interviewed to inform the focus of the final chapter.[25] Oral history has become an increasingly attractive source of primary information for researchers in recent decades. There are multiple resources of assistance when undertaking an oral history study, including journals such as the *Oral History Review* and *Oral History*. Additionally there have been innumerable methodological guides published, dealing with the basic concepts of the research area that traverse all disciplines.[26] The use of oral history within the History of Medicine is slowly becoming more widespread and the studies that have so far utilized this method are recounted in detail within chapter IV, although they are still limited in their overall use.[27]

However, there are inherent difficulties associated with using such a subjective, qualitative method as a researcher. The objections raised about oral history are that it does not have the same rigour that other methods of collating information might provide. There are variables that cannot be controlled or even defined when using oral history as a source. Memory is one such example; the value of memory is a contested area. Is memory more valuable than other forms of knowledge? Do we put a higher value on it because it is what

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G.P. (Dr George Pilkington)', *Cleveland and Teesside Local History Society*, Bulletin **49**; Geoffrey Stout (2000), 'Three Eminent Middlesbrough Women (Mrs May Hedley, Sister Ann Purvis and Dr Minnie Levick)', *Cleveland History*, Issue **78**; pp. 31-46; Geoffrey Stout (1987), 'Water Bourne Disease in 19th century Cleveland', *Cleveland Industrial Archaeologist*, **19**: pp. 15-20. These are just a few examples of the local history journal contributions that Dr Stout made on health issues in the region.

[25] Catherine Pope and Nick Mays (1995), 'Qualitative Research: Reaching the Parts Other Methods Cannot Reach: An Introduction to Qualitative Methods in Health and Health Services Research', *British Medical Journal*' **311**: pp. 42-45.

[26] Steven Caunce (1994), *Oral History and the Local Historian*, Longman, London, Robert Perks and Alistair Thomson (1998), *The Oral History Reader*, Routledge, London, Donald A. Ritchie (2003), *Doing Oral History: A Practical Guide*, Oxford University Press, Oxford.

[27] For example, Ronald Johnson and Arthur McIvor (2001),''Dust To dust': Oral Testimonies of Asbestos-related Disease on Clydeside, *c*. 1930 to the Present' *Oral History*, **29(2)**: pp. 48-61 and Angela Davis (2011), 'A Revolution in Maternity Care? Women and the Maternity Services, Oxfordshire *c*. 1948-1974', *Social History of Medicine*, **24(2)**: pp. 389-406.

someone attests to have been their experience and somehow seems irrefutable?[28] There can be differences and inconsistencies with what has been previously acknowledged, but that does not necessarily discredit either source.[29] Memories can also not be considered without due attention being paid to the cultural framework of that time, be it the Second World War or the strikes of the 1970s. The memory of an individual may not be the same as the established historical "truth", but that does not necessarily mean that either source has superiority over the other. These are the memories and interpretations of an individual; their personal experience of a given situation and cannot be automatically discounted. Oral history sheds light on a topic or event in a way that can never be easily gleaned from official records. It is the personal reflections on a given situation; reflections that can add substance and background to an area often in a way never previously considered tangible. It does not matter that the dates and times of events might be incorrect, those details can be verified elsewhere; it is the memory and meaning that said event held for the individual that is invaluable to the researcher. That is not to suggest that glaringly erroneous, false memories are to be accepted, but they are to be verified before being dismissed. Another issue for consideration is the concept of truth. When interviewing an individual about an incident or era, there is always the risk of what they might omit (often subconsciously) or what they might embellish. However, public records and statistics also do not always stand up to scrutiny. Such sources are themselves only as reliable and as objective as those that provide information on which they are based.[30] There are also issues associated with imposing meaning and intent where it never existed in the first place. However, to some extent, this is an inherent danger with history in general, sources of all kinds are open to interpretation and the context as such can often be skewed. Unavoidably, the researcher comes to the project with assumptions, questions and preconceptions based on existing

[28] Katherine Hodgkin and Susannah Radstone, 'Introduction: Contested Pasts' in Katherine Hodgkin and Susannah Radstone (eds) (2003), *Contested Pasts: The Politics of Memory*, Routledge, London, pp. 1-21.There can be differences and inconsistencies with what has been previously acknowledged but that does not discount either source.
[29] *Ibid*. p. 5.
[30] Valerie Raleigh Yow (2005), *Recording Oral History: A Guide for the Humanities and Social Sciences*, AltaMira Press, Oxford, pp. 9-10.

primary and secondary literature, this project is no different in that respect. However, as the veteran oral historian Yow observes '[t]he qualitative researcher must be conscious of assumptions and interests that inform the work and be aware of how and why these change during the research process.'[31]

GPs were recruited via an advertisement in the local paper (*The Northern Echo*), requesting any retired GPs in the region willing to be interviewed, about their experiences, to contact the University's School of Medicine and Health.[32] Recruiting GPs who fitted the criteria proved to be somewhat problematic and ultimately only a small sample could be taken. However, the doctors interviewed did come from a variety of practices and practice compositions from both Middlesbrough and its nearby towns. Therefore, this provided a worthwhile insight into the lives of GPs in the area from 1950-1980.[33] When using oral history as an analytical tool, as has been demonstrated, there are a number of considerations to be made, especially as far as the selection of interviewees are concerned. Even at an early stage of this part of the project there appeared to be a definite 'type' of person prepared to come forward and offer help. They were often individuals with an established or proven record of accomplishment within the field of general practice, even if it were essentially at a local level. The GPs interviewed have tended to be those with a relatively illustrious career; overall, they were often well published and highly regarded within the region. These men were also used to talking about their lives and their work already, so this might have explained their readiness to participate. However, it was not possible to either select or reject an interviewee on this basis, as only a small number of persons were willing to take part. No female GPs came forward for interview, nor did any of the male GPs interviewed make any mention of women working in their practices (outside of the established female roles of nursing or administration). That is not to suggest that there was a complete absence of female GPs in the area, although judging from the interviews carried

[31] *Ibid*., p. 8.
[32] The interviews were conducted with the approval of the School of Medicine and Health's Ethics Committee (date of approval 01/12/2008).
[33] Chapter IV further explores this particular strand, contemplating the issues surrounding both oral history interviews and the level of importance or relevance that can be established when using them.

out it seems to have been a predominately male profession within the region.[34] This factor requires consideration in the same way as the types of people who volunteered for a study such as this, and the overall impact these circumstances may potentially have on the project and the viewpoint accessed.

Once those willing to participate in the study had been identified and contacted, the interviewing process began, taking place over a four-month period from January 2009 to April 2009. The interviews were recorded using an Olympus VN-480PC digital voice recorder, with an additional microphone attached to the recorder for enhanced sound quality. It was decided whilst planning the interviews to adopt this method rather than using an external microphone attached to the interviewee to eliminate possible sound interference.[35] Additionally, the method of placing the recorder discretely in-between the participant and myself removed any potential awkwardness the interviewee might feel at talking directly into a microphone.[36] The interviews were semi-structured, with only an opening premise of what the study was to incorporate relating to public health issues the GPs faced; their daily workloads and routine; links with industry within the area; and the changes they witnessed over their career regarding the types of health issues and diseases they encountered.[37] Chapter IV of the thesis discusses the evolution of the interview technique as both the individual and successive interviews progressed. The interviews lasted, on average, 90 minutes although this varied depending upon how much information the interviewee felt they could provide, all those interviewed gave their time generously with no predefined time limits ever being imposed. Once completed, the recorded interviews were then transferred to a

[34] Dr Geoffrey Stout did interview one female practitioner in the course of his research in the 1980s; however, this appeared to be the exception. Additionally, the medical and trade directories suggest a dearth of female doctors in the town until after the 1980s.
[35] Ken Howarth (1999), *Oral History*, Sutton Publishing Limited, Stroud, pp. 138-149.
[36] Additionally, the interviews all took place at the GPs home residence, as those interviewed were by this time in their 70s and 80s and it was beneficial to ensure that inconvenience was kept to a minimum. Furthermore, risk assessment was carried out at a University level, and security measures such as phoning my supervisor on arrival and departure of the interview were implemented.
[37] The GPs were provided with an outline of what the study was about (at that time) as well as a consent form to allow the recording of the interviews to be used within the thesis and kept, if appropriate, for further use by other researchers. A copy of the participant information sheet and the consent form can be found in the appendix.

secure, password encrypted computer, to which only I had access, and the copy on the voice recorder deleted.

The aim of the project was not to analyse the interviews quantitatively. Therefore, they did not require coding; language, prose and phraseology, did not require evaluation. There had been a discussion early in the planning stages of the project to use coding software, such as NVivo, to analyse the interviews. Ultimately, due primarily to the limited number of participants that were forthcoming, it was decided that no significant quantitative analysis could be gathered from the small sample size. The significant part of the interview was the narrative, what the GPs said rather than the way in which they said it or the commonality of language they used.[38]

## Local Studies

Over the last sixty years, local history has become an area of increased focus for academic historians. Those who consider themselves 'professional' or academic historians have had a tendency to eschew the discipline; partially, due to its perceived close links to 'amateur' local history groups or genealogy.[39] Another factor cited against local history is that it is myopic and isolated from national and international events to have any significant relevance to key historical questions.[40] It is, however, despite such claims an area of growth. In part, this is due to the concepts of the relatively 'new' historical method of analysis known as micro-history.[41] This being the exploration of the individual or small community (microcosm) to examine and gain insight into the larger or national debate (macrocosm). Through contextualising what is discovered at the local level against what is perceived nationally or even internationally much can be learnt about the anomalies as much as the commonalities.

[38] The commonality of experience is a different matter and open for further analysis and interpretation.
[39] William G. Hoskins (1984), *Local History in England*, Longman, London, pp. 4-5. Hoskins states that in actuality 'it was the amateurs who founded the study of local history and topography in this country'.
[40] G. Levi, 'On Microhistory' in P. Burke (ed) (2001), *New Perspectives on Historical Writing*, Polity, Cambridge, p. 100.
[41] *Ibid*., pp. 97-119.

The definition of 'local' can be a problematic one, depending somewhat upon the historian. W.G. Hoskins defines it primarily as a small village, settlement or town, as larger communities (large towns, cities and regions) demand a different, broader set of criteria and capabilities for their proper examination.[42] Local history can also traverse and conjoin many disparate strands of historical areas, as well as spanning considerable periods. The accessibility of records at a local level also makes it an extremely viable and diverse arena for research, particularly for those who relish the 'hands on' nature of the task. This aspect is combined with the fact that many local archives contain a rich, vast, untapped source of information.[43]

In order to study and research local history, a varied range of historical knowledge is required. Hoskins cites that the knowledge required includes 'political, ecclesiastical, social, economic, military, and yet other kinds.'[44] This is because local history can be defined as being 'primarily about the origin and growth of community...why and when local communities changed.'[45] No community or individual can be considered as an isolated unit, therefore, this wide range of approaches needs to take place. The community and the people within it will also have functioned concomitantly, at least to some degree, at a national or even international level. This is particularly so in the case of local business, which spreads outwards from the local area, this being the initial focal point, but not the end.[46] Another element of this is that a large timeframe can be covered and explored, even in the case of quite a small area.

There is a vast array of sources available when researching local history; the starting point usually being the local archives, libraries and museums. These can all constitute initial sites for research, housing items such as manuscripts, local newspapers, electoral, census

[42] Hoskins, *Local History*, pp. 9-10. Kate Tiller describes 'local' as defined by 'people, place and community' not just geography or size. Kate Tiller (1992), *English Local History: an Introduction*, Alan Sutton, Stroud, p. 1.
[43] Tiller, *English Local History,* p. 6.
[44] Hoskins, *Local History*, p. 7.
[45] Tiller, *English Local History,* p. 1.
[46] Levi, 'On Microhistory', pp. 100-102. Levi uses the example that even an individual buying a loaf of bread can be incorporated into an analysis of the world's grain market.

and parish records, documents, diaries, maps and surveys. These can illustrate the many changes that an area can undergo and are readily available both online and at archives. There are also numerous journals dedicated to the study of local history, examples being *The Local Historian* or the *Local Population Studies*.[47] Many local archives also produce pamphlets and guides specific to the historical issues in that region.

Essentially this project can be considered a local study as it is set within the parameters of a distinct location. This does not exclude it from having significance beyond the region it is investigating. The project also includes analysis of the interactions between the local level of government, and indeed the medical profession, and their national counterparts. This is where significant exchanges can be assessed, as particularly in the first half of the period in question; directives tended to come from national government, but interpretation was left to the local authorities. This study can provide the opportunity to observe how this worked and how it progressed as the century unfolded. The local authorities were, at times, at odds with what national government demanded as their focus and aims for the town were not always compatible. Additionally, the thesis will question the level of support offered by national government and the relevance of its advice to those towns far away from its London stronghold. Martin Powell has distinguished between local and national service provision. Local people through election should make local government selection; national has no input from the local level. Local funding can either rely entirely on its own resources or grants from a central level to fulfil its local objectives.[48] The third difference is that, unlike local control and funding, national provision should be the same for everyone, regardless of age, location, gender or race. In theory at least, the inception of the NHS allowed this final criterion to become a reality.[49] Additionally, there is an intrinsic difference between personal health services and municipal health services. Levene *et al* describe personal health services as a predominately curative one (GPs), whereas municipal

[47] Tiller, *English Local History*, p. 21.
[48] Alysa Levene, Martin Powell, John Stewart and Becky Taylor (2011), *Cradle to Grave: Municipal Medicine in Interwar England and Wales*, Peter Lang, Oxford, pp. 20-22.
[49] *Ibid*., p. 22.

health services are local government led and funded initiatives, often concentrating on promoting preventive ideas and measures.[50] Local studies, such as this one, can also help to explain anomalies in health and the experience of healthcare based on the implementation of directives the local bodies often found difficult to follow or accommodate.

There have been some highly successful local studies within the history of medicine, although they have been thus far sparse in nature. Hilary Marland's 1987 study of the Yorkshire towns of Wakefield and Huddersfield from 1780-1870 proved to be a seminal work, which inspired subsequent local studies of medicine and health in Britain's industrial town's to take place.[51] John Welshman's study of Leicester also provides a vivid example of how an investigation can offer unique insight into the health on an industrial town.[52] More frequent, however, are studies that focus on an individual institution or theme. For example, Anne Digby's review of the York Retreat, John Pickstone's examination of hospital development in Manchester as well as Barry Doyle's research on the history of hospitals within Middlesbrough.[53] There are examples too of compiled works focusing on local medical history, even within the north east, but these tend to be isolated compositions, produced in association with local history groups.[54] However, there have been recent examples of essentially locally based studies being extended to cover wider themes and geographical areas, whilst retaining the concepts central to a local investigation. These include Emma Jones and John Pickstone's review of the recent history of the National Health Service (hereafter, NHS) and public health in Manchester and Doyle's comparative study of hospital

[50] *Ibid*., pp. 3-4.
[51] Hilary Marland (1987), *Medicine and Society in Wakefield and Huddersfield: 1780-1870*, Cambridge University Press, Cambridge.
[52] Welshman, *Municipal Medicine*.
[53] Anne Digby (1985), *Madness, Morality and Medicine: a Study of the York Retreat, 1796-1914*, Cambridge University Press, Cambridge, John V Pickstone (1985), *Medicine and Industrial Society: a History of Hospital Development in Manchester and its Region, 1752-1946*, Manchester University Press, Manchester and Barry Doyle (2002), *A History of Hospitals in Middlesbrough*, South Tees Hospitals NHS Trust, Middlesbrough.
[54] David Gardner-Medwin, Anne Hargreaves and Elizabeth Lazenby (eds.) (1993), *Medicine in Northumbria: Essays on the History of Medicine in the North East of England*, The Pybus Society for the History and Bibliography of Medicine, Newcastle-Upon-Tyne.

provision in Middlesbrough, Leeds and Sheffield.[55] Additionally, within the given examples, there have been numerous pleas made to continue and extend locally based research.[56]

## Middlesbrough

It became clear during the initial research stages of the project that Middlesbrough was the focal point for developments during the timeframe examined. The surrounding area, therefore, was to be used as a comparison to events in Middlesbrough, as it tended to exhibit conditions that were atypical within the region. There are numerous resources available in relation to the town, both in terms of secondary literature, and perhaps most importantly, the quantity of archival material that has survived in a variety of areas within the region and on a wide subject range. This is probably due, in part, to the unusual and accelerated growth of the town from the middle of the nineteenth century until the middle of the twentieth, owing to the expansion of industry, particularly iron and steel. The town has been the focus of many studies over the last hundred years, more often than not because it appears to provide a microcosmic view of the social construction of a town with the advantage of studying the event over a relatively short timeframe.[57] In short, Middlesbrough presents the researcher with the opportunity to witness, over the space of one hundred years, events that would perhaps have taken three times as long to occur in most other

[55] Emma L. Jones and John V. Pickstone (2008), The Quest for Public Health in Manchester: The Industrial City, the NHS and the Recent History, Manchester Primary Care Trust, Manchester and Barry Doyle, (2010) 'Labour and hospitals in three Yorkshire towns: Middlesbrough, Leeds, Sheffield, 1919-1938' *Social History of Medicine*, **23**: pp. 374-92.

[56] Such pleas are contained in the Welshman study as well as John V. Pickstone (1989), 'Medicine in Industrial Britain: The Uses of Local Studies', *Social History of Medicine*, **2**, 197-203.

[57] These are not all necessarily health related, with the exception of the work carried out by Barry Doyle on hospital provision and more recently his work on air pollution, very little has been researched at an academic level on the town's health. Local history groups have on occasion taken an interest in the various aspects of healthcare however, and these can provide a useful resource for locating references and archival sources. Barry Doyle and Robina Nixon (2001), 'Voluntary Hospital Finance in North-East England: The Care of North Ormesby Hospital, Middlesbrough, 1900-1947', *Cleveland History, The Local Bulletin of the Cleveland and Teesside Local History Society*, **80**: pp. 4-19; Doyle, *A History of Hospitals in Middlesbrough*; Barry Doyle (2007), 'Competition and Cooperation in Hospital Provision in Middlesbrough, 1918-1948', *Medical History*, **51**: pp. 337-56; Doyle, 'Labour and hospitals'; Barry Doyle (2010), 'Managing and Contesting Industrial Pollution in Middlesbrough, 1880-1940', *Northern History*, **47**: pp. 135-54.

towns and cities. Studies based in Middlesbrough have tended to look at the industrial history of the town, or merely provide a general overview of its development since the mid-nineteenth century.[58] There have been a few examples of studies that have taken place outside of that sphere, notably David Taylor's analysis on policing in the Middlesbrough from 1840-1914, and the challenges posed.[59] However, investigations relating to health, other than Doyle's work on hospital provision in Middlesbrough, tend to be more recent. Assessing the health issues the town has exhibited over the last twenty to thirty years, rather than historical interpretations.[60] Minoru Yasumoto has looked briefly at health provision in Middlesbrough during the mid-nineteenth century as part of a larger study of the town's growth, although once more largely reviewing hospital provision and workers contributions.[61]

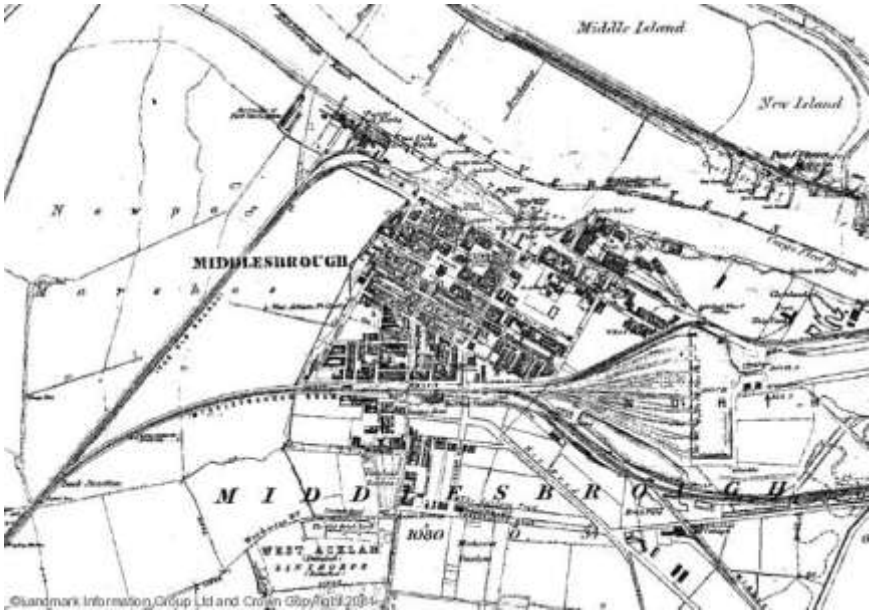
It is the precise nature of the aforementioned rapid growth that makes Middlesbrough what it is, and which is of such interest. The exponential rate at which the population grew initially provided strength to Middlesbrough. However, this growth also led to the town's eventual decline as the century progressed, buckling under the strain of an unsustainable populous. A cursory look at the town seems to suggest that lack of foresight and planning towards the future are possibly to blame. Victorian industrialists, excited at what they had created in Middlesbrough, did not stop to ask 'what if?' What if this was a temporary boom? What would happen if the iron ore eventually ran out? How would they provide housing for the workforce? Was it wise to encourage migration of labour from other areas of the country, could this drain resources in the area irrevocably? This is not to suggest that things had

[58] Ray Hudson (1985), *The Development of Middlesbrough's Iron and Steel Industry, 1841-1985*, University of Durham, Durham, William Lillie (1968), *History of Middlesbrough*, *An Illustration of the Evolution of English Industry*, Middlesbrough Corporation, Middlesbrough, AJ Pollard (ed.) (1996), *Middlesbrough Town and Community 1830-1950*, Sutton Publishing Limited, Stroud and Ian Stubbs and Jenny Parker (2008), *Middlesbrough: a Century of Change*, The History Press, Stroud.
[59] David Taylor (2002), *Policing the Victorian Town: the Development of the Police in Middlesbrough c.1840-1914*, MacMillan, Basingstoke.
[60] William F Kelly, Rashad Mahmood, Miranda J Kelly, Steve Turner, Keith Elliott (1993), 'Influence of Social Deprivation on Illness in Diabetic Patients', *British Medical Journal*, **307**: pp. 1115-1116, R S Bhopal, S Moffatt, T Pless-Mulloli, P R Phillimore, C Foy, C E Dunn, J A Tate (1998), 'Does Living Near a Constellation of Petrochemical, Steel, and Other Industries Impair Health?', *Occupational and Environmental Medicine*, **55**: pp. 812-822.and M. Roff (2003), 'Levelling the Playing Fields of England: Promoting Health in Deprived Communities', *The Journal of the Royal Society for the Promotion of Health*, **123**: pp.20-22.
[61] Minoru Yasumoto (2011), *The Rise of a Victorian Ironopolis: Middlesbrough and Regional Industrialization*, Boydell Press, Woodbridge, pp. 157-187.

improved dramatically by the middle of the twentieth century. The ability of those in power to remain complacent about the future continued.

In 1830, the establishment of Middlesbrough as a planned community took place, its purpose being to act as a port to the South Durham coalfields. *Map 1* illustrates Middlesbrough in the 1850s as the community begins to develop from the existing small agricultural society that it had been at the turn of the nineteenth century.

*Map 1*: Middlesbrough *c*1850






In the 1890s, (*Map 2*) the extensive development of the Iron and Steel industry in the north of the town and along the river can be clearly seen. The north was also the most densely populated area by the 1890s as the workers resided there to be as close as possible to their place of work.

[62] "Old Map of Middlesbrough" Scale 1:10,560, Ordnance Survey County Series 1st Edition 1849-1899, Published 1857, Landmark Information Group, UK. Using: EDINA Historic Digimap Service, http://edina.ac.uk/digimap, created: March 2012.

*Map 2*: Middlesbrough *c*1890



The 1930s (*Map 3*) show that the town has expanded even further south, and the north is now not as heavily populated as previously, although the industrial area has increased once again.

[63] "Old Map of Middlesbrough" Scale 1:10,560, Ordnance Survey County Series 1st Edition 1849-1899, Published 1895, Landmark Information Group, UK. Using: EDINA Historic Digimap Service, http://edina.ac.uk/digimap, created: March 2012.

*Map 3*: Middlesbrough *c*1930



The final phase of Middlesbrough's growth can be seen in *Map 4* (1980s) where industry has retreated from the northern area almost entirely, moving to the outskirts of the town such as Billingham. The populated area of the town has now grown significantly and has established trade and employment networks outside of the traditional industrial ones.

[64] "Old Map of Middlesbrough" Scale 1:10,560 Ordnance Survey County Series 3rd Edition 1919-1939, Published 1938, Landmark Information Group, UK. Using: EDINA Historic Digimap Service, http://edina.ac.uk/digimap, created: March 2012.

*Map 4*: Middlesbrough *c*1980



The initial boon of the town acting as a port began to decline in the 1850s, in its place came the iron industry, based around the ore supply located in the nearby Eston Hills. At the beginning of the nineteenth century, the area that was to develop into urban Middlesbrough was agricultural, both economically and socially. Changes came about due to a number of key factors; the development of the Stockton and Darlington Railway and the increasing demand for coal and the navigational limits of the river Tees. Iron was discovered in the Eston Hills in 1850 that led to a number of Ironworks growing quite quickly around the area including, amongst others, Bolckow and Vaughan in 1852 and the Bell Brothers in 1853.[66] In the 1850s, Middlesbrough land south of the newly constructed railway was sold to anyone who wished to develop there. Between 1880 and 1914, the growth in Middlesbrough was

[65] "Old Map of Middlesbrough" Scale 1:10,000 National Grid 3rd Revision, Published 1987, Landmark Information Group, UK. Using: EDINA Historic Digimap Service, http://edina.ac.uk/digimap, created: March 2012.
[66] David Taylor, 'The Infant Hercules and the Augean Stables: A Century of Economic and Social Development in Middlesbrough, c. 1840-1939 in Pollard, *Middlesbrough Town and Community,* p. 55.

due to the iron and steel industries.[67] The Crimean War provided a further boost to the industry leading to fourteen blast furnaces being erected in Middlesbrough itself and a further fourteen to the east of the town.[68] The iron industry served the town well and upon the back of this came diversification into steel manufacture towards the end of the nineteenth century. This expansion and influx of workers to Middlesbrough led to overcrowding, particularly in the north of the town where the majority of the workers' housing was located. Where there was overcrowding, there were the almost inevitable issues with sanitation and disease. It was difficult for these families to move away from the area as this meant not only an increased distance to travel to work but in virtually all cases an increase in rent. This in itself was not a viable option for most iron and steel workers and their families, many of whom already lived beyond their modest means.

Those in positions of power and influence within the area felt compelled to provide health care from an early stage. This is particularly visible in relation to hospital provision.[69] The community itself, with industry being at the heart of the decisions made, drove much of the impetus behind the evolution of hospitals in the town. The desire to provide adequate care for those who formed the foundation of industry's success in the region was paramount. The story behind the building of the first hospital in Middlesbrough features regularly in histories of the town.[70] Its inception occurred after a serious, and fatal, accident at a local iron works' in 1858. It became acutely apparent there was no system in place capable of effectively coping with such accidents. As industry was flourishing during this time, the reasonable assumption was that this would not be a solitary, isolated event. The cottage hospital set up in reaction to the accident was to become North Ormesby Hospital (hereafter, NOH), an important element of health care provision until its closure in the mid-1980s. Many of the GPs who practised in the area during the century passed through the NOH, either as

[67] *Ibid*.
[68] *Ibid*.
[69] Barry Doyle has studied this particular area at length, for a detailed discussion see, Doyle, 'Competition and Cooperation', pp. 337-56 and Doyle and Nixon, 'Voluntary Hospital Finance', pp. 4-19.
[70] For example Lillie, *The History of Middlesbrough*, pp. 173-4. It is often referred to, erroneously, as the 'first cottage hospital in England', a claim of which there is no substantial proof according to Doyle.

part of their early clinical training or in combination with their general practice work, on a part time basis, within the hospital's surgical team.

The first signs of decline began to manifest themselves during the interwar years of the twentieth century. The relatively narrow industrial base of the town meant that ultimately the people who inhabited Middlesbrough would suffer. The industrial expansion that took place meant that much of the region experienced an extreme housing crisis by the early part of the twentieth century. Middlesbrough was a prime example of this, where available housing was insufficient to meet the requirements of the expanding community. Combined with the fact that much of it was by this time in a state of disrepair, poor sanitation and ventilation were widespread, and families often had to share a single outside toilet. The most prevalent group of diseases within this locale was those that affected the respiratory tract. Pneumonia has a long association with Middlesbrough. Indeed, one outbreak that occurred in 1888 was so specific to the town and so virulent in nature that the medical profession and journals of the time referred to it as 'Middlesbrough Pneumonia'.[71] The condition continued to be a constant and aggressive spectre throughout the next decades. The occurrence of pneumonia and associated mortality figures of the disease were considerably higher than those seen in the neighbouring towns. The problem such a condition posed for both those in charge of providing medical care and the local officials was the distinct lack of agreement as to what the causal factors of the illness were. One serious issue at the turn of the century was that pneumonia, despite the persistently high mortality rates, was not one of the infectious diseases that, upon diagnosis, required reporting to the MOH. These divisive issues and the way in which they were dealt with will be addressed in full throughout Chapter I of the thesis.

Respiratory tract diseases remained endemic within the town although as with the rest of the country by the beginning of the Second World War infectious diseases had begun to decline. These were subsequently overtaken by chronic illnesses such as cancer and

[71] Geoffrey Stout (1980), 'The 1888 Pneumonia in Middlesbrough', *Journal of the Royal Society of Medicine*, **73**: pp. 664-668.

heart disease.[72] Infant mortality was also worryingly high in Middlesbrough for much of the period examined and will play a key role in the investigation, particularly chapter two. The persistently high rates within the town were a cause for concern both locally and nationally until they eventually began to converge with the national rates in the 1950s. The thesis shall examine these figures and aim to look for causal factors and possible explanations.

The ports located around the region were entry points for disease, as well as acting as hot spots for crime and prostitution. Venereal disease clinics were set up in the towns most affected by this problem. Diseases such as syphilis did not just affect men, although they did outnumber the females admitted to the infection clinics by roughly 3 to 1.[73] It is clear from the MOH reports that foreign sailors seemed to shoulder the weight of responsibility for such diseases' prevalence. The annual reports for Middlesbrough listed the nationalities of the seamen alongside representative statistics for the numbers treated.[74] By blaming the town's problems on a transient population, the pressure upon the council to act was alleviated, as there was little they could do to alter the habits of visitors and foreigners.

Suspicion and accusations regarding the influx of migrants to the town continued to promulgate, especially during times of high unemployment.[75] When the region was going through its period of rapid expansion, this migration was positively encouraged, as there were not enough people available from the local community to meet the needs of the industries that had been established within Middlesbrough. However, in times of economic downturn the migrant population bore the brunt of the local communities' displeasure; the local economy no longer being able to support its own workers let alone shoulder the responsibility for any migrant workforce.[76]

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[72] TA/CB/M/H/4-15, 'Annual Reports of the Medical Officer of Health, Middlesbrough, 1904-1957', Teesside Archives, Middlesbrough.
[73] TA/CB/M/H/8 - 'Annual Reports of the Medical Officer of Health, 1914-1920'
[74] *Ibid*.
[75] This was considered particularly so in the case of the influx of Irish miners to the region in the late nineteenth century.
[76] See Ray Hudson (1989), *Wrecking a Region: State Policies, Party Politics, and Regional Change in North East England*, Pion, London, p. 219. Hudson highlighted this as being particularly prevalent after World War Two when industry began its slow decline.

Unemployment was also considered to have a negative effect on the health of the community. It placed extra strain on the family, not just in the case of unemployment but also ill health. Families still had to pay their rent, buy clothes and food whilst the meagre benefits they did receive from employee contribution schemes were apt not to stretch as far as was required. Workers often resisted turning to their GP for medical advice. This was due to an inability to afford their services, certainly outside of the male workers of the family but also owing to the inaccessibility of GPs in for those living in the northern quarter.[77] The idea that unemployment and ill health placed stress on family members received more credence from the medical profession as the twentieth century progressed. The anxiety alone that prolonged spells of unemployment bring can have health implications, with stress and depression due to unemployment and financial worries prevailing throughout the century. A survey of practice workload carried out in 1972 at the Norton practice near Stockton, recorded depression as the second most common condition, with seven per cent of consultations, anxiety was fifth.[78] The problems concerning unemployment began with the decline of the traditional, established industries after the end of the First World War. The need for British steel began to decline after this time, when cheap foreign steel compromised the British export market. In 1901 Teesside had been ranked third in the world for the production of pig iron (only Pittsburgh and the Ruhr region produced more) and fifth for steel production.[79] Ferdinand Zweig gave a description of industrial workers as part of his study in 1952 entitled *The British Worker*.[80] He used Middlesbrough and the Northeast as an example, stating how workers in the town lived in 'closely-knit communities' and were amongst the best-paid workers in the country. Steelworkers, he continued, tended to dominate any town they were in, and that up to 90% of them were 'regular pub-goers';

[77] As shall be examined there were few GP practices in this area of the town and workers were even more reluctant to visit the works doctor for fear of being signed off from work or worst still, in the case of a severe illness, losing their job entirely.
[78] Geoffrey Marsh and Peter Kaim (1976), *Team Care in General Practice*, Croomhelm, London, p. 53. Rather unsurprisingly for the region, upper respiratory tract infection was first.
[79] Dennis Chapman (1945), *A Social Survey of Middlesbrough: an Inquiry into Some of the Factors Relevant to the Planning of Urban Communities made for the Ministry of Town and Country Planning*, HMSO, Middlesbrough, p. 1.
[80] Ferdynand Zweig (1952), *The British Worker*, Penguin Books, Harmondsworth, p.36.

highlighting the strong social relationship that the workers in the region had with alcohol.[81] Industry and subsequently employment in Teesside was heavily affected by the depression of the 1930s. The region, somewhat surprisingly, was not designated a 'special area' by the government.[82] These industrial areas were those worst affected by the depression as defined by the government. Once identified these areas then received assistance in their rehabilitation. Matters did not improve dramatically with the shift from iron and steel to the petrochemical industry in the 1930s. This merely led to a shift in the types of disease observed and higher unemployment rates as many of the positions within this new industry required highly trained and job-specific skills.

Industry ironically, whilst helping to create and shape Middlesbrough was also its antagonist, especially in regards to ill health within the town. Historically, the portrayal of the region has been that of suffering some of the worst air pollution associated with heavy industry in the whole of the country. It was not only the air quality that had deteriorated, but also the soil and the rivers running through it. This led to numerous health risks and concerns throughout the course of the century. In Charles V. Dingle's (d. 1945), (the then MOH for Middlesbrough), annual report of 1908 he attributed the fact that respiratory diseases constituted the greatest proportion of deaths in the town to 'situation and subsoil formation, together with a smoke and grit laden atmosphere...'[83] There were also questions of pollution of the water supply by industry, combined with inadequacies in the sanitation of the existing sewage supply. The people of Middlesbrough, however, were reluctant to criticise industry, at least openly so, fully aware of how much their existence relied upon it, a theme that was to endure well into the twentieth century.

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[81] *Ibid*., p.37.
[82] (Anon) (1935), 'Teesside and its Industries', *Daily Telegraph Supplement*, p. 14.
[83] TA/CB/M/H/4, 'Annual Reports of the Medical Officer of Health, Middlesbrough, 1904-1909', Teesside Archives, Middlesbrough. Taken from the 1908 report. Anon (1898), 'Middlesbrough Medical Officership', *The North-Eastern Daily Gazette*, May 25th. Dingle, born in nearby Whitby, received his MD from Durham Medical School. He was appointed in favour of Dr Millard of Birmingham (Millard himself went on to be a highly successful MOH in Leicester)

In a study undertaken in the 1990s, Peter Phillimore discussed the impact of 'fears, values, habits and lifestyle' on health.[84] He compared the health of Middlesbrough and Sunderland, two towns only twenty-five miles apart but with decidedly different experiences of health. Phillimore argued that it is not always possible to define lifestyle as merely 'smoking, eating, drinking and physical exercise', but has to include much more, such as fear of unemployment or the pressure of financial worries and the implications these elements bring.[85] An example, therefore, could be the reaction to sudden ill health by an individual, in perhaps deciding not to visit their GP for fear of losing days at work and in turn wages. Alternatively, it could be the anxiety that something is seriously wrong, or even not wanting to bother the GP unduly over something they feel may be trivial. This attitude also existed at the turn of the century, and in Lady Bell's study *At the Works*, published in 1907, there is a chapter dedicated to the working environment and health.[86] Here, Bell comments on the reluctance the workers exhibited to take adequate time off work to recover from illness for fear of the financial implications it may bring to their family. Fear plays an appreciable role when it comes to pollution from local industry, but this is secondary to the worry of what life would be like if the industry were not there. Studies over the last twenty years have demonstrated that the attitude of those living and working in the region has often become one of resignation. This is in so much that they feel their health will be affected no matter what they do, and it is a question of by what and how much, rather than if at all. It is clear that attitudes to lifestyle have played a large role in shaping the populations' health on Teesside and in Middlesbrough.

As can be seen from this brief review of issues relating to the town, Middlesbrough has experienced a variety of health related issues throughout the course of the century, the

[84] Peter Phillimore (1993), 'How do Places Shape Health? Rethinking Locality and Lifestyle in North-East England' in Stephen Platt, Hilary Thomas, Sue Scott and Gareth Williams (eds.) (1993), *Locating Health: Sociological and Historical Explorations*, Avebury, Aldershot, p. 173.
[85] *Ibid*., pp. 174-6. Also see Peter Phillimore and Suzanne Moffatt (1999), 'Narratives of Insecurity on Teesside: Environmental Politics and Risks', pp. 137-153 in John Vail, Jane Wheelock and Michael Hill (1999), *Insecure Times: Living with Insecurity in Contemporary Society*, Routledge, London.
[86] Florence Bell (1985), *At the Works: A Study of a Manufacturing Town*, Virago Press Limited, London (original published in 1907), pp. 85-107.

majority of which have proved to be detrimental. The key to understanding the effects of these issues is to assess the reaction to them and the speed with which local authorities and medical practitioners developed strategies to combat them. It is also clear that the patterns of health were not the same throughout the entire district and were dependent upon the cooperation of all the main groups involved. In addition, the success of public health policies to tackle poverty, poor nutrition, sanitation and mortality rates appear to be dependent upon the interactions between the key groups within Middlesbrough. The following chapter shall look at how the various groups worked together, or at times against one another, to combat infectious disease during the late nineteenth century.

## Chapter I: 1880-1900: Middlesbrough, the Adolescence of Hercules

Any study focused on the history of an industrial town in the twentieth century must first outline the late-nineteenth century context. This earlier period was to be highly influential upon the experience of the community in the formative years of the twentieth century, not least in Middlesbrough, and never more so than in the examination of GPs and public health. The decisions and actions of the medical profession and local authorities in the later Victorian years had significant ramifications over the following thirty to forty years. Indeed, significant changes only began to occur towards the end of the First World War.

Middlesbrough was remarkable even within a region dominated with the spectre of ill health and a poor quality of life; the town's record was consistently abysmal. Middlesbrough may well have had comparable industries, weather conditions and a similar social class composition to nearby towns, but that was where likenesses tended to end.

In 1801, Middlesbrough had been a small farming community with a population of fewer than fifty, by 1901 estimates place the figure at in excess of 100,000.[87] It is of little surprise, perhaps, that this explosive growth by the late nineteenth century, in combination with the development of heavy industry within the town, caused serious health problems for its inhabitants. Victorian industrialists became so preoccupied with creating this 'infant Hercules', as the then British Prime Minister William Gladstone described the town in 1862, that inadequate attention was paid to ensuring that the infrastructure existed to cope with such a population boom.[88]

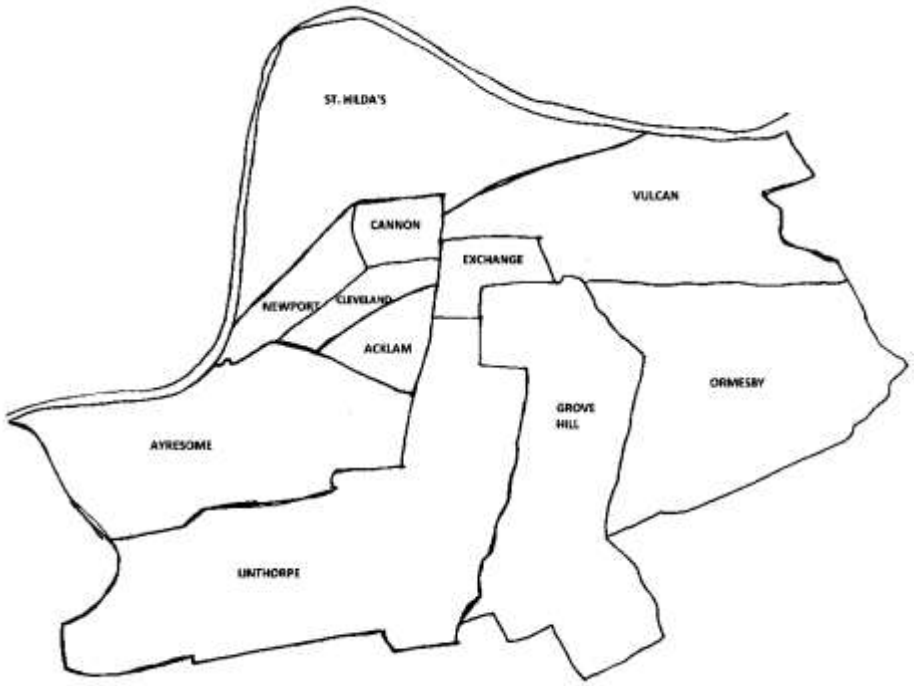
The degeneration of the town accelerated thereafter, particularly in the northern area where the bulk of the industry resided. This area had previously been marshland, which had been drained to accommodate the vast iron works known locally as the 'Ironmasters District'.[89] North of the railway was the Cannon Street area purpose built to house the iron plant workers. This damp, low-lying area was not ideally suited for residential

[87] Doyle, *A History of Hospitals in Middlesbrough*, p.5.
[88] Taylor, 'The Infant Hercules and the Augean Stables', p. 53.
[89] Lillie, *History of Middlesbrough*.

accommodation. Many of the houses built during this period were condemned and demolished during the slum clearance of the 1930s, due to their damp, insanitary conditions.[90] This area provided ideal conditions for diseases such as pneumonia to flourish. Indeed, in 1891, Councillor Smith, a member of the Middlesbrough Sanitary Committee felt that 'It was from the Marsh district that the epidemics emanated.'[91] This area included the St. Hilda's, Vulcan and Cannon Wards of the town (*Fig. 1*).

*Fig. 1*

Map of Middlesbrough Wards




This district was also heavily populated and families suffered from high levels of overcrowding. By the turn of the century, many who lived there did so in poverty and substandard conditions. It is difficult to determine exactly why this was the case iron workers

[90] L Polley, 'Housing the Community, 1830-1914' in Pollard, *Middlesbrough Town and Community*, p. 170.
[91] Anon (1891), 'The Health of Middlesbrough: The Marsh Road Question', *The North-Eastern Daily Gazette*, June 27th.

were notoriously better paid than those in comparable employment, such as the coal miners of County Durham to the North.[92]

Middlesbrough withstood a number of specific and endemic conditions, particularly attacks on the respiratory system. The most notorious of which was pneumonia, this condition affords us the opportunity to examine not only the health of the town in relation to its neighbours but also provides an insight into the cooperation, or lack thereof, between the various groups of the town, namely the medical practitioners, industry and the local authority. This chapter in exploring the history of the disease within the town also examines issues of disease notification, epidemics and the interrelationship of the Sanitary Committee and the town's GPs. In addition, it shall assess the interactions of the local authorities with the LGB, and the implementation of national government initiatives.

However, we shall begin by examining the role of the GP in Middlesbrough at the end of the nineteenth century. This chapter shall review how the GPs reacted to health challenges within the town. From the appeals of successive MOHs for the doctors assistance during epidemic outbreaks, to the attempts of the GP community to form a cohesive, united and ultimately powerful group within the town after the establishment of the Middlesbrough District Medical Society (hereafter, MDMS). In addition, the chapter plots the progress of GPs throughout the town, tracing their movement to the different Wards of Middlesbrough.

## General Practice and the Middlesbrough District Medical Society

The paucity of sources for the later nineteenth and early twentieth centuries makes it difficult to trace the movements and actions of GPs in a given locale. Trade directories provide one possible avenue of exploration. Obituaries, articles and correspondence published in medical journals are also potentially useful, and these are examined in Chapter III. Together

[92] Kenneth G.J.C. Knowles (1952), *Strikes: A Study of Industrial Conflict with Special Reference to British Experience between 1911 and 1947*, Blackwell, Oxford, p. 172.

the first three chapters will allow us to chart the progress of practitioners over a significantly longer period (1880-1940) than the confines of this chapter will allow.

One of the most interesting and revealing ways to explore the work of the modest medical community in the Victorian town of Middlesbrough is to review the attempts to form medical societies both within the town itself and the surrounding district. Medical societies, especially in the nineteenth century, had very similar goal and mission statements upon their inception. Hull Medical Society, re-established in 1889, wanted 'The advancement of science and camaraderie'. York Medical Society, formed in 1832, with 'The purpose of producing and diffusing medical knowledge'. The reasons behind the formation of such societies varied from perceived inactions by a town's council to the desire to share medical experiences or a need to protect the interests of practitioners from external pressures.[93] However, there is a lack of available records of local medical societies, especially those formed in the nineteenth century. Records of meetings are rare and are often nothing more than an outline in a local history journal detailing the date of formation, name of the President (often obtained from an obituary) and more infrequently the rules and regulations of the society in question. Rarely have any minute books or papers presented at meetings survived, and if they have, as with the MDMS, they cover on a brief period.

There were remarkably few medical societies formed in the Middlesbrough district throughout the nineteenth and twentieth centuries. The first of these, the South Durham & Cleveland Medical Society that was established in 1873 and ran until 1885, but unfortunately, left no records, other than a typed copy of meetings held in July and September 1874.[94] Around 1910, there was a move made to form an 'Association of General Practitioners for Collective Research'. This group is briefly mentioned in the Ernest Ward book, *Medical Adventure: Some Experiences of a General Practitioner* (1930) and again in a

[93] Jacqueline Jenkinson (1993), *Scottish Medical Societies, 1731-1939: Their History and Records*, Edinburgh University Press: Edinburgh, p. 34.
[94] TA/Accession 3107, Box 7, Miscellaneous Papers concerning Medical Societies in Middlesbrough, 1870-1930, Teesside Archives, Middlesbrough.

1974 article about Ward.[95] The association originated in Stockton and aimed to draw in doctors from across the region to discuss and promote research amongst GPs. The enterprise garnered an enthusiastic amount of interest, but the First World War came along and dampened the fervour somewhat. The onset of the war meant that many of those who had expressed an interest (a figure touted to be around 200) became directly either involved in the war effort or had to stay behind to run busy, overworked practices. Finally, in the 1930s W.S. Dickie formed a 'Clinical Club'. This Club attempted to attract doctors from the Teesside area to meet and discuss professional matters, ideas and research. Again, there is little in the way of surviving documentation about the Society other than anecdotal mentions.[96]

The MDMS, formed in 1899, proved successful in attracting professionals from all over the town and surrounding area. There was an annual subscription of half a guinea (around 10s 6d) for all members. The first President of the society was Dr R.E. Howell and its Chairman was Dr Samuel Walker.[97] The society also held monthly Council Meetings. These assemblies were additional to the general and special meetings of the whole group. The Council (President, Chairman, Secretary and so forth) tended to discuss the issues that were raised in the general meetings, sometimes in depth or they merely deliberated on what course of action to take prior to the next meeting.[98] The objectives of the society were set out in their rulebook for 1899, and were defined as follows:[99]

I. To maintain the honour and interests of the Medical Profession, and to promote cordial relationship and friendship amongst its members

[95] Ernest Ward (1930), *Medical Adventure: Some Experiences of a General Practitioner*, Bale & Danielsson, London and R.M.S. McConaghey (1974), 'Ernest Ward and Collective Investigations', *Journal of the Royal College of Practitioners*, **24**, pp. 568-571.
[96] TA/Accession 3107, Box 7, Miscellaneous Papers concerning Medical Societies. Stout did not manage to find any substantial information regarding any of these Societies, other than the MDMS. No other medical groups were to be formed in the district until the 1960s.
[97] TA/Accession 3034, Box 3, Minute Book for the Middlesbrough District Medical Society, 1899-1900. The first meeting took place in Middlesbrough, June 27th 1899.
[98] TA/Accession 3034, Box 3, Council for the Middlesbrough District Medical Society, Minute Book, 1899-1900.
[99] TA/Accession 3034, Box 3, Rule Book of the Middlesbrough District Medical Society, 1899.

II. To endeavour to maintain by the means of papers, discussions and demonstrations a high standard of professional efficiency

The idea of a local medical society was first discussed amongst the professionals of the town in 1893, spearheaded by the then MOH for Middlesbrough, Dr Malcomson. The reason behind the desire to form such an association being cited in the First Annual Report in 1899 as '…the time had come to try and put a stop in some increase to the "quackery" that is rampant in our midst.'[100] Six years later when the society was founded this need to retain some degree of exclusivity and ownership of practice within the town was still foremost in the minds of its inaugural members.

Much of the business dealt with at the meetings of the society concerned financial matters. They attempted to decide amongst themselves issues regarding, not only payments from friendly societies and works clubs, but also to agree the fees they could charge one another for attending emergency calls to patients who were not on their own list.[101] There were clearly instances, especially midwifery cases, where the patients' regular physician could not attend, the reasons for which are not alluded to. As virtually all of the GPs within the town were members of the society, adherence to these rules was mandatory. Failure to observe the rules effectively excluded any GP, not only from the decisions his (or her) cohorts were making, but they also became outsiders professionally and personally.[102]

The problem of patient indebtedness to members of the society was also raised during a meeting in early 1900.[103] Dr Knott provided the members with a detailed breakdown of what a local collection agent was prepared to offer, and how much he would require as payment in return. The services of a debt collector appear to have not only been the requisition of outstanding payments, but also auditing books of both members and other debt

[100] TA/Accession 3034, Box 3, Minute Book, Meeting December 12th, 1899. These were Malcomson's words and were used in the First Annual Report in 1899 to explain the origins of the Society.
[101] *Ibid*., Meeting February 13 1900.
[102] This can be seen from the actions of the Society when an outsider was brought in to cover the positions that they had excluded themselves from within the Friendly Societies.
[103] TA/Accession 3034, Box 3, Minute Book, Meeting March 13 1900.

collectors they used (*table 1*). Additionally, the collector would prepare a blacklist of nonpayers so that the doctors could refuse them treatment in future unless, presumably, they were paid in advance.[104] The concept of blacklisting *en masse* outlined by the MDMS was not a new one. Glasgow Southern Medical Society had a black book, whereby society members listed patients who had not settled their accounts. Likewise, the Glasgow Western Medical Society employed a debt collector in 1908 to secure unsettled debts for all of its members.[105] Debts were pursued tirelessly; unless evidence was presented that it was a hopeless case and needed to be dropped.[106]

*Table 1*

Debt Collection Rates and Services, 1900

| | |
|---|---|
| Full-time Collection (for entire membership) | 20% commission (for guaranteed £100 to £150 p.a.) |
| Individual Members | 20% commission and/or audit the books of other collectors for 5% |
| Hourly rate | 1/- per hour to keep books for members and prepare blacklists |

Source: TA/Accession 3034, Box 3, Minute Book for the Middlesbrough District Medical Society, 1899-1900, Teesside Archives, Middlesbrough

Members decided that overall they would rather deal with the issue as individuals than as a collective. The doctors rebuked the notion of hiring just one collector to deal with all the debts from those who were members. This might have been because the doctors felt they could negotiate preferable terms with other collectors or even recoup payments from their patients directly.

The doctors also discussed and set a range of fees that they agreed would be common rates for services performed within Middlesbrough (*table 2*). These included one off

[104] *Ibid*.
[105] Jenkinson, 'Scottish Medical Societies', p. 33.
[106] Digby, *The Evolution of British General Practice,* p. 119.

charges for things such as midwifery cases but also the weekly rates for works' and family clubs, an area where the doctors had a degree of control, unlike with the charges for friendly societies. One additional lucrative source of income was the provision of sick certificates for club members, especially for those with long-term conditions. Jacqueline Jenkinson, in her comprehensive study of Scottish medical societies also notes the importance of fee schedules to practitioners.[107] Jenkinson sees the value in this 'mutual exchange of information' and above all cooperation of practitioners within a distinct locale. Competition for patients at this time was high and external pressure from local authorities, MOHs and even friendly societies encouraged practitioners to band together.[108] The market was highly competitive and often led GPs in a given area to undercut one another in order to attract patients.[109] This may have been amongst the reasons that the MDMS was formed, so that members of the Society could agree fees as a collective rather than compete. This move was concomitant with overtures from the British Medical Association (hereafter, BMA) that it would not tolerate its members either canvassing or undercutting fellow practitioners.[110]

*Table 2*

Middlesbrough District Medical Society, Additional Fees Discussed During Meetings (1899-1900)

| Fee | Amount (£ s d) |
|---|---|
| Midwifery Fee (if paid within 7 days) | 15/- |
| Midwifery Fee (if paid after 7 days) | 21/- |
| Works Clubs (single man) | 1d. per week |
| Works Clubs (man & wife) | 3d. per week |
| Works Clubs (man, wife & Family under 16 years) | 4d. per week |
| Club Certificates (after initial 2) | 6d. per certificate |

Source: TA/Accession 3034, Box 3, Minute Book for the Middlesbrough District Medical Society, 1899-1900, Teesside Archives, Middlesbrough[111]

[107] Jenkinson, *Scottish Medical Societies*, p. 33.
[108] *Ibid*., pp. 31-32.
[109] Digby, *Evolution of British General Practice*, p. 102.
[110] *Ibid*.
[111] *Ibid*., p. 101. Usually a service available more for those patients who could afford it, with a sliding scale of between three and ten guineas for private patients.

No matter how cohesive the Medical Society appeared to be, it ceased to operate only six years after its inception in 1905.[112] Perhaps the junior members of the group felt that the demands of the hierarchy were unsustainable and did not serve their needs, especially by controlling so closely their tenures and in doing so their patient roll and income.[113] A significant portion of the concerns of the group surrounded friendly societies, works' and family clubs, as the doctors battled for their interest within such schemes. This issue will form a substantial element of chapter II.

The doctor's listed in Ward's Trade Directories at the end of the nineteenth century can be seen in *Table 3*.[114] There were twenty-five listed in total, and the doctors held practices and positions all over town.

*Table 3*

Listed in Wards Trade Directory 1898/99 for Middlesbrough as Surgeons (or General Practitioners)

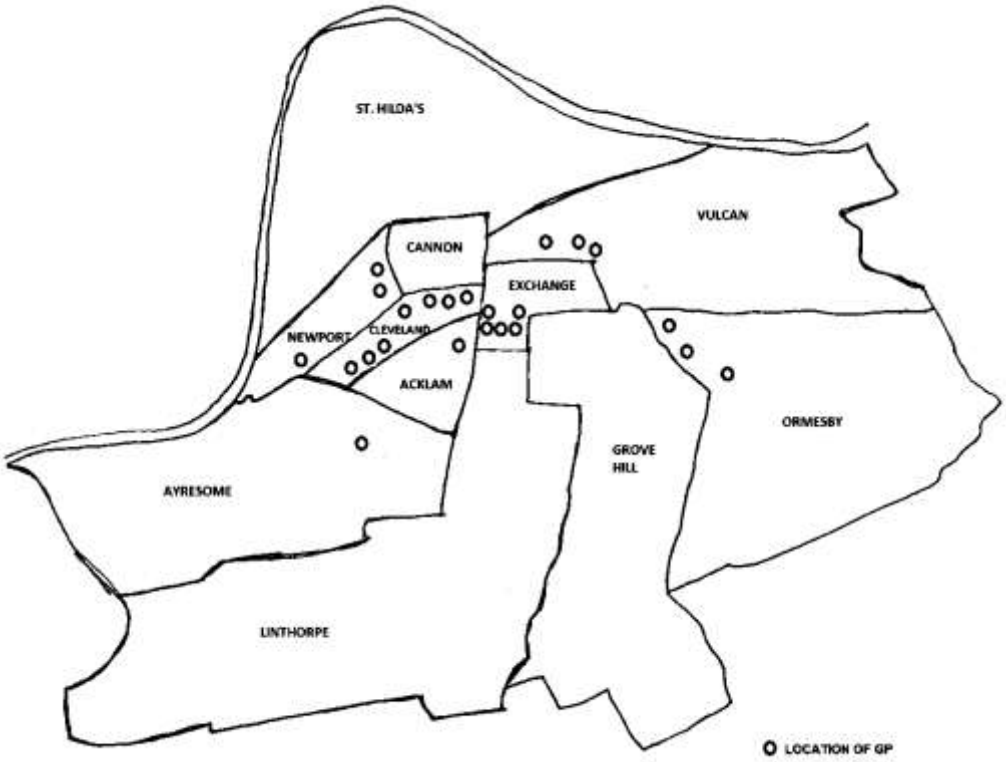
| | |
|---|---|
| Bateman S. | McCrindle J.R.R. |
| Christie J.G. | Munro F. |
| Clarke J.P. | Pentony E.P. |
| Cook J.W.C. | Scanlan A.E |
| Edwards J.W. | Steel W. |
| Ellerton J. | Veitch W.Y. |
| Fyfe G. | Walker S. |
| Hamilton J. | Webster A. |
| Hedley J. | Williams W.J. |
| Howell R.E. | Yeates |
| Keenan T.F. | Considine P.B. |
| Knott W. | Young H |
| Longbotham G. | |

Source: Wards Directory of Darlington, Hartlepool, West Hartlepool, Stockton, Thornaby and Middlesbrough, 1898-9, R Ward and Sons, Newcastle-Upon-Tyne, p. 626.

[112] TA/Accession 3107, Box 7, Miscellaneous Papers concerning Medical Societies in Middlesbrough, 1870-1930.
The Minute Book was locked after the last meeting in 1905 and was not opened until the 1960s after a replacement key was procured.
[113] Chapter II shall examine in detail the meetings of the MDMS that took place from 1900-1905, especially in relation to friendly societies.
[114] Wards Directory of Darlington, Hartlepool, West Hartlepool, Stockton, Thornaby and Middlesbrough, 1898-9, R Ward and Sons, Newcastle-Upon-Tyne, p. 626. The doctors are listed under the heading 'surgeons or general practitioners', however, no distinction is made as to which they were, if indeed there was any difference at this time.

*Fig. 2* demonstrates where the doctors were located, geographically, in the town.[115] The GPs were concentrated around the Wards of Cleveland, North Linthorpe and Exchange. The northern Wards of St. Hilda's, Vulcan and Cannon where the workers tended to reside were poorly represented, if at all. This meant that patients from these areas had to travel a substantial distance to see a GP.

*Fig. 2*
Location of GPs in Middlesbrough Wards, 1898/1899




Data compiled from Wards Directory of Darlington, Hartlepool, West Hartlepool, Stockton, Thornaby and Middlesbrough, R Ward and Sons, Newcastle-Upon-Tyne, editions running from 1898-1918

[115] *Ibid*. There are twenty-three GPs positioned on the map as opposed to the twenty-five listed in the directory as Drs Steel and Scanlan and Drs Yeates and Considine held positions at the same practice.

There are one or two potential drawbacks to using Trade Directories to identify GPs within a given locale. Firstly, it is difficult to obtain a complete set; there can be large gaps of five to ten years between those available, as was the case with Middlesbrough. Secondly, not all the doctors listed were practising GPs, some might have worked as consultants, medical officers or in some other medical capacity, there is no distinction made.[116] The Trade Directories often listed the private address of the doctor as well as the address of their surgery, which complicates matters when identifying where surgeries were located within the town.[117] Finally, not all GPs entered themselves their details in the directories, or at least consistently. This can been seen in the case of Dr Longbotham who was listed in 1898/9, is omitted in 1902/3 but reappears at the same address in 1904/5 and thereafter.[118] Some doctors are listed only once, but evidence from other sources suggests that they continued to practice medicine in the town in some capacity. However, the Trade Directories do provide possibly the only means of observing how doctors' numbers grew over time and where surgeries moved to within Middlesbrough.

The doctors in Middlesbrough, at this time, held multiple positions, not always necessarily medical. These duties help to explain the visibility of certain doctor's within reports and articles, and, therefore, the exclusion of others. GPs looked for medically related appointments within their community in order to raise their profile and enhance the chances of career advancement.[119] By the end of the nineteenth century, it was common for doctors to hold an appointment outside of general practice. In her study of general practice, Anne Digby found that seven out of ten doctors had such an appointment between 1880-1910, the most popular being poor law medical officer, public vaccinator, MOH or a role working with the police or schools.[120] Dr Veitch, for example, alongside running his own general practice

[116] The doctors in the Trade Directories are listed under the heading, 'Surgeons (or General Practitioners)'.
[117] The two things (private address and surgery) were not always necessarily the same, even in the early twentieth century.
[118] Wards Directory of Darlington, Hartlepool, West Hartlepool, Stockton, Thornaby and Middlesbrough, R Ward and Sons, Newcastle-Upon-Tyne, editions running from 1898-1918
[119] Digby, *Evolution of British General Practice*, p. 261.
[120] *Ibid*., pp. 79-80.

was also the police surgeon.[121] The GPs were also regularly called upon to provide evidence in court, especially when they had been involved as the attending physician. For example, there were two separate high profile cases of serious child neglect in the town in late 1899 and early 1900. Drs Keenan and Benson, respectively, gave evidence at the trials, garnering media attention in doing so.[122]

A number of GPs in the town, including Drs Longbotham, Young, Fulton and Knott, held the position of Medical Officer to the poor law.[123] Many of the GPs were deeply involved in assisting the community it times of distress. Dr Steel visited those requiring assistance during the early 1890s, after Cleveland began to feel the fool effects of the miners' strikes taking place in Durham and Northumberland.[124] In an article published in the local press, Steel is described as a prominent resident of Middlesbrough doing his part during the crisis, determining the needy and deserving cases requiring support and relief.

Equally sought after was the role of Public Vaccinator, after the resignation of Dr Craster in 1893, there were applications from Drs Veitch, Malcomson, Cooke, Hopgood, Longbotham and McCrindle, with Dr Veitch successfully securing the appointment.[125]

[121] Anon (1896), 'Inquest at Middlesbrough', *Northern Echo*, December 29. Veitch was also the President of the Cleveland "Lit and Phil", a non-medical but prestigious role that afforded a high level of visibility within the local press.
[122] Anon (1899), 'Child Neglect at Middlesbrough', *Northern Echo*, December 21 and Anon (1900), 'Neglected Children at Middlesbrough', *Northern Echo*, March 23.
[123] Anon (1892), 'Middlesbrough Board of Guardians', *Northern Echo*, January 22, Anon (1892), 'Middlesbrough Board of Guardians', North-Eastern Daily Gazette, September 22.
[124] NA/MH/32/98 'Correspondence and Papers Related to the Northern District, Including Press Reports of Distress in Certain Northern and Mining Towns, Including the Durham Miners' Strike of 1892', National Archives, Kew.
[125] Anon (1893), 'Middlesbro' Guardians', *Northern Echo*, January 20.

*Table 4*

Posts of Medical Officer to Works in Nineteenth Century Middlesbrough (post 1880)

| Doctor | Name of Works |
|---|---|
| W Y Veitch | Acklam (1883)<br>Samuelson's (1890s) |
| H D Levick | Ayrton Rolling Mills (1899-1915)<br>Newport Rolling Mills (1899-1915) |
| E P Penton | Cleveland Wire Mills (1915) |
| M Sanderson | Eston (1898) |
| J W C Cook | Roseberry Steelworks (1880-1883)<br>Westgarth England Marine Co (1883) |
| A E Scanlan | Roseberry Steelworks (1883)<br>Teesside (1883) |
| G F Longbotham | Samuelson's (1900s) |
| E E Craster | Bolckow & Vaughan (1890)<br>Teesside (1890)<br>Westgarth England Marine Co (1890) |

Source: TA/Accession 3220, Box 10.5, Envelope 9, Medical Officers to Works 1883-1915, Teesside Archives, Middlesbrough

As well as being doctors to the family clubs, friendly societies and working as panel doctors for the Insurance Committee, GPs within Middlesbrough often held positions as a works doctor (or Medical Officer as they were referred to) to one of the various iron and steel works that resided in the town. *Table 4* gives a sample of those who could be identified through available records as holding a position at one of the works, often for only a year before moving on.[126]

It was not only the GPs that held multiple positions, the role of MOH was incredibly stressful at this time, especially for those who continued in general practice. In the midst of the smallpox epidemic within the town in 1898 the then MOH, Dr Malcomson, died suddenly. His death was attributed to '…apoplexy, which was largely induced by the hard work and anxiety which have recently fallen upon Dr Malcomson.'[127] An extensive article appeared in

[126] TA/Accession 3220, Box 10.5, Envelope 9, Medical Officers to Works 1883-1915. Stout used any available directories that listed the doctor and his position; unfortunately, these were only available for a very limited number of year – 1883, 1890, 1898/99 and 1915.
[127] Anon (1898), 'Sudden Death of Dr Malcomson', *The North-Eastern Daily Gazette*, March 1.

*The North-Eastern Daily Gazette* the same day as his death.[128] It painted a picture of an overworked, stressed individual who died, aged just 47 years, due to the pressures of the various roles he had taken on, including MOH of the town and MOH of the Tees Port Sanitary Authority, to name but a few.[129] His counterpart in Stockton, Dr Clegg, had died the previous year aged 40 after having resigned from the role 18 months previously due to ill health (although Clegg also felt compelled to resign after a financial scandal in 1895 led to him being declared bankrupt after a highly public trial).[130]

Medical men within Middlesbrough understandably played an integral role when epidemics affected the town. The next section reviews the impact of pneumonia on Middlesbrough and GPs responses during the town's long association with the disease.

## Middlesbrough and Pneumonia

It was only during the 1880s that health officials within Middlesbrough voiced concern about Pneumonia. Pneumonia, an inflammatory condition of the lung occurring via an infectious agent, can be affected by environmental conditions. Modern medicine marks pneumonia as infectious but not excessively contagious, with the most likely mode of transmission that of an infection by bacteria or a virus, it commonly occurs in those with a weakened immune system either from recent illness or through the effects of smoking or heavy drinking.[131] Thus those with pre-existing medical conditions which lowered the immune system, had an increased the risk of individuals contracting the disease.[132] The elderly and young are also

[128] Malcomson had died in the early hours of the morning, March 1st 1898, the local paper dedicated several pages of the paper that day to the announcement.
[129] *Ibid*.
[130] Anon (1897), 'Death of Dr Clegg of Stockton', *The North-Eastern Daily Gazette*, January 2, Anon (1895), 'The Failure of Dr Clegg, of Stockton', *The North-Eastern Daily Gazette*, April 17, Anon (1895), 'The Affairs of Dr Clegg, of Stockton', *Northern Echo*, April 18. Bankruptcies were rare amongst the medical profession despite the problems encountered in the late nineteenth and early twentieth centuries in recouping outstanding debts. Digby, *Evolution of British General Practice*, p. 97.
[131] *Ibid*.
[132] Jacalyn Duffin, 'Pneumonia', in Kenneth F Kiple (ed.) (1993), *The Cambridge History of Human Disease,* Cambridge University Press, Cambridge, pp. 938-941.

amongst the most susceptible.[133] The form of pneumonia that appears to have been prevalent within Middlesbrough was that of pleuro-pneumonia.[134]

In late nineteenth century Middlesbrough, there was little that could be done to combat the illness through medical intervention; bed rest was the usually prescribed for sufferers. The respected physician, William Osler (1849-1919), described pneumonia as a self-limiting disease, with the only rational course of treatment being an expectant one.[135] He considered pneumonia to be an illness that resolved itself spontaneously, with or without treatment, and, therefore, the best treatment was to try to relieve pain and any other untoward symptoms whilst leaving the cure of the actual disease to nature.

Middlesbrough was not typical of the North East region, especially in relation to its experience of pneumonia. Data from the Registrar General 1901-1910 *(table 5)*, shows that Middlesbrough's pneumonia rates were three times higher than Darlington, and 2.5 times greater than nearby Stockton and Hartlepool.[136] While Sunderland, Durham and Newcastle-upon-Tyne all had death rates from the disease higher than the average for England and Wales (which was 1.25 per 1,000 living persons), they did not remotely compare to the figures for Middlesbrough.

[133] *Ibid.*
[134] Although lobar pneumonia did prove to be just as persistent over the course of the thirty years examined.
[135] William Osler (1892), *The Principles and Practice of Medicine (1st edition)*, Appleton and Company, New York, p.529.
[136] PP 1914-16 (Cd.8002) VIII, Supplement to Registrar General's Seventy-Fifth Annual Report, 1917, pp. 648-71.

*Table 5*

Crude Death Rate (per 1,000 living persons) and Deaths (all ages) from Pneumonia in the North East of England, 1901-1910

| Town | Crude Death Rate per 1,000 Living Persons from Pneumonia | Deaths (all ages) from Pneumonia |
|---|---|---|
| Middlesbrough | 3.09 | 4,724 |
| Hartlepool | 1.03 | 1,317 |
| Stockton | 1.48 | 1,004 |
| Darlington | 1.50 | 638 |
| Sunderland | 1.79 | 3,353 |
| Durham | 1.36 | 1,066 |
| Newcastle-upon-Tyne | 1.65 | 3,985 |

Source: Registrar-General's Report: *Supplement to Seventy-Fifth Annual Report* 1912, pp. 648-71.[137]

The data thus suggest problems specific to Middlesbrough. The first significant outbreak within the town that received national attention took place in 1888 and provided an ideal opportunity to analyse the potential causes behind the presence of the disease in Middlesbrough. This epidemic also provides one of the earliest, albeit limited, opportunities to assess the role GPs in Middlesbrough adopted when faced with a public health crisis.

## 1888 Outbreak

In 1888, it came to the attention of the LGB that there was a suspected outbreak of pneumonia in Middlesbrough, to what appeared to be an epidemic level.[138] The number recorded deaths from pneumonia for that year was 388. From February to July alone, 285 died from the disease. This was worryingly high, especially when compared to the 480 deaths for the same six months during the entirety of the previous eight years. While

[137] The crude death rate measures the death rate per 1,000 living persons of a given population (country, borough or town). This was the preferred measure used within both the Registrar General's and the MOH Annual Reports at this time. The standardized death rate was not provided for individual diseases until after this period. Anne Hardy (1994), ''Death is the Cure of all Diseases': Using the General Register Office Cause of Death Statistics for 1837-1920', *Social History of Medicine*, **7**: pp. 480. For the purposes of comparison, total death at all ages from pneumonia is provided.

[138] PP 1889 (C.5818-I), *Local Government Board: Supplement to Eighteenth Annual Report, Containing Report of Medical Officer 1888*, 1889, p. 163.

Middlesbrough was used to seasonal outbreaks of pneumonia, this epidemic was so worrying that it drew the attention of the MOH, Dr John A. Malcomson (1851-1898), who described it as 'a serious and very fatal epidemic'.[139] The LGB upon receiving the details of the outbreak responded by sending one of their senior investigators, Dr Edward Ballard (1830-1897), to the town.[140] A key and alarming feature of this precise epidemic was its virulence, with patients often described as delirious by the second day. The condition could prove fatal as early as three days after its onset.[141]

Upon his arrival in Middlesbrough, Ballard first sifted through an almost endless list of causes suggested by local people and medics. Climate, topography, industrial pollution and intemperance were favoured explanations.[142] Medical practitioners held that the 1888 epidemic was due to adverse weather, reporting as they did, that the autumn and winter seasons had unusually persistent easterly winds and fogs that led to an increased dampness of the atmosphere.[143] The fogs emanated from the marsh area located along the banks of the river Tees, the area of the town where the ironworkers and their families resided. Additionally, Middlesbrough was situated in a hollow meaning that such meteorological systems were prone to linger over the town. This peculiarity again separated it from its neighbouring towns that, although experiencing the same general climate, did not appear to suffer as severely as Middlesbrough.

Ballard did not agree with this hypothesis he pointed out that if the epidemic had occurred predominately due to weather conditions, as MOH Malcomson seemed to favour, the fact that only certain groups appeared affected should not have occurred. Children aged under five year olds were not affected to the same extent as those aged five

[139] Stout, 'The 1888 Pneumonia', p. 664.
[140] Dr Edward Ballard was a well-respected inspector for the Local Government Board throughout the later decades of the nineteenth century. He was commissioned by the Board to observe and report on numerous crises during the period. Anon (1897), 'Obituary: Edward Ballard, M.D. F.R.C.P, F.R.S', *British Medical Journal*, **1883**: pp. 281-82.
[141] *Supplement to Eighteenth Annual Report* 1889, p. 299–314.
[142] *Ibid*., p. 163.
[143] *Ibid*., p. 209.

to fifteen years of age.[144] *Table 6*, as presented in the Ballard report, demonstrates the age distribution of deaths due to pneumonia in 1888.[145]

*Table 6*

Total Deaths Registered in the Middlesbrough District as due to Pneumonia, 1888

| Age (years) | Deaths |
|---|---|
| Under 5 years of age | 68 |
| At 5 and under 15 | 14 |
| At 15 and under 25 | 26 |
| At 25 and under 35 | 71 |
| At 35 and under 45 | 91 |
| At 45 and under 55 | 81 |
| At 55 and under 65 | 89 |
| At 65 and upwards | 50 |
| | |
| Total | 490 |

Source: PP 1889 (C.5818-I), *Local Government Board: Supplement to Eighteenth Annual Report, Containing Report of Medical Officer 1888*, 1889, p. 188.

The section of the community most affected by the illness appeared to be males of working age (25-65 years). Consequently, industry faced the harshest criticism from the population, regularly cited as the major factor for the persistent nature of the disease in the town. Commentators suspected two variables, the effects of a polluted atmosphere and the working conditions of the men at the steel and iron works. Indeed, there was an insistence amongst some medical practitioners and workers within the town that slag dust, produced as a by-product in the manufacture of steel, was the leading cause of the high rates of pneumonia.[146] Inhalation of this dust, they believed, damaged the lungs and increased susceptibility to the disease. It was a theory favoured by the community itself. They believed this was a new disease, specific to Middlesbrough, which had only arrived with the development of this new steel making process (whereby the slag produced by turning iron

[144] *Ibid*., p. 211.
[145] *Ibid*., p. 188.
[146] *Ibid*., pp. 236–39.

into steel was sifted to produce a form of manure).[147] GPs within the town were conflicted as to the impact industry had upon the town's health. For example, Dr Hedley did not believe that the often-blamed 'slag-dust' was responsible for the increase in pneumonia cases. Hedley did not feel that there was any more risk working in the iron and steel mills than in any other industry or part of the town.[148] This may well have been true, given how indiscriminate the epidemics appear to have been, but it was also slightly disingenuous on Dr Hedley's side, as not only were male workers the worst affected but he also acted as the resident works doctor for the North-Eastern Steel works. During an interview, with a Parliamentary Departmental Committee investigating compensation for industrial diseases in 1906, Hedley defended the works. He claimed that the situation had improved post-1888, with the existing mill burned down and replaced by a new one, limiting the diseases associated with the movement of slag dust including pneumonia.[149] This demonstrates the conflicting issues which practitioners in the town faced as the doctor's tried to juggle their dual loyalties, firstly to their patients but then in certain cases also to their industrial employers.

However, ironworkers, who formed the bulk of the victims, were not the only section of the community that was affected. Ballard was of the opinion that those working in the mills were vulnerable to infection but that it was not the direct cause. Yet hard evidence to support these various hypotheses was difficult to pinpoint because little pathological work had taken place on any of the victims of the disease prior to his arrival. This was primarily due to the reluctance or the 'repugnance' as Ballard described it, of the community involved to permit autopsies.[150] Indeed, one autopsy, undertaken after his arrival, had to be performed

[147] *Ibid.*
[148] *Report of the Departmental Committee on Compensation for Industrial Diseases, 1907*, p. 85. The North-Eastern Steel works had one of the slag-mills that produced the reputedly problematic 'slag-dust'.
[149] *Ibid*.
[150] *Supplement to Eighteenth Annual Report* 1889, p. 209.

'...hurriedly in consequence of the noisy opposition of neighbours. It was only made at all through police assistance.'[151]

Despite such setbacks, Ballard had an alternative theory as to how the epidemic had taken hold in Middlesbrough, and why it specifically appeared to be restricted to the working classes. The American bacon that the lower classes consumed over the weekends aroused suspicion.[152] The ham that arrived from America before being processed in the town itself and consumed as bacon. In the case of Middlesbrough, the bacon produced remained within the district, with only negligible amounts shipped to other areas of the country, which might explain the isolated nature of the epidemic.[153]

Ballard worked closely with the bacteriologist Dr Emanuel Klein (1844-1925), who identified that, of the lung tissue and sputum samples from infected individuals sent by Ballard, thirteen of the twenty were poisonous to guinea pigs and mice.[154] The animals, after injection with material from the diseased lungs of pneumonia victims, exhibited symptoms similar to those displayed in infected patients. Bacon removed from houses where pneumonia related deaths had occurred appeared to be poisonous. Heating the bacteria dissipated its effects; logic thus dictated that cooking should have eliminated the problem. However, in Middlesbrough bacon received minimal cooking before eating to preserve the juices and help keep the meat looking as close to fresh pork as possible. When Ballard examined the effects of the epidemic on the middle classes, he found they had not been affected as the lower classes had, nor did they eat the supposedly infected cut of meat. [155]

Ballard had previously investigated an outbreak of food poisoning at the Duke of Portland's Welbeck Abbey Estate (Nottinghamshire) in 1880.[156] None other than American Ham was considered to be the source of the outbreak, furthermore the reason given as to

[151] *Ibid*., p. 302.
[152] *Ibid*., pp. 217–24.
[153] *Ibid*., pp. 221.
[154] *Ibid*., p. 218–20. Dr Emanuel Edward Klein was born in Hungary in 1844, moving to England in 1871 where he often worked as a histologist and bacteriologist for the LGB. Klein published extensively on topics such as Asiatic cholera and the oriental plague. Anon (1925), 'Obituary: E.E. Klein, M.D, F.R.S', *British Medical Journal*, **3347**: p. 388.
[155] *Supplement to Eighteenth Annual Report* 1889, p. 222–23.
[156] Anne Hardy (1999), 'Food, Hygiene and the Laboratory: A Short History of Food Poisoning in Britain, circa 1850-1950', *Social History of Medicine*, **12:2**, p. 294.

why, was that the meat had been inadequately cooked. Ballard received acclaim and garnered notoriety for the thoroughness of his investigation. Given his track record, it is no surprise that Ballard would seek a similar explanation for Middlesbrough's pneumonia epidemic. Food poisoning had also become Ballard's focal interest after the Welbeck case, compiling reports for the LGB of any suspected outbreaks.[157] However, the evidence in Middlesbrough was at best circumstantial, and the symptoms of the Welbeck outbreak were significantly different to those of pneumonia. Additionally, Ballard effectively discredited the food poisoning theory in the case of Middlesbrough when he discovered that the inhabitants of the town's Workhouse did not consume any of this meat, yet were still affected by pneumonia.[158]

Ballard turned his attention to the Workhouse he hoped this would determine the cause of the outbreak due to the isolated location, and lack of interaction between its community and the general Middlesbrough population.[159] The workhouse was located a couple of miles outside the main area of the town, near the small village of Linthorpe. The percentage of fatalities in the workhouse, the age and gender distribution of the disease, and the recovery rate differed from the rest of Middlesbrough. The people in the workhouse were in a poor state of health, undernourished and susceptible to disease. Residents did not often visit the main town, even if they were free to do so, the exception being the children, who went to school in nearby Linthorpe. In Ballard's opinion, this explained how pneumonia had found its way into the workhouse population in the first place.[160] Additionally, the children in the workhouse were disproportionally affected, especially when compared to their Middlesbrough peers. It certainly reinforced the idea of communicability. Ballard could see few other explanations for pneumonia being present if it were not contagious.[161] However, Ballard identified the sewerage system as the only factor that both adults and children had in

[157] *Ibid*., p. 296.
[158] *Supplement to Eighteenth Annual Report* 1889, p. 254. Any such product, if at all purchased, was prepared on site rather than bought in from the butchers that supplied the rest of Middlesbrough.
[159] *Ibid*., p. 241.
[160] *Ibid*., p. 252.
[161] *Ibid*.

common.[162] Ballard thought that these inadequacies were responsible not only for the spread of the disease but also the subsequent high fatality rates. He conceded that the drainage was problematic throughout the town; however, nowhere near to the scale of that in the workhouse. This was of substantial concern to Ballard who remained convinced that this could be the source of pneumonia, at least within the workhouse.[163] The Board of Guardians appeared to have been aware that there was a problem with the sanitation of the workhouse.[164] Despite this, they were initially resistant to acting upon the information and recommendations they received from Dr Ballard. The main issue of resistance was a financial one the Guardians clearly did not appreciate the involvement of outside agencies, in this case the LGB, and did not appreciate being told where funds and energies should be devoted. The workhouse was a conundrum, both for the Board of Guardians and Ballard. Neither party understood how pneumonia had arrived there if it were not infectious.

Whilst Ballard's 500-page report was extensive and thorough, it did little other than add to speculation, because it proffered no one clear reason.[165] No guidance regarding the suspected contaminated food source resulted, nor was any further investigation made into the perceived problems with slag dust, at least not for a further twenty years. Within the medical journals, there was a prodigious amount of debate and speculation, as to its origin and the precise nature of the disease. This debate intensified after the report of Ballard became public. Many clamoured for attention in the *Lancet* and the *British Medical Journal* to dispute Ballard's claims that this was a new disease, 'epidemic pneumonia'.[166] They reported

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[162] *Ibid*., p. 254.
[163] Ballard, although thoroughly scientific and modern in both his approach and utilisation of the latest techniques still cited the old 'miasma theory' of contamination as a likely source of the outbreak. Alain Corbin (1986), *The Foul and the Fragrant: Odor and the French Social Imagination*, Berg, Leamington Spa.
[164] Anon (1888), 'The Outbreak of Pneumonia at Middlesbrough', *The North-Eastern Daily Gazette*, August 10.
[165] D Powell (1895), 'A Discussion on Acute Lobar or Croupous Pneumonia; Its Etiology, Pathology, and Treatment.', *British Medical Journal*, **1819**: p. 1151. This paper, which postdates the outbreak, seems to suggest that the logical conclusion is that the epidemic was due to 'sewer gas emanations'. This illustrates how much speculation arose from the epidemic, continuing long after the event itself.
[166] Anon (1888), 'Diseases of the Respiratory Organs at Middlesbrough', *British Medical Journal*, **1431**: p.1191, Anon (1888), 'The Epidemic of Pneumonia at Middlesbrough', *British Medical Journal*, **1438**: p. 166, Anon (1889), 'A New Specific Fever: Pleuro-pneumonic Fever', *British Medical Journal*,

similar outbreaks in other parts of the country and indeed Europe, and pointed to several studies that had already identified pneumonia of this type, dating back to 1864. These criticisms were a disservice to Ballard's work. His aim had, in fact, been to distinguish the pneumonic fever observed in Middlesbrough from the 'pythogenic pneumonia' of previous outbreaks in other areas.[167]

## The Visibility of the Medical Practitioner

The GPs of Middlesbrough are largely conspicuous in their absence amongst the pages of Ballard's report. Whilst the LGB investigator lavished praise on the few doctor's that proved to be of assistance, he is somewhat ambivalent towards the rest. Ballard commented on the lack of corroborative evidence he received from the town's GPs. This was after MOH Malcomson made a request for doctors to supply any case notes of pneumonia.[168] Ballard was supplied with only twelve sets of records, one of which was from the Medical Officer of the Workhouse. Therefore, there were only eleven practitioners that provided a full set of cases, Ballard noted that most GPs did make a return, but remarkably few supplied enough to be of any significant value to his investigation. Ballard considered the aforementioned twelve sets to be the only cases he felt could be trusted as either accurate or comprehensive.[169]

This, potentially, assists in building a picture of the attitudes of GPs towards a number of key issues. Conceivably, it was not of the upmost importance to the majority of practitioners in Middlesbrough to keep comprehensive records of cases attended, or they did not feel compelled to supply said records to the LGB investigator. As an early observation of

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**1477**: p. 899, Anon (1889), 'The Pneumonia Epidemic of Middlesbrough', *The Lancet*, **133**: p. 742, Anon (1890), 'Pleuro-pneumonic Fever', *British Medical Journal*, **1559**: p. 1133-34.

[167] JW Moore (1889), 'A New Specific Fever: Pleuro-pneumonic Fever', *British Medical Journal*, **1478**: pp. 971-2. Drs Moore and Grimshaw, to describe what they considered a new zygomatic strain of the disease, first used the term Pythogenic pneumonia in an 1875 publication. The word 'pythogenic' relates to that originating from filth or putrefaction. T.W. Grimshaw and J.W. Moore (1875), 'Pythogenic Pneumonia', *Dublin Journal of Medical Science*, **59**: pp. 399-420.

[168] *Supplement to Eighteenth Annual Report* 1889, p. 195.

[169] *Ibid*.

the involvement, GPs had with public health officials and concerns it tends to suggest reluctance on their behalf to become involved. Perhaps, in the minds of the GPs, it was further evidence of unnecessary external interference. Alternatively, at a time when there was no obligation to keep standardized patient records, many felt unable to assist Ballard with his request. That is not to suggest that Ballard was met with indifference, as he pointed out the lack of demarcation of patient types within individual practices in Middlesbrough would have made it difficult to extract meaningful data from many of the reports he received.[170] Ballard commented on the 'intermingled' nature of practices in Middlesbrough, where pauper, club and contract practices were grouped and run as one by the majority of practitioners in the town.[171] For his part, Ballard does not provide any details of his interactions with practitioners in the town. The Ballard report does not contain explicit details of any of the conversations or interviews that took place between himself and the medical men of the town, with the possible exception of MOH Malcomson and some of the Medical Officers of the towns' hospitals and the Workhouse. However, he does mention the overall thoughts and impressions of the town's practitioners regarding the causes of the outbreak and how it was being spread throughout the town. The GPs within Middlesbrough become increasingly vocal during subsequent outbreaks, probably due to the closer relationship they appear to have with Malcomson's successor, MOH Dingle. Whilst the report lacks clarity as to the involvement of the town's practitioners, it does at least provide a basic idea of those doctor's that were substantially engaged with assisting Ballard and the cases they attended. This was most evident when Ballard tried to assess the communicability of the disease. The LGB investigator identified the incidence of multiple cases of pneumonia in a single residence.[172] *Table 7* lists the practitioners that supplied information on this issue. It is

[170] *Ibid*., p. 200.
[171] *Ibid*.
[172] *Ibid*., pp. 292-98. This added to the idea that was put forward by MOH Dingle a decade later that pneumonia within the town was indeed infectious and this could be demonstrated most effectively by the high number of inter-house infections that occurred.

reasonable to assume that they were the same GPs that Ballard alluded to regarding the supply of case notes.

*Table 7*

Medical Attendants: Multiple Pneumonia Cases within a Single Residence, Middlesbrough, 1888

| Medical Attendant | Number of Cases |
|---|---|
| Dr Batemen | 19 |
| Mr Longbotham | 12 |
| Dr Malcomson | 9 |
| Dr Veitch | 6 |
| Dr Ketchen | 5 |
| Dr Craster | 4 |
| Dr Hind | 3 |
| Dr Riordan | 2 |
| Dr Young | 2 |
| Dr McCraig | 2 |
| Dr Knott | 2 |
| Dr Hinselwood | 1 |
| Dr Cook | 1 |
| Dr Andson | 1 |
| Dr Williams | 1 |

Source: PP 1889 (C.5818-I), *Local Government Board: Supplement to Eighteenth Annual Report, Containing Report of Medical Officer 1888*, 1889, pp. 292-98.

Dr Hinshelwood was the resident surgeon of the North Riding Infirmary; Dr Malcomson was the MOH for Middlesbrough and Dr Longbotham acted as the Medical Officer for the Workhouse. Dr Longbotham also ran a private practice. This is one of the earliest indicators that during the late nineteenth century through until the early twentieth century, doctors in Middlesbrough often held more than one medical post, whilst retaining a general practice position.

The practitioners' thoughts on the cause of the outbreak received minimal attention within the report. This might be because the observations are somewhat generic and involved blaming adverse climatic conditions or attempted to place the blame upon the sufferers, specifically the workers. The lifestyle of the population, in particular the workers,

resonated with the increase of the disease. Men hanging around on street corners in the cold and damp air, particularly after working in the heat of iron and steel works all day did little to allay concerns over the epidemic spread of pneumonia. Indeed, during 1888, many GPs in the town reported that Monday morning was their busiest day of the week, witnessing most new cases on this day.[173] In his 1888 report, Ballard describes this as attributed within the town to 'the Saturday night's orgies at the public house'.[174] Ballard moved quickly to discredit this theory, using the GPs own records against them.

*Table 8*

Onset of New Pneumonia by Day of Week, Middlesbrough, 1888

| Day of the Week (Outbreak of Attack) | Number of Cases |
|---|---|
| Sunday | 68 |
| Monday | 89 |
| Tuesday | 67 |
| Wednesday | 69 |
| Thursday | 54 |
| Friday | 46 |
| Saturday | 80 |

Source: PP 1889 (C.5818-I), *Local Government Board: Supplement to Eighteenth Annual Report, Containing Report of Medical Officer 1888*, 1889, p. 224.

*Table 8* demonstrates that there was almost the same number of cases reported to have commenced on a Saturday as there were on a Monday.[175] Therefore, the distribution of cases could not solely be attributed to the weekend drinking habits of the workers. Additionally, Monday would have been one of the earliest opportunities for a new weekend case to be reported to the GP; hence, the elevated numbers for that day.

The GPs had little involvement in this outbreak outside of their curative role. The reporting of cases was not yet mandatory, even on a voluntary basis. Therefore, it was left to the various medical officers of the town and its institutes to assist the LGB investigator. Practitioners within Middlesbrough continued to espouse their views on pneumonia and its

[173] *Ibid*., p. 224.
[174] *Ibid.*
[175] *Ibid*.

causes throughout the following decades. For example, in 1913, J Watkin Edwards attempted to demonstrate the impact pneumonia had on the males of the town during the early twentieth century using the steel town of Sheffield as a comparison (*Table 9*).[176]

*Table 9*

Death Rate from Pneumonia (1911) in Workers aged 25-65, per 1,000 living persons

| | |
|---|---|
| In County Boroughs of the North | 1.6 |
| In a Town such as Sheffield | 1.2 |
| In Middlesbrough Amongst Females | 0.9 |
| In Middlesbrough Amongst Males | 3.4 |

Source: J. Watkin Edwards (1916), 'An Address on Industrial Diseases Prevailing Amongst Iron and Steel Workers in Middlesbrough', *The British Medical Journal*, **2899:2**, p. 98.

Watkin Edwards considered that the 'men engaged in iron and steel manufacture were much more liable to the disease than others.'[177] Although this theory was somewhat negated by his use of Sheffield as a comparison to Middlesbrough as the former steel town did not demonstrate such problems with the condition. He also observed that 'natives' of Middlesbrough were more susceptible to the disease than migrants to the town were.

As we shall see in the next section, GPs were to become an increasingly prominent and vocal presence during subsequent epidemics, although at times this did place them at odds with the town's authorities.

## Epidemics, Notification and General Practice

Pneumonia continued to be an insidious and endemic presence within Middlesbrough well into the twentieth century. The illness was also a source of debate within the town regarding notification of infectious disease. However, it was not the only epidemic disease to raise questions about notification, especially the involvement of GPs in the process. The following section shall assess the importance of the Infectious Disease Notification Act (1889) and, more specifically, the part that medical practitioners played. It shall examine whether they

[176] J. Watkin Edwards (1916), 'An Address on Industrial Diseases Prevailing Amongst Iron and Steel Workers in Middlesbrough', *The British Medical Journal*, **2899:2**, pp. 98.
[177] *Ibid*., p. 97.

had an active or passive role in enforcing the act and their interactions with the MOH and public health officials. When examining the contemporary journal and newspaper articles, as well as official reports, it becomes apparent that there were doctor's within Middlesbrough whose names emerge repeatedly. Their names are a recurrent feature during the latter part of the nineteenth century and included Drs Veitch, Hedley, Longbotham, Fulton and Watkin Edwards. There were unquestionably more doctors in the town throughout this period than those named. However, in Middlesbrough, there were doctors who, possibly through seniority, had acquired authority over the rest of their cohorts. If the records are reliable then these doctors either were consulted first or perhaps were simply willing to offer their services and opinions ahead of the rest. This section assesses possible reasons why this pattern developed.

There were three diseases, serious enough, to garner attention from the local and national press, namely, pneumonia (1888-1901), enteric fever (1890/01) and smallpox (1897/8). Pneumonia, as already mentioned, was a critical and recurrent manifestation within the town. In the case of enteric fever (also referred to as typhoid fever), the River Tees that supplied a large proportion of the Tees Valley, including Middlesbrough was thought be the source of the outbreak. There was a great deal of attention placed upon the water companies in an attempt to find the cause of the epidemic and essentially place the blame with an identifiable group. Both sides used the opinions of GPs to argue the veracity of their claims. Smallpox was a national concern during the nineteenth century, and pressure was applied by the national government on local authorities to act quickly. In this respect, the actions of the Middlesbrough authorities were pre-determined. The three disparate conditions provide an intriguing comparison of the varying levels of response; communication and success Middlesbrough had combatting epidemics during this critical period of its development.

## Interactions of GPs

Enteric fever provides an example of how the medical men of the town were involved, directly and indirectly, during an epidemic.[178] In this instance, their thoughts regarding enteric fever in the 1870s were regurgitated during the 1890s outbreak by the general manager of the Stockton and Middlesbrough Water Board, D.D. Wilson to provide both credence and validation to his argument that the district's water supply was not responsible for the outbreak.[179] During the epidemic, an inspector from the LGB was sent to the area to assess the situation, and draw conclusions. The inspector in question was Dr Frederick W. Barry.[180] Barry investigated the sanitary circumstances of the town, this included housing, drainage and the sewerage system.[181] After due consideration of these possible causes, Barry concluded that it was indeed the River Tees that was the source of the outbreak. The river, in his opinion, had been polluted at the town of Barnard Castle (to the north of Middlesbrough), where public and private waste had been delivered directly into the water.[182] The outbreak, he determined, had taken place after unseasonably high summer rainfall had led to flooding, which carried the waste further downstream.[183] Barry, it would appear, was confident in the conclusions he drew. However, there was vociferous, vocal, opposition to his findings by the water companies that used the River Tees as their supply source.

Barry's report was favourably received by the regions MOHs as the medical men felt exonerated from blame. However, it was met with consternation by the water board,

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[178] Anon (1894), 'The Report on Enteric Fever in the Tees Valley', *The British Medical Journal*, **1725:1**, pp. 132-38.
[179] D.D. Wilson (1891), 'Typhoid Fever: Notes on the Recent Epidemic', *Northern Echo*, October 29–December 7. Wilson even had his findings published in 1893, including the theories and tables that were produced in the *Northern Echo* publications. The Stockton and Middlesbrough Water Board was one of the companies that were accused in Barry's report of being responsible for the outbreak.
[180] PP 1893-4 (C.7054) *Twenty-first Annual Report of the Local Government Board, 1891-92: Supplement in Continuation of the Report of the Medical Officer for 1891: Enteric Fever in the Tees Valley*, 1894. Barry was a senior medical inspector for the LGB, he had previously been an MOH in Yorkshire and had served with apparent distinction. Anon (1897), 'Obituary: Frederick W. Barry, M.D., D.Sc., F.R.S.Ed.', *British Medical Journal*, **1920**:**2**, p. 1127.
[181] Stout, 'Enteric Fever in the Tees Valley', pp. 35-36.
[182] *Ibid*.
[183] *Ibid*.

representatives of which felt that not all the facts or causes had been fully explored, and they had been made a scapegoat for the epidemic. Consequently, the water companies took the opportunity to perform their own investigations, leading to the publication of their findings in the *Northern Echo*. Whilst there was reluctance by Wilson to blame Dr Barry directly for his conclusions, the inference was there. Wilson preferred to suggest that the MOHs instead almost certainly kept Barry away from evidence of poor sanitation within the districts.[184] This was what the water board felt to be the real culprit and not their water supply. Wilson went as far to suggest an element of collusion between Barry, himself a medical man, and the MOHs to 'choose' water as the source of the epidemic rather than anything the MOHs might have been responsible for dealing with.[185] Regularly throughout the articles, Wilson referred to Ballard's report from 1888 on the pneumonia outbreak in Middlesbrough.[186] Wilson pointed to the extensive work that Ballard carried out concerning the state of sanitation and the sewerage system within the town. Ballard had considered the sanitation problems within Middlesbrough to be amongst the strongest contenders as to why the pneumonia epidemic had spread so quickly. Wilson seized on this information and suggested that this might also have been the source of the problem in the case of the enteric fever outbreak. He further pointed to the fact that Barry did not consider the sanitary state of the district as thoroughly as Ballard had. Rather, Barry appeared to have already decided upon the drinking water being contaminated at source and then passed on by the water suppliers.[187] Barry's report does seem to be decidedly different from that of Ballard's in 1888, where all possibilities were considered before any conclusions were drawn. If the outcome had already been decided upon prior to the investigation, then the report was nothing more than a perfunctory attempt to appease an already anxious community.

This was at a time of considerable concern over the quality of water within Britain and Europe. Water analysis, filtration systems and reliable storage of water was a topic of debate

[184] Wilson, 'I: Introduction', October 29.
[185] *Ibid*.
[186] *Ibid*., 'III: Diagrams', November 3.
[187] *Ibid*.

amongst MOHs and pressure was exerted upon private water companies to improve their supply.[188] However, by the 1880s, water analysis was largely ignored and reports such as those produced for the Tees outbreak did little to improve the reputation of the process.[189] The analysis of the water from the River Tees implied that it was not contaminated with enteric fever, yet the rising number of cases from those drinking water from it suggested otherwise. It was not until the late 1890s, after E.E. Klein perfected a method for identifying the presence of water-borne disease such as typhoid, that MOHs and LGB investigators began to use chemical analysis again.[190]

Barry had understandably compared the incidence of enteric fever amongst consumers in the district supplied by the river Tees against those who did not consume water from this source. This led to the conclusion that the Tees water supply was the problem. Those who did not use water from this river did not suffer from the epidemic as severely as those who did. Despite the conclusions of the report being made public knowledge, it did not, apparently, deter the population from using the water for the same purposes they had always done.[191]

The idea that sanitation was more of an issue than the investigative report suggested dated back to a town council meeting held in Middlesbrough in 1874.[192] The Corporation requested advice from the medical men of the town. The authority asked for possible suggestions as to the elevated mortality from typhoid fever. Of the medical men canvassed the information supplied suggested that they considered a lack of sanitation, poor hygiene and overcrowded homes as the key factors behind the prevalence of the disease.[193] Dr Veitch put it down to '...imperfect drainage, generally.'[194] Dr Hedley went further; he stated that the town was '[f]avourably situated for the production of typhoid, as is the case in damp

[188] Bill Luckin, 'Pollution in the City', in Martin Daunton (ed.) (2000), *The Cambridge Urban History of Britain: Volume III 1840-1930*, Cambridge University Press, Cambridge, p. 220.
[189] Christopher Hamlin (1990), *A Science of Impurity: Water Analysis in Nineteenth Century Britain*, University of California Press, Berkeley, pp. 284-285.
[190] *Ibid*., p. 286.
[191] Anon (1891), 'The Water Question', *Northern Echo*, October 29.
[192] Wilson, 'Typhoid Fever: 'V: Overcrowding', November 11th.
[193] *Ibid*.
[194] *Ibid*.

and low-lying districts. And that there was a much larger proportion of people to each house than in ordinary towns.'[195] Dr Ketchen deemed the spread of the disease was most likely due to direct communication between the drainage and sewerage systems of the houses.[196] A Dr Thorne-Thorne published a report in 1875, similar to the one undertaken by Dr Barry. Unlike Barry, he declared '[t]hat there was nothing which in any way connected the water supplied by either the Stockton and Middlesbrough Water Company or the Cleveland Water Company with the prevalence of fevers in the district supplied by them respectively.'[197] Thorne-Thorne, by the time Barry's report was published, was the MOH of the LGB; he even wrote the introduction that accompanied the 1893 account. However, Thorne-Thorne appeared to have had a change of heart regarding the source of enteric fever in the region and was adamant that the Tees and the water sourced from it was the culprit.[198] Subsequent reviews of the outbreak were quick to dismiss the possibility of the cause being due to defective drainage or infected food. Contaminated water was the preferred choice of causal agent amongst such authors. One medical author, Dr W. A. Winter, wrote about the epidemic retrospectively in 1898, and stated that whilst debate still raged as to the definitive cause it had highlighted some fundamental issues. These included the necessity for better filtration, certainly at a domestic level; the importance of the role of the MOH in tracing epidemics via statistical analysis; and finally, the adoption of the Infectious Diseases notification Act throughout the country to ensure that accurate records be maintained.[199] As with the epidemic outbreaks of pneumonia, no correlation between the epidemic outbreaks of enteric fever and the relatively high incidence of endemic cases was made. It appeared to Dr Barry when reporting on the epidemics that they were distinctly different in cause and nature to the endemic strain. The subsequent report by the LGB inspector, Dr Robert Bruce Low (1846-1922) in 1896, found that once again the wards worst affected were those in the north:

[195] *Ibid*.
[196] *Ibid*.
[197] *Ibid*.
[198] Stout, 'Enteric Fever in the Tees Valley', p. 37.
[199] W.A. Winter (1898), 'Notes on an Epidemic of Enteric Fever', *Transactions of the Royal Academy of Medicine in Ireland*, **16:1**, p. 400.

Newport, Marsh, Vulcan and Cannon.[200] Low considered the persistent prevalence of enteric fever to be "indigenous" to the area, due in no small part to the "unwholesome" conditions within Middlesbrough.[201] Low could not even apportion blame to the water supply, as Middlesbrough had changed its supply after the previous outbreak yet this had led to no cessation in the number of cases reported. Once again, the defective nature of the sewers within the town was called into question. However, even Low concluded his report by blaming the vast majority of the problems witnessed on the "dirty habits" of the lower classes within the town.[202]

It was disingenuous of Wilson to use the medical men to validate his argument, especially as their comments did not pertain to the 1890/91 outbreak, rather one that had occurred over fifteen years earlier. However, it is eminently understandable as to why Wilson chose to do so. The individuals he referenced would have been instantly identifiable to the readership. The doctor's would have been credible sources that could be used to persuade a wider audience and allay fears concerning the water supply. During the 1890/91 epidemic of enteric fever, the medical men of the town were muted in their response, hence the lack of contemporary quotes within Wilson's articles. Instead, information tended to be passed on by the various MOHs of the Tees district. This example demonstrates the way in which the views of the doctors could be manipulated into being used almost as propaganda, or rather misappropriated if necessary to advance an idea or argument. This tactic was to be employed by the local authorities of Middlesbrough just as readily as a Water Company general manager had. A similar situation arose in the late 1890s surrounding the issue of smallpox re-vaccination. On this occasion, the canvassing of the opinions of the town's medical men was to be used with, ostensibly, both positive and negative connotations.

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[200] See *Fig. 1*, for the location of these Wards within the town.
[201] Anon (1896), 'Health of Middlesbrough: The Government Inspectors' Report', *The North-Eastern Daily Gazette*, November 26th. Dr Low was a medical inspector for the LGB and a well-respected epidemiologist; he had also been an MOH in North Yorkshire, prior to his commission with the LGB. Anon (1922), 'Obituary: Robert Bruce Low, C.B., M.D.Edin., D.P.H.Camb., Late Assistant Medical Officer, Local Government Board' *British Medical Journal*, **3230:1**, pp. 822-4. The medical inspectors sent to the town, seem to have had experience of the region, with both Barry and Low previously MOHs in the Yorkshire area. Middlesbrough at this time, it should be noted, was part of the North Riding of Yorkshire.
[202] *Ibid*.

There were various theories as to how smallpox had found its way into Middlesbrough, certainly to an epidemic level in the late 1890s. The three favoured amongst the community and medical men alike were; the visit of a wild beast show in November 1897; the influx of 800 navvies to help in the laying of new tram-lines, and finally, ships arriving from Bilbao, Spain, trading iron ore.[203] This may well have been the initial point of entry for the disease, but it was not what ultimately caused the rapid proliferation of smallpox throughout the town.

To explain the epidemic, Dingle looked back over the previous decade and found smallpox had been an endemic presence in Middlesbrough. He stated that there had to be more than one causal factor for its occurrence.[204] Therefore, Dingle believed that the port and the arriving ships were the most likely source. However, in the case of this outbreak, Dingle felt that the focus for the spread of the disease was centred on the death of an Irish woman in late 1897.[205] The woman was a Roman Catholic, and as was the tradition, a large wake had been held in her home that lasted for two days. This led to reportedly hundreds of visitors to the house, which, in Dingle's opinion, aided the spread of the infection throughout the town.[206] This could also, however, be attributed to the long-held anti-Irish sentiment within Middlesbrough that dated back to the mid-1800s when there had been a large influx of Irish immigrants to work in the iron mills.[207] It was felt they had brought trouble and disharmony to the town, and they were subsequently the targets of suspicious contempt. This was a common expression of anti-Irish sentiment, repeated throughout the nineteenth century in Britain. The Irish were considered lazy, unclean and problematic within any population that they settled amongst.[208] Much of this was sentiment derived from contemporary writers and social reformers such as Thomas Caryle, Friedrich Engels and

[203] Dingle, 'Middlesbrough Small-pox', pp. 174-5. Spain had itself suffered a smallpox epidemic in 1897.
[204] *Ibid*., p. 175.
[205] *Ibid*.
[206] *Ibid*., p. 176.
[207] Taylor, 'The Infant Hercules and the Augean Stables'. An examination of the Irish immigrants in the north east of England takes place in Roger Cooter (2005), *When Paddy met Geordie: the Irish in County Durham and Newcastle 1840-1880*, University of Sunderland Press, Sunderland.
[208] David Feldmen, 'Migration', Daunton, *The Cambridge Urban History of Britain: Volume III*, p. 197.

J.P. Kay. Indeed, Engels considered that the Irish were stubborn in their reluctance to integrate themselves into the society in which they now lived.[209] Observers in many British towns during the nineteenth century reported the same feelings, that the Irish were responsible for the social ills of industrial society and ultimately a burden on Britain.[210] Conversely, industrial employers were more generous towards their Irish employees; they valued them for their labouring skills, a precious commodity in a town such as Middlesbrough.[211] As Donald MacRaild has contested, what is harder to determine is the opinions of the ordinary, indigenous population of an area, and whether these stereotypes were in fact just that, perpetuated by reformers and local authorities in order to explain problems within their own town.

Aside from placing the blame, somewhat questionably, with the Irish, it was also noted that those homes that were in the poorer quarters were most frequently attacked by smallpox.[212] This theory linked the prevalence of smallpox to a general lack of cleanliness, hygiene and a nutritious diet amongst the poor. Even those living in the worst affected areas, in the mind of Dingle at least, could have avoided the disease if they had improved their hygiene.[213] Once again, public officials blamed the community in Middlesbrough for the predicament they found themselves experiencing. The townspeople had allowed smallpox into their homes through their insanitary ways. The arguments used in Middlesbrough at this time were similar to those of Birmingham, but the problem was TB. The MOH of Birmingham mapped the city to see which areas were the worst and in doing so, it meant that the authorities could legitimately target those wards and the people who resided there.[214] This kind of segregation took place in Middlesbrough too, in an attempt to isolate those problematic wards from the rest of the town and place the blame with the inhabitants of

[209] Michael de Nie (2004), *The Eternal Paddy: Irish Identity and the British Press, 1798-1882*, University of Wisconsin Press, Madison, pp. 19-20.
[210] Donald M MacRaild (1995), 'Irish immigration and the 'Condition of England' Question: The Roots of an Historiographical Tradition', *Immigrants and Minorities*, **14(1)**: pp. 70-71.
[211] *Ibid*., p. 74.
[212] Dingle, 'Middlesbrough Small-pox', p. 176.
[213] *Ibid*.
[214] Marjaana Niemi (2000), 'Public Health Discourses in Birmingham and Gothenburg, 1890-1920', in Sheard and Power, *Body and City*, p.128.

those areas. Marjaana Niemi has compared the experience of Birmingham and Gothenburg in Sweden concerning pulmonary TB and the respective sanitary authorities' attempts to combat the disease. The authorities in Gothenburg considered TB to be because of unhealthy homes and that was where the focus needed to be centred.[215] In Birmingham, like Middlesbrough, specific areas of the town were considered the problem, namely the social classes that lived there. The people who lived in these "infected" areas were the problem not the homes they lived in per se. Ultimately, the responsibility lay with the individual, as was the case in Middlesbrough concerning both pneumonia and subsequently with infant deaths. As Niemi states '[i]ndividuals were expected to triumph over circumstances'.[216] Health authorities, certainly in Middlesbrough and Birmingham, could choose what they used as evidence to support their claims, anything that was contrary to their viewpoint on a particular topic was ignored. Certainly, in the nineteenth century, as Millward and Bell have observed, local authorities were mainly composed of laymen who lacked specialist knowledge of available technology and medical understanding.[217] In the case of Middlesbrough, the relatively late development of the town compounded these issues, as the authorities struggled to develop an infrastructure that the ever-expanding town could function within successfully.

The smallpox epidemic in Middlesbrough lasted for nine months, and during that time, the Corporation of the town was forced to act. In addition to the obligatory hospital provision, sanitary inspectors were sent to visit each house where a case had been notified; they promoted both isolation and disinfection.[218] Members of the household were also 'offered' free vaccination. Families where a case of smallpox was identified were offered either the option of vaccination or complete quarantine. In reality, this was not a choice at all; families did not want and could not afford to be separated or be unable to work. It was also

[215] *Ibid*., p. 140.
[216] *Ibid*., p. 141.
[217] Robert Millward and Frances Bell (2000), 'Choices for Town Councillors in Nineteenth-Century Britain: Investment in Public Health and its Impact on Mortality', in Sheard and Power, *Body and City*, p. 143.
[218] Dingle, 'Middlesbrough Small-pox', pp. 174-5

traumatic for the members of the family who were removed, especially in the case of children.[219] This description of events somewhat supports the claims of coercion by the authorities, subsequently made by anti-vaccinationists.

The issue of vaccination, or rather re-vaccination, was contentious , even in a town as allegedly well vaccinated as Middlesbrough. A census had been taken to try to ascertain how many people had been affected and of those, how many had been vaccinated. The figures gathered, Dingle felt, demonstrated the need for re-vaccination. Even amongst those vaccinated, there was an increase in the likelihood of contracting the disease with age.[220] There were no deaths recorded amongst those under the age of ten who had been vaccinated. Over this age if re-vaccination had not taken place then the risk increased exponentially. This led Dingle to declare that re-vaccination should occur at ten yearly intervals, not just once but throughout the lifespan of the individual to provide 'absolute' protection.[221]

According to Dingle, there were remarkably few instances in Middlesbrough of a re-vaccinated individual being attacked by the disease. Dingle even explained away any 'anomalies', putting them down to an inefficient procedural protocol during the mass vaccinations that the town had held.[222] If the all-important lymph had been rubbed, or torn off by accident during vaccination, then it had not been successful and the protection of the vaccine would not be conferred to the individual. Dingle reviewed the handling of the epidemic, and vaccination in general and singled out three key points. Firstly, he stated that vaccination, when performed to LGB standards, was a safe method of protection against smallpox. Secondly, even if performed badly, it might still have afforded the individual a certain level of protection. Finally, re-vaccination was vital to maintain maximum immunity. Dingle stated that re-vaccination should even be enforced legally.[223] He then went on to berate anti-vaccinationists for putting doubt into the mind of the public, leading to the

[219] *Ibid*.
[220] *Ibid*., pp. 178-9.
[221] *Ibid*., p. 179.
[222] *Ibid*.
[223] *Ibid*., p. 180.

promotion of 'conscientious objectors'.[224] Dingle cited cases where vaccination had saved individuals from smallpox, reporting on the lack of illness amongst those who had to deal directly with those infected, namely medical and sanitary staff. He also defended his decision to keep schools open throughout the epidemic. Primarily because there were very few children affected and school provided a healthier environment than their homes for many of the children. Children who stayed at home had been much more likely to be exposed to the disease, both within the house and out on the streets.[225]

Throughout the epidemic, there had been a problem with crowds, due in the main to curiosity, especially when people were removed from their homes to an isolation hospital. The onlookers often had to be held back, leading to the police being used on occasion.[226] Dingle felt there was a need for past mistakes to be addressed as well as the prejudice that surrounded vaccination. The public had been inherently mistrustful of the process due to what they understood of both it and smallpox itself.[227]

All of this action came at a cost, particularly a financial one. The total estimated cost was placed at around £20,000. A loan of £12,000 was provided by the LGB, the rest of the costs were met by a 'special rate' imposed by the local council.[228] The majority of these costs had arisen from the erection of the temporary accommodation and all that it entailed, such as furnishings and plumbing. The Sanitary Committee at the end of the outbreak were congratulated on their endeavours by the LGB.[229] Although, the plaudits received might have been because the management of the epidemic at Middlesbrough had been more successful than the then recent experience of Gloucester.[230] The grant from the LGB, however, did require the building of a new infectious diseases hospital as a caveat; additionally no further cases of smallpox were to be received at the current site. The reasons behind the request

[224] *Ibid*.
[225] *Ibid*., p. 181.
[226] *Ibid*., p. 182.
[227] *Ibid*.
[228] *Ibid*., p. 183.
[229] *Ibid*.
[230] Gloucester had in 1895, experienced a severe outbreak of smallpox, resulting in 434 deaths that included 281 children. The town had been wholly unprepared for such an epidemic, with inadequate vaccination, isolation and quarantine systems in place. Jennifer Glynn and Ian Glynn (2004), *The Life and Death of Smallpox*, Profile Books, London, p. 161.

are not elaborated upon, although it might well have been due to the understanding that the current hospital was located too close to the town for it to be safe.[231]

The year after the epidemic, the 1897/8 outbreak received further attention, this time from the anti-vaccination movement, primarily in the form of councillor J.T. Biggs of Leicester. The anti-vaccination movement within England had formed around 1853, as a response to the first attempts to make vaccination compulsory.[232] Anti-vaccinationists were drawn to the town because it had a high percentage of its inhabitants already vaccinated yet there were regular outbreaks of smallpox.[233] Although, the outbreaks witnessed in Middlesbrough were not as high as those towns that had a low rate of vaccination.[234] However, the mere fact that incidences of the disease still occurred and minor outbreaks took hold, led the anti-vaccinationists to use Middlesbrough as an example as to why vaccination was neither effective or safe. They held that the community was wilfully misinformed about vaccination's success rate by being promised that they would not contract smallpox.[235]

Leicester was renowned as an 'unvaccinated' town; instead of vaccination, the town's medics favoured improved standards of sanitation and social conditions as a means to combat smallpox.[236] Biggs used Middlesbrough as the counterpoint to his anti-vaccination stance. He pointed out that

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[231] *Ibid*.
[232] Glynn and Glynn, '*The Life and Death of Smallpox'*, p. 153.
[233] The history of the anti-vaccination movement is studied in Nadja Durbach (2005), *Bodily Matters: the Anti-vaccination Movement in England, 1853-1907*, Duke University Press, London. Although no mention is made of the situation in Middlesbrough, Biggs is referenced, mainly in connection with his stance in Leicester.
[234] Anon (1898), 'Leicester Anti-vaccinators at Middlesbrough', *The British Medical Journal*, **1949:1**, pp. 1219-20. Leicester being the notable exception to this particular rule.
[235] J. T. Biggs (1899), 'Middlesbro' Smallpox Epidemic: The Case Against Vaccination', *The Northern Echo*, June 26–July 8.
[236] The reluctance of Leicester to vaccinate in the case of Smallpox resulted in a serious delay to a diphtheria program in the 1930s. John Welshman (1997), 'The Medical Officer of Health in England and Wales, 1900-1974: Watchdog or Lapdog?' *The Journal of Public Health Medicine*, **19:4**, p. 445.

'The fatality rate of "fully protected" Middlesbrough was 8.5 more than that of "unprotected" Leicester, while the percentage diminution gain in the smallpox rate is nearly 60 per cent in favour of Leicester.'[237]

He attributed this difference to sanitation. Middlesbrough had a high rate of vaccination coverage but an extremely poor sanitation record. By contrast, Leicester had 'discarded' vaccination yet had a much improved attitude towards sanitation, which had allowed for practical gains that Biggs determined as being '…well abreast of modern requirements.'[238]

Middlesbrough, in many ways, did acknowledge its problem regarding sanitation but was slow in addressing the issue in any practical manner. Even by mid-1899 the best that Dingle could offer was that there was an urgent need for '[t]he education of the public generally in sanitary matters.'[239] Biggs also provided examples of cases of vaccinated individuals who subsequently died of smallpox and were retrospectively categorized as 'unvaccinated', or worse still, conveniently omitted.[240] The accusation was vehemently denied by Dingle. However, the anti-vaccinationists pointed to the fact that there were too many cases of misdiagnosis or wrongful categorization in Middlesbrough for the erroneous cases to be a genuine mistake.

Subsequently during the late 1890s, Middlesbrough started to reflect on the events of the outbreak and the supposed efficacy of its vaccination policy. A meeting was held in Middlesbrough on July 5th 1898, where the events of the epidemic, the recording and reporting of information pertaining to it, were discussed.[241] There were issues that arose surrounding the admission of patients to the isolation hospitals and how their vaccination state was recorded. It transpired that many had been entered after the patient had died and

[237] Anon (1899), 'Councillor Biggs on the Middlesbrough Smallpox Epidemic', *Leicester Chronicle and the Leicestershire Mercury*, July 1.
[238] *Ibid*.
[239] Anon (1899),'Middlesbrough Wants Protection from Smallpox', *Northern Echo*, August 2.
[240] Biggs, 'Middlesbro' Smallpox Epidemic', 'VIII: Vaccination Fallacies', July 7.
[241] *Ibid*., 'IX: Incidents of the Epidemic', July 8.

this subsequently drew both criticism and doubt as to the veracity of the records.[242] This caused such an outcry, led by the anti-vaccinationists, that a clause was added to the Vaccination Bill of 1898 that made it obligatory to enter the vaccination status of patients upon admission to an isolation hospital.[243] This amendment was due almost entirely to the erroneous recording that took place in Middlesbrough during the epidemic. However, Biggs noted there was no penalty for such registration not being carried out despite the amendment having been made statutory.[244] Biggs concluded his dissection of the epidemic by stating that it came about '...not as a result of neglected vaccination, but in spite of vaccination, for no town could under any coercive laws be better vaccinated than Middlesbrough.'[245]

As part of the promotion of re-vaccination that occurred within Middlesbrough, the medical men of the town's opinions were canvassed.[246] These views were used on pamphlets and bills distributed to promote smallpox vaccination, and specifically re-vaccination within Middlesbrough. This was made in an effort to connect with the community directly and allay any fears they may have had about smallpox vaccination. The authorities, by using GPs and local doctors, had been hoped that the community would respond favourably as these were well known and well-respected public figures endorsing the program.[247] The names used on the leaflets were again familiar within the Middlesbrough medical community. They included Dr John Hedley, Dr J. Watkin-Edwards and Dr Longbotham, regular contributors on committees and medical investigations within the town. On the subject of re-vaccination, Dr Hedley was quoted as stating: 'I believe that successful re-vaccination is an absolute protection against smallpox.'[248] Similarly, Dr J. Watkin-Edwards was recorded as saying: 'My firm belief is that smallpox after efficient re-vaccination is

[242] *Ibid*.
[243] *Ibid*.
[244] *Ibid*.
[245] *Ibid*.
[246] *Ibid*., 'IV: Primary Vaccination', June 30.
[247] *Ibid*.
[248] *Ibid*.

practically unknown.'[249] Responses that were negative about the topic were certainly not reported within the pamphlets. It gives the impression that the medical men of Middlesbrough were whole-heartedly supportive of vaccination. Whilst this is difficult to confirm with any assurance, the anti-vaccinationists do not cite any members of the medical community in the town who agreed with their stance. Of course, this could also be because those who lived and worked in Middlesbrough would not want to declare such allegiances when it would possibly have proved counterproductive to their careers in such a pro-vaccination town.

However, the pamphlets were to be used against the Corporation, as Biggs reprinted the opinions of ten of the town's physicians in his articles against re-vaccination. This time, compared to enteric fever, it was not only the frequently evoked names of medical men that were used but also the regular GPs of Middlesbrough, including Dr J.W. Benson, Dr J.W.C. Cook and Dr Frank P. Month.[250] Dr Cook assured that re-vaccination gave 'absolute immunity', Dr Month declared it 'an almost absolute preventive of smallpox' and Dr Clarke insisted it offered 'complete protection'.[251] The language used is decisive, allows for little doubt as to the success of re-vaccination, and is endorsed by men with perceived authority and knowledge on the subject. It is not possible to determine how widespread dissemination of these pamphlets were, but given that the authorities in Middlesbrough wanted all persons under ten years of age re-vaccinated it might be safe to assume they were widespread.[252] Biggs criticised the employment of such printed material in the town, especially the use of well-known doctors to persuade the population to submit to re-vaccination.[253] The use of ordinary GPs in the pamphlets, in effect, guaranteeing the absolute success of re-vaccination was even more questionable than using the luminaries of the town.

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[249] *Ibid*.
[250] Biggs, 'Middlesbro' Smallpox Epidemic', 'IV: Primary Vaccination', June 30. There was no 'Dr Frank P. Month' in Middlesbrough at this time. There was a Dr Frank Mort, so it would appear that this was a typographical error.
[251] *Ibid*.
[252] *Ibid*.
[253] *Ibid*.

Despite this, it is still difficult to assess the true nature of the GPs role during such epidemic outbreaks. GPs would have been at the forefront, alongside the sanitary inspectors, despite their apparent lack of visibility in public accounts. Often referred to as simply "the doctor" they were integral to notification and visitation of infected houses, a dangerous position during an outbreak of a disease such as smallpox. The problem with contemporary reports on epidemics is that they tended to focus almost myopically on municipal achievements rather than the doctors (and nurses) that were directly involved with infected individuals.

In his 2010 publication on the history of smallpox, *Angel of Death*, Gareth Williams uses the 1897 outbreak of the disease in Middlesbrough as a case study.[254] Williams aims to demonstrate that the town was treated harshly in the face of extreme adversity by both the press and the anti-vaccination movement. Williams praises the actions of the MOH and the local authorities for their endeavours to minimise the impact of the disease despite the catastrophic effect that it had on trade and Middlesbrough's reputation. These points are undeniably true, from the swift construction of a temporary isolation hospital to the enhanced re-vaccination program in its wake. There are two issues to contemplate when analysing Williams' assessment of the epidemic, the town's response and the subsequent involvement of the anti-vaccination campaigners. Ostensibly, the latter appear opportunistic, having chosen a moment of weakness to expose seemingly inherent flaws in smallpox vaccination. Additionally, the town did respond favourably and suitably to the outbreak, diverting all attention and resources to enforcing its halt. However, was this as altruistic as it appears to Williams and was the actions and criticisms of the press and anti-vaccinationists unjustified as he suggests?[255] Smallpox was an issue of national importance and its impact on trade in a town so reliant industry was critical. The local authorities in Middlesbrough knew that they had to supress the outbreak, not only to minimize the risk of it spreading further afield, but also to lessen the effect on trade.

[254] Gareth Williams (2010), *Angel of Death: The Story of Smallpox*, Palgrave MacMillan, Basingstoke, pp. 307-314.
[255] *Ibid*., pp. 313-314.

In *The North-Eastern Daily Gazette,* an article was published aimed at dispelling rumours regarding Middlesbrough and disease. The article addressed these issues and informed the reader that,

> '…every reputable merchant and shopkeeper is surrounding himself and his business with quite a superabundance of preventives, and that the chances of the dissemination of infection by Middlesbrough goods are at the present moment not only microscopical but probably even much slighter than they are with articles distributed from any other town where no suspicion of the existence of smallpox is entertained.'[256]

The paper went on to outline the amount of gossip that had coursed through the town at the height of the epidemic. Indeed, 'eight or ten days ago a doctor's carriage could not be seen at the door of a patient suffering from a very ordinary complaint without giving rise to the most disquieting rumours.'[257] Pneumonia, enteric fever, scarlet fever and measles had all caused considerably more deaths than smallpox during year on year epidemics within Middlesbrough. However, these diseases were not intrinsically terrifying, especially to those outside the town, as smallpox. Therefore, whether the authorities wanted to or not, all resources had to be focused upon smallpox during this epidemic, no matter the financial cost.

In the case of vaccination, Middlesbrough was a victim of its own success and publicity. Middlesbrough had made much of its high vaccination rate and the onset of this epidemic suggested it had failed. This left the town's authorities open to criticism from the anti-vaccination movement. Williams explains that Middlesbrough had a high rate of vaccination amongst infants, but low re-vaccination in adults, hence the problematic situation that arose.[258] However, he then goes on to present the mortality figures for the epidemic which claimed 201 lives, '107 of them children under ten years of age'.[259] If the town was so

[256] Anon (1898), 'A Good Name', *The North-Eastern Daily Gazette*, February 18.
[257] *Ibid*.
[258] Williams, *Angel of Death*, p. 309.
[259] *Ibid*., p. 312.

well covered by infant vaccination, why were the majority of deaths occurring in young children? The answer, can of course lay with vaccination techniques or families resisting vaccination, but in the case of the latter Middlesbrough's statistics quickly discredit this line of argument. Whilst Williams is quite correct in his assessment of the immediate action of the town, his assessment is made in isolation to the history and facts of Middlesbrough's responses to previous public health threats and therefore many of the criticisms within the local press during the smallpox outbreak were made with this in mind. As Williams points out local government was at times at odds with the MOH as to the health of Middlesbrough, often downplaying the level of ill health especially when compared to the more frank assessment of the MOH.[260] However, both groups were not above using the medical community to assuage the fears of the town's population, especially regarding vaccination.

Perhaps the single most divisive issue between the local authorities and the medical men of Middlesbrough during the late nineteenth century was that of notification. This was especially apparent when it came to pneumonia. However, it was not an issue exclusively reserved for that disease alone.

## Issues of Notification

In the latter years of the nineteenth century, little had changed for the better within Middlesbrough. MOH Dingle was quite clear in his opinion of the health of the town; he saw the effects of year on year epidemics within the area and did not disguise the facts as they appeared. In 1898, he declared 'Middlesbrough might, without much fear of contradiction, be aptly termed the "home of epidemics", for during the past ten years it has gone through epidemics of nearly all the principle zymotic diseases.'[261] This came ten years after the town had made the decision to adopt the Infectious Diseases Notification Act. The act came into effect in 1889 but remained at this stage optional for sanitary committees outside of London

[260] *Ibid*., pp. 307-308.
[261] Dingle, 'Middlesbrough Small-pox', p. 174.

(where it was compulsory).[262] It came after several attempts over the previous decade by MOHs to coerce the LGB into adopting some form of infectious disease registration, particularly in the case of smallpox. The diseases covered by the act included smallpox, Asiatic cholera, diphtheria, membranous croup, erysipelas and a number of fevers such as typhoid, enteric, scarlet and puerperal.[263] There was also the additional caveat that, after approval by the LGB, an authority could add other diseases to the list. The local authority was to pay 2 shillings and 6 pence to medical practitioners when notifying from private practice (during the aforementioned outbreak of enteric fever in Middlesbrough it was dubbed the 'half-crown fever' within the local newspaper, the *Northern Echo*) and 1 shilling for those notified from a poor law practice.[264] Indeed, Anne Digby, looking at the income of two GP practices in Wantage, Oxfordshire over the late nineteenth and early twentieth centuries, acknowledged that notification could add up to several hundred pounds per year, even at the half-crown rate.[265] When revenue from insurance and assurance companies was added, especially after World War One, the GPs earnings could grow considerably.[266]

There were issues surrounding notification that went far deeper than superficial complaints as to the infectious nature of a disease. As Graham Mooney outlines in his review of the development of notification in the nineteenth century, GPs feared that notification might lead householders not to seek medical assistance, worried of repercussions such as isolation of family members and the stigmatisation that surrounded certain conditions.[267] Therefore, the BMA had initially wanted the householders rather than the GPs to notify the disease to the MOH, to absolve the GP from breaking any

[262] Graham Mooney (1999), 'Public Health versus Private Practice: The Contested Development of Compulsory Infectious Disease Notification in Late-Nineteenth-Century Britain', *Bulletin of the History of Medicine*, **73**: pp. 238-67.
[263] John M Eyler (1997), *Sir Arthur Newsholme and State Medicine 1885-1935*, Cambridge University Press, Cambridge, pp. 34-5.
[264] *Ibid*.
[265] Digby, *The Evolution of British General Practice*, p. 120.
[266] *Ibid*., p. 121.
[267] Mooney, 'Public Health versus Private Practice', p. 259. Additionally, it was feared that the act might impact upon GPs income, if patients were removed to isolation hospitals follow-up consultations would be redundant.

confidentiality issues of the doctor-patient relationship.[268] Notification also gave the impression that the GP was not equipped to deal with epidemics and the subsequent ramifications of any outbreak. That it was the MOH and public health officials that had such knowledge and authority, rather than the GP.[269] This was one of the first instances that placed the MOH as a direct rival to the GP, for patients and services. GPs were wary of MOHs by the late nineteenth century as medical officer roles moved from part to full time.[270] The GPs considered the MOH to be dominated by councillors and bureaucrats rather than representing the medical profession and its viewpoint. This, in no small part, led to the withdrawal of GPs from municipal medicine, perhaps to their detriment as the sector continued to expand. Certainly in the case of Middlesbrough, notification remained sporadic and inconsistent, with the GPs effectively picking and choosing when to become involved.

Urban Middlesbrough chose to adopt the act in the winter of 1889, and included the list of diseases specified. The local authority had already resolved, in 1884, to pay the aforementioned half-crown to any practitioners notifying the MOH of such diseases.[271] This was not a particularly unusual course of action at this time, as many authorities had also devised similar schemes under the remit of the 'Local Improvement Acts'. What is far more revealing, however, is the Middlesbrough Corporation's response to requests to supplement that list with epidemic diseases specific to their town once they had adopted the official act. It would appear that they became increasingly bureaucratic, recalcitrant in their stance, and opted to work entirely to the letter of the act rather than adopt a more open interpretation of it, with the discretionary leeway that it provided.

Pneumonia provides an excellent case study with which to demonstrate how the medical practitioners and the local authority were often at odds when it came to notification. The sticking point between the two groups often appeared to concern the issue of the infectious nature of the disease, when in reality it masked the unease the Councillors felt over

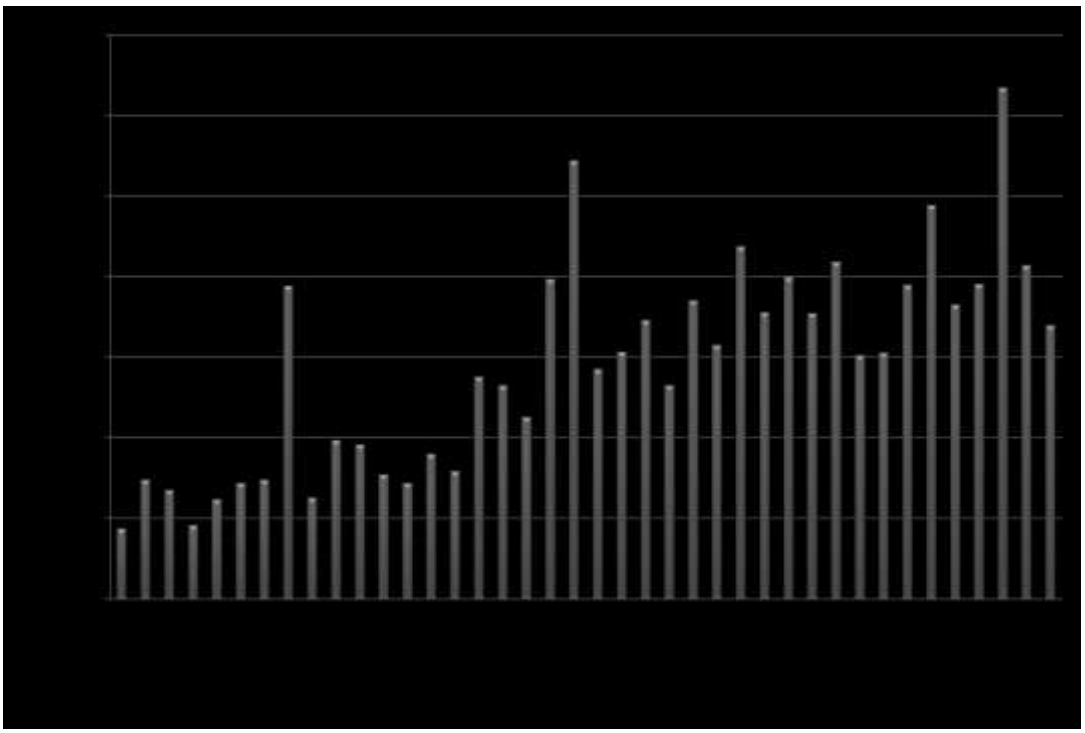
[268] *Ibid*., p. 260.
[269] *Ibid*.
[270] Digby, *Evolution of British General Practice*, p. 301. This was initially a position filled by a GP but as the role expanded, it became a full time appointment.
[271] Wilson, 'Typhoid Fever', II Making Statistics', October 31.

escalating costs and the threat of increasing council rates. This was specifically so during the period 1899-1901, when a series of year on year epidemics of pneumonia crippled the town. The period is made interesting by Dingle's efforts to track the progress of the disease and if possible, to identify what the causal factors were, while at the same time being hampered by the Sanitary Committee, whose members were extremely reluctant to have pneumonia declared infectious.[272] By 1899, the outbreaks were becoming alarmingly and increasingly severe (*graph 1*), although little had been done to pinpoint the source of the infection, even though Ballard's exhaustive report of 1888 had alluded to a number of possibilities.[273] It should also be briefly noted that other infectious diseases affected the statistics for pneumonia within the town. These are particularly applicable during later outbreaks, specifically from 1907 onwards. Pneumonia often arose in the form of a secondary complication after a bout of measles if not treated efficiently. There was a noticeable increase in the deaths attributed to measles during years when deaths from pneumonia rose.[274] Another disease, which was to affect the death rates from pneumonia within the town, was influenza. It is interesting to note that, in 1918, there were 634 deaths recorded as pneumonia and only 353 deaths registered as influenza or pneumonic-influenza as practitioners occasionally called it.[275]

[272] The Sanitary Committee members were selected by the local authority to oversee sanitary matters in the Borough. In the case of Middlesbrough, they comprised of a variety of representatives from public life, dominated by Councillors and Aldermen. The MOH had to report to the Committee, who could subsequently request and direct the work they felt needed to be addressed.
[273] *Supplement to Eighteenth Annual Report*, 1889.
[274] TA/CB/M/H/11, Medical Officer of Health Annual Report for 1930, Teesside Archives, Middlesbrough. From 1901 to 1910 amongst those aged under 5 years of age, there were 824 deaths from measles and a staggering 2,117 registered as due to pneumonia. In those aged five and above there were only 42 deaths from measles and 2,617 from pneumonia.
[275] *Ibid.* Pneumonia was eventually added to the list of infectious diseases requiring notification within the borough of Middlesbrough in 1919. This came after the highest recorded number of deaths from pneumonia within the town in 1918, at 634.

*Graph 1*

Deaths due to pneumonia in Middlesbrough taken from the Medical Officer of Health Annual Reports 1881-1920



Source: CB/M/H/1-11, Medical Officer of Health Annual Reports for 1898-1930, Teesside Archives, Middlesbrough

In numerous meetings through 1899 and 1900, the Middlesbrough Sanitary Committee debated the pros and cons of making pneumonia a notifiable disease. The community GP representative, Dr John Hedley (1843-1927), gave evidence, as did the MOH.[276] Both men felt compulsory, or at least voluntary notification was the way forward in combating the disease. Dr Hedley pushed the town to adopt compulsory notification of pneumonia.[277] At the same meeting, Hedley tried to make a case for the study of 'consumptive' cases in the same manner.[278] He even suggested that the town's floating hospital, moored on the Tees, be allowed to treat consumptive patients. The town clerk

[276] Anon (1899), 'The Health of Middlesbrough', *Northern Echo*, January 4, Anon (1900), 'The Health of Middlesbro', *Northern Echo*, April 4. Hedley was an influential, well-respected member of the medical community in Middlesbrough, even being elected mayor of the town in 1902. His wife, May Hedley, was instrumental in the establishment of a home nursing service for injured workers in 1888, leading to the development of the District Nursing Association in Middlesbrough the following year. Stout, *Three Eminent Middlesbrough Women*, pp. 33-35.
[277] Anon (1899), 'Notification of Pneumonia in Middlesbrough', *The North-Eastern Daily Gazette*, January 4.
[278] *Ibid*.

denied this suggestion outright because the Tees Sanitary Authority would never approve the idea, for the risk they would need to be removed in the case of an outbreak of cholera.[279] At this time, there had been no cholera epidemics in the country for a number of years, going back to 1892. Even then, in Middlesbrough the epidemic had been extremely well controlled and prepared for in advance of its potential arrival.[280] If the floating hospital were not to be used for any epidemic outbreak other than cholera, this would appear to be a rather wasteful use of assets. Once again, it seems to point to excessive bureaucracy and cautiousness, only this time on the part of the Tees Sanitary Authority, the MOH of which was Dr J Watkin Edwards.[281] The situation regarding the Floating hospital was not to change, between 1910 and 1917 it received and treated only twenty-seven cases. This included isolated cases of diphtheria, smallpox, enteric fever and measles.[282] Making it what appears to be a costly and underused venture. Perhaps, in the case of pneumonia, the hesitancy to use the floating hospital was due to the issue of its status as an infectious disease, as MOH Dingle dismissed the idea of removing patients from their homes to a place of isolation.[283] The same went for the other members of the Sanitary Committee, although, in their case, this was possibly due to the implication of the costs that would be incurred. In the case of a severe outbreak, it was estimated that the cost of notification alone could run to £960 per annum or 1*d* on the rates.[284]

Dingle in particular felt that by adopting notification pneumonia could be monitored in order to establish common links between those who contracted it. His tentative investigations revealed that it appeared communicable, with familial transmission occurring, and even amongst those who had merely been in contact with an individual with the disease. Dingle went even further by claiming that the 'infection' somehow lay dormant within the

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[279] *Ibid*.
[280] Anon (1892), 'The Health of Middlesbrough', *The North-Eastern Daily Gazette*, September 27.
[281] Stout, 'Floating Hospitals on the Tees', pp. 24-5. This was until 1904 when Watkin Edwards resigned to concentrate on his own practice and MOH Dingle took over this role too.
[282] *Ibid*., pp. 25-26.
[283] Anon (1899), 'Notification of Pneumonia in Middlesbrough', *The North-Eastern Daily Gazette*, January 4.
[284] *Ibid*.

homes of those previously infected, awaiting the optimum conditions required for its reappearance. It should be noted that the conditions required were not explicitly defined by the MOH, and were mentioned merely as a reason to add the disease to the town's list. He also made a case for notification by suggesting that those cases that were notified had a greater chance of surviving than those that were not. He based this assertion on the fact that those houses received a visit from a representative of the Sanitary Committee to advise on matters of disinfection, nursing, and when required, isolation of the patient.[285] After notification, a visit to the house took place and a form of enquiries was completed. Importantly it recorded whether there had been previous cases of pneumonia in the house.[286] Whilst Dingle remained enthusiastic about the benefits of notification only 100 cases were notified and in 1899, there were 397 deaths, increasing to 543 in 1900 (*graph 1*). The volume of cases that remained anonymous was undoubtedly large.

The councillors seemed to have more opinions on the infectiousness of pneumonia than the medics. Councillor Carey, an insurance agent, considered that it could not be infectious, as during his daily work he had encountered numerous cases of fatal pneumonia but never a second in the same house.[287] Councillors Roberts, Mattison and Keay, thought the repeated outbreaks of pneumonia were due to the defective drainage within the town rather than any communicability.[288]

The Sanitary Committee concomitantly persisted in trying to get the LGB to commit on whether or not they considered pneumonia infectious. There was an acknowledgement amongst the councillors that they did need to act, or at the very least be seen to act. Perhaps then, it was not entirely remiss when Councillor Roberts suggested that notification clouded the issue of pneumonia.[289] The committee and the MOH did become so obsessed by terminology that both groups all but ceased to look for any other answers.

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[285] TA/CB/M/H/1 - Annual Report 1899. Dingle produced a leaflet that could be distributed to households where cases of pneumonia had been located.
[286] *Ibid*.
[287] Anon (1900), 'Infectious or Not Infectious?', *The North-Eastern Daily Gazette*, March 8.
[288] *Ibid*.
[289] *Ibid*.

Roberts felt that 'They should set themselves to work to improve the town and thereby remove probably the sources of the disease.'[290] By saying, 'improving the town', what Councillor Roberts meant was to address the issue of sanitation in Middlesbrough. Dingle felt they needed to learn about the disease, and how it spread through the town. He stated that the LGB might not have known whether pneumonia was infectious, but Middlesbrough had an opportunity to find out due to its large number of cases. In doing so it 'would benefit the town and the country.'[291]

Dingle agreed that if they could not make pneumonia a disease requiring compulsory notification, then voluntary notification was the least the Sanitary Committee should sanction. In reality, both aspects needed to be addressed, that is, sanitation and notification had to be considered and implemented in order for subsequent outbreaks to be limited and epidemics to be all but expunged. The Sanitary Committee were concerned with the message that any such notification strategy might send to the public. In an 1899 meeting, Alderman Bulmer went as far as to declare that the committee 'must do nothing to create an opinion that there was another epidemic'.[292] This sense of not wanting to disclose what they saw as causing unnecessary panic throughout the town further delayed matters. In 1900, the same arguments were being debated, whilst the disease continued to escalate. Understandably, perhaps, the Councillors were acutely aware of the perils, financially at least, of making the wrong decision and allocating money to the incorrect place. Had the authorities made pneumonia notifiable then this would have meant paying the medical practitioners their fee. Not only this but also providing funding for disinfection and removal of patients to hospitals for isolation. The Sanitary Committee wanted clarification and approval from the LGB before they proceeded further towards notification.

Dingle was acutely aware of how the LGB worked, far better than the Councillors were and as suggested by the Taylor, Stewart and Powell study the LGB was notoriously

[290] *Ibid*.
[291] *Ibid*.
[292] Anon (1899), 'The Health of Middlesbrough'.

conservative in its actions and responses.[293] This is aptly demonstrated during a spring 1900 meeting of the Committee, when in response to Alderman Archibald's suggestion to contact the LGB to find out whether pneumonia was an infectious disease or not, he replied that they did not know enough about the disease.[294] He continued that the LGB would merely respond that they were unable to give an opinion. Sure enough, Dingle was correct, the letters the Committee received back were all along these lines, requesting more information and referring the Sanitary Committee back to their guidelines. Without a positive response from the LGB, the Councillors were reluctant to adopt any notification policy. Alderman Archibald was worried about the legality of declaring a disease notifiable without proof that it was infectious. This central authority was perceived in certain circumstances to be 'an impartial arbiter and dispenser of advice.'[295]

In March 1900, the Sanitary Committee asked the Local Government Board if they had any evidence that would enable them to determine whether pneumonia was infectious. They finally received a response in mid-May, which merely directed them to five key reports, ironically including the Ballard report of 1888 from their own town.[296] Understandably, the committee expected a slightly more helpful, less derisory response. Perhaps, however, the wording of the request provoked such a response. The Sanitary Committee had asked the LGB

> 'whether they have any evidence before them of the existence of unusual sanitary or climatic conditions in places where pneumonia had been prevalent, and whether they have any facts which indicate that the disease is infectious.'[297]

Having spent almost twenty-five years with pneumonia a constant and pervasive threat within the town, the LGB expected that the sanitary authorities, medical practitioners and the MOH might have been best placed to understand what was going on. The decision

[293] Becky Taylor, John Stewart and Martin Powell (2007), 'Central and Local Government and the Provision of Municipal Medicine, 1919-39', *English Historical Review*, **496**, pp. 397-426.
[294] Anon (1900), 'Middlesbrough and Pneumonia: Still increasing death rate', *Northern Echo*, May 2.
[295] Taylor *et al*, 'Central and Local Government', p. 418-23.. As the Taylor *et al* study notes the Ministry of Health, like its predecessor the LGB, could give 'weight and prestige to certain proposals.'
[296] TA/CB/M/C/2/20, Minutes of the Sanitary Committee, 1895-1900.
[297] TA/CB/M/C/1/60, Minutes of the Middlesbrough Town Council, 1899-1900.

was then taken to ask the LGB once more, this time definitively, whether they considered pneumonia an infectious disease. This time the reply was not only quicker, but also succinct. The LGB directed their secretary to state that 'they decline to express any opinion on the question whether pneumonia is an infectious disease.'[298] No further correspondence took place between the two groups, and Middlesbrough was now left to make up its own mind, with no guidance or clarification that they seemed to desire.

The Sanitary Committee considered the Board almost obstructive in their attitude. The LGB, for example, requested information from Middlesbrough's Sanitary Committee as to the progression of work on sanitary improvements, especially the midden scavenging.[299] This request received almost childish indignation from the committee with Alderman Hinton suggesting that they replied that they 'declined to express any opinion thereon.'[300] The same response, almost word for word, the Committee had received from the LGB concerning the infectious nature of pneumonia. The issue of the infectious nature of the disease and the implications this had on compulsory notification rapidly became a fractious topic amongst the main protagonists. Dingle decided that the key group to have on his side were the medical practitioners of the town.

This is one of the few instances, where there is a record of the interaction between Dingle, who was a member of the MDMS and frequently attended meetings, and the GPs of Middlesbrough. Dr Samuel Walker (President), during a meeting in March 1900, suggested that it was now perhaps appropriate that the society became involved in trying to establish why pneumonia was so problematic within Middlesbrough. Walker looked to Dingle for any suggestions or data that might be pertinent.[301] Rather than supply the Society with any information on the current epidemic, Dingle seized it as an opportunity to request help from his colleagues. Dingle appealed to any members with influence within the town council or other public bodies to exert it. The MOH clearly saw the authorities were the biggest

[298] *Ibid*., June 6 1900.
[299] Anon (1900), 'Middlesbrough's Sanitary Problems', *Northern Echo*, June 7.
[300] *Ibid*.
[301] TA/Accession 3034, Box 3, Minute Book, Meeting March 13 1900.

obstacle to attempts to secure at least voluntary notification of pneumonia. Dingle's chief allies were the GPs, and if he could convince them to work with him, whilst reinforcing the seriousness of the circumstances concerning pneumonia, notification could become a reality. Dingle requested the members of the MDMS to help him form an opinion as to the probable cause of the disease and in turn identify suitable forms of treatment and prevention. Additionally, he requested specimens from them, wherever possible, of the 'tobacco juice' sputa that the condition produced.[302]

Whilst the ideas set out by Dingle were allowed to distil in the minds of the doctors, further discussion was adjourned, and a special meeting of the society arranged for later that same month. During the course of that meeting, Dingle presented a compelling case based on the morbidity records for both Middlesbrough and the wider North East region.[303] He discussed the death rates attributed to pneumonia in Sunderland, Hartlepool and Stockton; Dingle highlighted the stark differences between those towns and Middlesbrough. Respiratory diseases accounted for 8% of deaths in those towns whereas the figure stood at over 19% in Middlesbrough.[304] The MOH presented evidence about the hold the 'serious form of pneumonia now prevalent in the town was now taking'.[305] He further discussed the probability that there were several different kinds of pneumonia with distinctive organisms particular to each. This hypothesis was aimed at giving credence to the assertion that certain types of pneumonia found in the town were infectious; as Dingle commented, 'much in the way that typhoid fever was infectious'.[306] However, the GPs were reluctant for notification to be endorsed unless it could be determined that pneumonia was an infectious disease. The members present at the meeting evidently did not feel constrained by any pre-existing judgements on this issue, as the medical men voted twenty to three in favour, that 'at least

[302] *Ibid*.
[303] *Ibid*., Meeting March 27 1900.
[304] *Ibid*.
[305] *Ibid*.
[306] *Ibid*.

one' of the strains of pneumonia in Middlesbrough was infectious.[307] This led the President to put forward a resolution,

> 'that the prevalence of pneumonia in this town is such that in the opinion of the members of the society notification of the disease would assist in its elucidation and respectfully request the town council to make it notifiable for twelve months.'[308]

The phrasing used for both the vote and subsequent resolution is significant. Firstly, the GPs are not committing themselves to all types of pneumonia being infectious, just one of the strains that existed in Middlesbrough. A number of the members of the MDMS had been GPs in Middlesbrough during the 1888 epidemic, namely Drs Veitch, Hedley, Longbotham and Knott. They had provided Ballard with records of cases that had occurred within the same household during that epidemic. Therefore, the notion of the communicability of pneumonia was already well established in their minds, as was the concept that pneumonia in Middlesbrough was town specific.[309] The second key issue is that of Dingle persuading the members to lobby the town council and apply pressure in that area. Dingle had been unsuccessful in his attempts to convince the local councillors to make pneumonia notifiable, but the medical practitioners of the town were an influential group. There was power and strength in numbers. The town clerk sent a response to the Society concerning notification, expressing thanks for the members' help. Further to this, he enquired whether they would be willing to notify pneumonia for 1s per notification, a reduction from the usual 2s 6d. The members decided to agree to participate but requested that the sum went to the nurses' home instead.[310] The Sanitary Committee agreed to this concession if the doctors signed their consent for such payments to be made on their behalf.

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[307] *Ibid*.
[308] *Ibid*.
[309] *Supplement to Eighteenth Annual Report* 1889.
[310] TA/Accession 3034, Box 3, Minute Book, Meeting May 8 1900.

By December 1900, all but four of the GPs had supplied their permission.[311] The Society managed to achieve, albeit for twelve months, what Dingle had failed to do namely place pneumonia on the notifiable diseases list for Middlesbrough. Indeed, Jacqueline Jenkinson acknowledges the input that medical societies in Scotland had in matters of public health; practitioners discovered that they had an elevated persuasive power as a collective than as individuals.[312]

However, this success was short-lived. Dingle had appealed perhaps to the vanity of the GPs to enforce changes that he found difficult, but that did not necessarily result in their compliance or absolute cooperation when it came to carrying out the notification. In October 1900, Dingle requested that it be brought to the attention of the MDMS that few notifications were being made. In the previous returns, there had been twenty-seven deaths attributed to pneumonia, yet only twenty-one notifications were received, a questionable situation given that the number of cases of pneumonia would always exceed the number of deaths by some margin.[313] Pneumonia did not prove fatal in all cases yet, seemingly, mortality in Middlesbrough exceeded morbidity. In terms of the epidemic, by October 1900, the worst had passed. Perhaps the GPs no longer felt that it was necessary to be as thorough with the notifications. The official statement from the MDMS is concise and somewhat dismissive, aimed at appeasing Dingle rather than reassuring him. The Society thought that the problem lay with locums. Many of the town's GPs were away and the locums hired were wrongfully reporting bronchia-pneumonia as pneumonia in the death returns or simply not notifying at all.[314] There is no explanation provided as to why 'many medical men' would be absent, and it seems unlikely that the explanation provided is an accurate or adequate one. However, it does advance the conception once more that pneumonia in Middlesbrough was specific, so much so that only the town's GPs could correctly identify the condition, anyone from outside

[311] TA/CB/M/C/2/21, Minutes of the Sanitary Committee, 1900-1904. It becomes unclear after this point whether or not the 1*s* fee were ever paid to the nurses' home or whether due to the missing signatures the payment was withheld.
[312] Jenkinson, *Scottish Medical Societies*, p. 34.
[313] TA/Accession 3034, Box 3, Minute Book, Meeting October 9 1900.
[314] *Ibid*.

was prone to error and misdiagnosis. The idea that there was such a disease as 'Middlesbrough Pneumonia' was an enduring one even by 1900; it might even be argued that it was thriving.

This was not the first time that the GPs of Middlesbrough had been approached to notify cases of pneumonia. The previous year in 1899, they had agreed, with few exceptions, to notify the Health Department of any cases of the illness for a period of six months (February to July).[315] With the reintroduction of notification, the following May (1900), the vital epidemiological indicators Dingle was so sure he could isolate, were evidently unforthcoming.[316] This might explain the reluctance on behalf of the council to sanction further notification when it did not seem to provide definitive answers the first time. However, as Dingle commented the notification periods always seemed to be implemented too late, and the opportunity for a thorough investigation had already passed.[317] These factors might then explain the apparent apathy that existed amongst the councillors and the GPs when it came to discussions surrounding pneumonia. There was also another explanation; there was what can only be considered as miscommunication between the MDMS and the Middlesbrough Sanitary Committee regarding notification. It is difficult to tease out the details of how this misunderstanding arose, but it left the two groups in opposition concerning the subject, and the GPs malcontent. In the *North-Eastern Daily Gazette*, March 29th 1900, there was a summary, allegedly, of the Special Meeting the MDMS held to discuss pneumonia.[318] The anonymous report stated that the MDMS members considered pneumonia not to be excessively problematic, not infectious and that there was no specificity to Middlesbrough.[319] However, it reported that members urged the Sanitary Committee to make the disease notifiable. This would seem contradictory, if the doctor's did not consider pneumonia any of the things outlined in the newspaper report then why would notification be an appropriate

[315] TA/CB/M/H/1, Medical Officer of Health Annual Reports for 1898-1903, Annual Report for 1899, Teesside Archives, Middlesbrough, p. 54.
[316] *Ibid*., Annual Report for 1900, p. 16.
[317] *Ibid*.
[318] Anon (1900), 'Middlesbrough Doctors and Pneumonia', *North-Eastern Daily Gazette*, March 29.
[319] *Ibid*.

course of action. The minutes of the MDMS, as previously discussed, told an entirely different story. Dr Hedley at the subsequent meeting of the Sanitary Committee denied that the press report was accurate and instead informed the Committee that the majority of MDMS members had considered pneumonia within Middlesbrough communicable to some extent.[320] However, the seed of doubt was firmly planted in the minds of the Sanitary Committee members and it did little other than to reaffirm the notion that notification was pointless. The reports in the local press on both of these meetings damaged the relationship between the MDMS and the Sanitary Committee.

A member of the MDMS wrote a passionate rebuttal of the claims of the Sanitary Committee that the request for notification by the Society was a moneymaking scheme on the GPs behalf. The article appeared anonymously in the *North-Eastern Daily Gazette*.[321] The author, signed "Medicus", was outraged by the discourteous treatment of the Medical Society, and tersely commented that they would effectively be loathed to assist the Sanitary Committee in the future after such flagrant ingratitude.[322] This exchange between the two parties helps to explain the apparent reluctance of the town's GPs to engage in public health matters. The GPs felt they were underappreciated and wasting their time, they had clarified that notification of pneumonia was not for the purposes of isolation but investigation. They hoped that by making the disease notifiable the cause of pneumonia's prevalence in Middlesbrough could be determined and a potential course of action identified. It would be reasonable to assume that any existing ties between the medical men and the local authority would consequently have been placed under tremendous strain. What Dingle had initially anticipated would act as leverage within the town council, using the GPs influence, quickly dissipated into a fractious situation and perhaps irrevocably damaged the already laboured relationship. The *North-Eastern Daily Gazette* clearly felt partially responsible for the deleterious state of affairs and printed, in May of the same year, a meritorious and

[320] Anon (1900), 'Health of Middlesbro': High Death-Rate from Pneumonia', *Northern Echo*, April 4.
[321] Anon (1900), 'Pneumonia', *North-Eastern Daily Gazette*, April 5.
[322] *Ibid*.

celebratory piece, extolling the philanthropic virtues of the medical men of Middlesbrough.[323] The editorial applauded the MDMS for its handling of the issues surrounding the notification of pneumonia. The paper also praised the decision of the MDMS members to donate their 1s per case fee to the Nurses' Home. Interestingly the article also explained how pneumonia is not widely considered infectious in areas outside of the town, but medical men in the district had long been under the allusion that something specific was at present in Middlesbrough's case.[324]

Looking at how the local authorities, medical profession and the LGB interacted on issues of notification, it is clear to see how the issue of cost and the restrictions they placed upon themselves both financially and in interpreting the 1889 Act often clouded the outcome. The Sanitary Committee tended to, begrudgingly, work within the framework of the Act when they knew they had little alternative, such as was the case with smallpox. However, if there were a loophole the Committee could exploit, then they would. This was demonstrated when they questioned the communicability of pneumonia and the legality of the disease being made notifiable. The Committee claimed to be doing so in the interest of exploring other possible reasons for the excessive presence of the disease, such as the state of sanitation, housing and even industrial pollution. In reality, there was no concerted effort made to deal with these either, just yet more referrals to more sub-committees and boards seeking further clarification. Perhaps, understandably, there was always reluctance to point the finger at industry; judiciously they chose not to bite the hand that fed the town.

This illustrates the almost impotent position of both the MOH health and the medical practitioners of the town. They were rarely afforded the opportunity to have their wishes regarding notification granted. However, even though they agreed to voluntary notification without payment, few cases were subsequently reported to the MOH. Other than the minutes of the MDMS, remarkably few records have survived which reveal the thoughts of the GPs on the matter. The only other available sources that occasionally include the opinions of the

[323] Anon (1900), 'Pneumonia Notification', *North-Eastern Daily Gazette*, May 14.
[324] *Ibid*.

GPs are the minutes of the Sanitary Committee and newspaper reports. Graham Mooney's summary as to the medical profession's attitudes towards notification in its early years can also be used to appraise the response of the GPs in Middlesbrough, they were '…prepared to argue for notification, on the other hand they would do so only if it did not impose any duty upon them under compulsion.'[325]

Notifications were a substantive source of income for the GPs but also time consuming and bureaucratic. The GPs were held accountable for the notifications they made, or rather those that they failed to supply, as was the case with pneumonia. It was not unheard of for the number of deaths for a notifiable disease to exceed the number of notifications made. During an epidemic, notification caused a considerable amount of extra administrative work for the GP. The table below (*table 10*) is taken from the 1900 Annual Report of the MOH for Middlesbrough and illustrates the sheer volume of notifications that could occur during an epidemic, in this instance, smallpox.

*Table 10*

Notifications Received from Medical Practitioners in Middlesbrough 1897 and 1898

| 1898 | Small-pox | Scarlet Fever | Diphtheria | Enteric Fever | Puerperal Fever | Croup | Erysipelas | Continued Fever | Typhus Fever | Totals |
|---|---|---|---|---|---|---|---|---|---|---|
| Jan | 32 | 24 | 15 | 22 | 1 | 3 | 7 | | | 104 |
| Feb | 637 | 18 | 8 | 18 | | 1 | 6 | 1 | | 689 |
| Mar | 518 | 19 | 2 | 20 | | | 10 | | | 569 |
| Apr | 145 | 32 | 3 | 13 | | | 18 | | 1 | 212 |
| May | 44 | 27 | 4 | 18 | 1 | | 15 | | | 109 |
| Jun | 14 | 9 | 2 | 10 | | | 6 | | | 41 |
| Jul | 5 | 14 | 6 | 12 | | 1 | 4 | | | 42 |
| Aug | 2 | 9 | 1 | 13 | | 1 | 5 | | | 31 |
| Sep | | 23 | 1 | 23 | | 1 | 5 | | | 53 |
| Oct | | 26 | 4 | 42 | | | 6 | | | 78 |
| Nov | | 18 | 2 | 30 | 1 | | 9 | | | 60 |
| Dec | | 18 | 6 | 13 | | | 7 | | | 44 |
| Totals | 1,397 | 237 | 54 | 234 | 3 | 7 | 98 | 1 | 1 | 2,032 |
| | | | | | | | | | | |
| 1897 | 12 | 245 | 38 | 166 | 5 | 5 | 93 | 7 | Nil | 571 |

Source: TA/CB/M/H/1, Medical Officer of Health Annual Reports for 1898-1903, Annual Report for 1898, Teesside Archives, Middlesbrough, p. 16.

[325] Graham Mooney (1994), *The Geography of Mortality Decline in Victorian London*, Unpublished Doctoral Thesis, Liverpool University, p. 215.

Smallpox accounted for the majority of cases notified in 1898, followed by scarlet fever and enteric fever. It is 1897, that perhaps presents a 'normal' view of infectious disease in Middlesbrough. However, at least four of the diseases are negligible for both years.[326] When the controversy that surrounded the potential notification of pneumonia is considered, it would seem that there was a case for the disease being added if only from the standpoint that the mortality figures (and therefore morbidity) were closer to the epidemic level witnessed with smallpox than the barely visible puerperal fever or croup. Despite the increased workload, an epidemic could also prove lucrative if a GP examined and reported a large number of cases. For any potentially unscrupulous doctor, the temptation to manipulate their records could prove immense and such a situation arose during the enteric fever epidemic in 1890/91.

In his publication regarding the typhoid fever epidemic in the Tees Valley during 1890, Wilson took issue with notification and reporting of mortality and morbidity statistics. Wilson wanted some clarification on the stark difference between cases notified and the subsequent death rate. In areas where compulsory notification had been adopted by 1890, there had been 801 cases with 117 deaths in the first three quarters of the year.[327] Whereas, in the districts without compulsory notification there had allegedly been 104 cases of typhoid fever with 56 deaths.[328] Wilson could not reconcile the large difference between the two sets of figures, and suggested that 'half-crown fever' might have overtaken doctors notifying within the compulsory districts. The inference of the term 'half-crown fever' was that cases were being notified that were not necessarily typhoid fever in order to secure payment. Wilson questioned why the death rate was not proportional to cases notified, or at least to a similar level in the districts where no payment was received for identified cases brought to

[326] TA/CB/M/H/1, Annual Report for 1898, p. 16.
[327] Wilson, 'Typhoid Fever: 'II: Making Statistics', October 31.
[328] *Ibid*., *'I: Introduction'*, October 29. In his own report, Wilson increased these figures within the notification areas to 1870 notifications and 140 deaths for the year ending 1890.

the MOHs attention. Wilson also alluded in his articles to a case in the Stockton Sanitary District where a prosecution for false notification of cases was to be brought to court.[329]

This information came from a meeting of the Stockton Urban Sanitary Authority. A motion was introduced to bring charges against an unnamed doctor that they felt had erroneously notified cases of enteric fever to claim his fee.[330] Under the Infectious Disease Notification Act (1889), a doctor could be fined up to 40*s* for either not reporting a case of an infectious disease to the MOH, or for notifying a case that did not exist.[331] The doctor in question had notified 83 cases compared to 63 spread amongst the remaining 11 doctors in the district with reported cases. The figure seemed implausibly high to the members of the committee, especially MOH Dr JH Clegg. Beyond that, they had proof of wrongdoing, as evidence had been forthcoming that the doctor in question had reported a case of continued fever without even taking the temperature of the patient.[332] The council felt that the only course of action left open to them was prosecution, and this appeared to be because of two reasons. Firstly, it was the cost to the authority and the ratepayers; they had to be seen to protect their finances. Secondly, and perhaps most importantly, they did not want to spread panic amongst the public.[333] The council most certainly did not want to give the impression that there was an epidemic when there was not. Figures as high as this being notified from one practice alone tended to suggest that there was a problem. Appearances were significant and the Sanitary Authority did not want any suggestion that the town was not a healthy place, especially when in this instance it might not even have been true. It is difficult to assess whether or not this individual doctor was acting fraudulently in order to gain fees; certainly, the figures for his practice (even when the size of that practice was considered) do seem high in comparison to the rest of the town. On the other hand, it might also have been a combination of hearsay and a desire to alleviate concern at a time of an outbreak, not to

[329] *Ibid*.
[330] Anon (1891), 'Serious Charges Against a Medical Man', *The North-Eastern Daily Gazette*, September 19.
[331] *Ibid*.
[332] Anon (1891), 'The Notification of Diseases at Stockton', *The Yorkshire Herald and the York Herald*, September 19.
[333] Anon (1891), 'Serious Charges Against a Medical Man'

mention a council trying to reduce its expenditure at a time of crisis. There is no further correspondence about the prosecution of the doctor, although it is probably safe to assume that it went ahead after the members of the authority carried the motion unanimously. The concept of fraudulent claims was one that had beset the debate surrounding notification prior to the 1889 Act. Mooney cites the opinions of Dr Edward Morley, a GP in Blackburn in 1882 who considered that some doctor's would falsify certificates in order to claim the fee.[334]

Events such as these allowed for further doubt over the veracity of the figures supplied to Dr Barry in the course of his investigation into the cause of the outbreak of enteric fever. Doubt that was compounded by claims such as those made by the MOH for Stockton that regarding the compulsory system of notification '[t]o it and it alone, was the grave epidemic which existed last September traced to its source.'[335] The MOH for rural Stockton went even further when he stated that notification meant that it '[e]nabled statistics to be made, which made a very strong case that the Stockton and Middlesbrough Water Company's water was the probable cause of the two severe outbreaks of typhoid fever.'[336] It is difficult to understand exactly how those statistics could corroborate such a theory. The figures might well have shown where the disease was and in what concentrations but they could not indicate, definitively, either the source or the cause.

The problems that surrounded the GPs and their involvement with notification of diseases continued into the early twentieth century. During an outbreak of epidemic measles in 1907, Dingle emphasized the importance of notification and isolation. The MOH requested that if necessary, after the condition had been identified, the medical practitioner should ensure that suitable cases '…be removed to the Borough County Isolation Hospital.'[337] This suggested that the progression of the epidemic was in the hands of the GPs.

Just over two decades later there were concerns surrounding the notification of tuberculosis. So much so, that Dingle was required to repeat the responsibilities of the GPs,

[334] Mooney, 'Public Health versus Private Practice', p. 263.
[335] Wilson, 'II: Making Statistics', October 31.
[336] *Ibid*.
[337] TA/CB/M/H/4, 'Annual Reports of the Medical Officer of Health 1904-1909', Teesside Archives, Middlesbrough, p. 84.

this time with the potential threat of action if ignored. Dingle received a communication from the Ministry of Health in June 1931, which informed him that a large number of tuberculosis cases had not been notified, at least not until after the death of the individuals.[338] He urged all medical practitioners (general practitioners in particular) to comply with the regulations of the Public Health Act of 1896. Practitioners had to report any case of tuberculosis that was detected within the first 48 hours. If GPs failed to notify the disease, the doctor's would be subject to proceedings being brought to recover a set penalty.[339] During the previous year, (1930-31) the number of cases that were not notified were 9.89% of the total notifications; 21.6% of deaths from tuberculosis were not notified prior to death.[340]

As can be seen from the records, notification, at least from the GPs viewpoint, was a contentious issue. The process was difficult to enforce and as has been demonstrated it was a system in which the doctors did not always feel obligated to participate. Conversely, notification was a system open to potential abuse by the GPs if they fraudulently made claims. Additionally, the greater debate nationally at this time, rather than notification, was that of payments to GPs for smallpox vaccinations.[341] The argument was as to whether it was preferable to have GPs perform vaccinations in return for a set fee or to only allow public vaccinators to undertake the task. There was a general feeling that private practitioners would influence the process needlessly and not be to subject to the same level of inspection or regulation that the public vaccinators were.[342] However, in Middlesbrough debate centred on notification of disease and concerns over the efficacy of its smallpox vaccination process in general. This meant that opinions on the matter of who should undertake vaccinations did not surface in the available records.

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[338] TA/CB/M/H/13, 'Special Reports of the Medical Officer of Health, Middlesbrough, 1930,1931 & 1932', Teesside Archives, Middlesbrough. Dingle does not clarify whether this is a general correspondence from the Ministry of Health or an issue specific to Middlesbrough.
[339] *Ibid*., Once more Dingle does not indicate exactly what or how much the penalty is.
[340] *Ibid*.
[341] J.A. Magee, J. Lloyd Roberts and E. Rice Morgan (1898), 'Private Practitioners and Public Payments for Vaccination', *The British Medical Journal*, **1946(1)**: pp. 1046-1047.
[342] *Ibid*., p. 1047.

## Conclusion

The role of the GPs within Middlesbrough is difficult to assess with any certainty during this early period of the town's history. The work and thoughts of the doctors are most visible through the minutes of the MDMS, formed at the end of the nineteenth century. The society's membership included the majority of Middlesbrough's medical men, and on issues such as notification and fees, the doctors demonstrated that as a group they could act as a single, cohesive, autonomous unit. The GPs were often reluctant to be drawn into any discussions pertaining to public health matters, preferring instead to remain muted unless their opinions were actively sought. When the treatment of the doctors by Middlesbrough Sanitary Committee over the problem of pneumonia is considered, it is perhaps not that surprising that the GPs tended to avoid becoming embroiled in such matters. Additionally, this factor might assist in explaining the actions of GPs in the subsequent decades that will be examined further in the following chapters.

However, the doctors were equally reluctant to stand against the local authorities as is evidenced by this exchange between the MDMS and the Middlesbrough Sanitary and Housing Reform Association. The Association was established in 1900, aimed to challenge the Sanitary Committees decisions and enforce changes in the poorest and most neglected areas of the town.[343] The newly formed Association approached the MDMS to enquire about the possibility of medical involvement on the Committee.[344] However, Dr Howell responded that the Society was unable to offer its support, feeling instead that individuals better dealt with such matters than any collective association.[345] Given the objectives of the Association, it is of little surprise that the Medical Society members were keen to distance themselves, officially. This was despite possibly having similar complaints regarding the implementation of the suggestions, made by the MOH, to improve health within the town. What perhaps makes this stance by the MDMS a little harder to understand is they had recently had an

[343] Anon (1900), 'Sanitary Reform in Middlesbrough', *Northern Echo*, April 4.
[344] Anon (1900), 'Middlesbrough Sanitary and Housing Reform Association', *North-Eastern Daily Gazette*, April 26.
[345] *Ibid*.

altercation with the Sanitary Committee regarding the notification of pneumonia. Therefore, it is perhaps confusing that the medical men did not see the potential of this new group, unless they thought that the aims of the Association would have either conflicted with or overshadowed their own.

The distribution of doctors during this period was predominately restricted to the central Wards of the town; a factor that compounded the problems that the workers of Middlesbrough had with health care provision and access. This was combined with the fact there was a relatively small number of GPs situated in the town at this time trying to serve and treat an ever expanding populous. Therefore, it is not difficult to see how problematic attempts to implement plans to combat the successive, serious epidemics Middlesbrough encountered would have been.

This chapter has also demonstrated the difficulties that the key groups encountered during the formative years of the town's growth. Middlesbrough had to deal with successive epidemics without time to reflect before the next one would arrive. This perhaps explains the perceived inaction of the authorities in trying to prevent epidemics from reoccurring repeatedly. They may well have sanctioned investigations, or in the case of the LGB inspections, had them thrust upon them, but the information gathered was often overlooked as officials hastily prepared for the outbreak of another, quite different epidemic. It was this lack of foresight and planning that led Middlesbrough to be so exposed perhaps even more so than the other towns in the region.

Middlesbrough also had a higher concentration of migration than most of the surrounding towns. Furthermore, it was also a port, and this added to the difficulty of trying to stop disease finding its way into the town. It is interesting to note, that very little mention is made within official reports, even in a speculative nature, of the possible danger the ports posed. The inference when such topics were broached was that it was foreigners bringing disease to the town rather than something that originated from within. This is a recurrent theme, with the Irish, migrant workers receiving much of the blame, for not only the spread of disease within Middlesbrough, but also for any trouble or civil disturbance.

The interaction between the key players in the chapter is critical. In the case of epidemic disease, and illness in general, it is the interface between the local authority (in the guise of the Sanitary Committee) and the medical profession, with the MOH acting almost as a go between at times, that proved to be the pivotal one. The medical community had less input than perhaps might have been expected; their role was limited unless they managed to secure a representative position within one of the council-led committees or inquiries. The GPs were occasionally consulted, usually whenever the MOH felt that he required further medical support on an issue. Alternatively, they were sometimes canvassed for their opinion, to be used almost as sound bites to reinforce the position that the Sanitary Committee had taken regarding their response to an epidemic, as with smallpox. There is also the suggestion of personal agendas throughout the sources analysed, regardless of whether or not the individuals involved were medics or councillors, they also tended to have secondary occupations.[346] These roles often conflicted with either their main job or conversely with their position on the committee. Nor were they above using the council meetings as a platform to exercise their personal agendas. The individuals had their interests to protect and could not allow their employers to be held liable. This resulted in the population taking more than its fair share of the blame for the proliferation of disease with Middlesbrough, as was the case in Birmingham and shall be discussed in the case of Sheffield and Leicester in chapter II. There was little or no consideration given by the local authorities or the MOH as to the impact on the community, especially strange considering that the records show that those most affected by the illness were the male workforce of the town. The repercussions for these workers and their families were devastating, not just in the case of time lost from work and loss of vital wages but also from the impact on those families who found themselves without a breadwinner if, in the worst case scenario, the head of the household died. No mention of this emerges amongst any of the reports on the situation; in fact, the families bore

[346] In the case of councillors, generally it was their primary employment, with their committee roles simply additional status.

a great deal of the blame from the authorities they were held responsible for the conditions in which they found themselves, both at work and home.

However, as Anthony Wohl has noted in his 1983 book *Endangered Lives*, progress or lack thereof was not always due to 'conscious political or economic philosophy' but rather the inexperience of local authorities. In particular, in dealing with the challenges urban living posed them. As Wohl put it, 'uncertainty bred ignorance.'[347] Jim Turner when reviewing unemployment in Middlesbrough, in his 1985 study, draws similar conclusions, but is much more critical of local authorities than Wohl. Turner considered the 'persistent civic ineptitude' of the local officials to be a reason for much of Middlesbrough's problems, particularly in the late nineteenth and early twentieth centuries.[348] There was growth in all towns and cities, but usually, this was growth in towns and cities that, at the very least, already had some semblance of an infrastructure that could be expanded upon. Northern industrial towns such as Sheffield or Leeds saw their population figures treble within the first fifty years of the nineteenth century.[349] In the case of Middlesbrough, however, the impact of such growth was much more dramatic due to the lack of pre-existing services or infrastructure.

The idea that local officials and the various committees were just trying to do their best under often exceptionally difficult circumstances, was one that was not lost on the author Winifred Holtby. Holtby's mother had been a County Alderman and her time in that role had left her daughter privy to the inner machinations of local government. In a letter addressed to her mother, Holtby commented how she had come to consider local government '…the first line of defence thrown up by the community against our common enemies…' and that '[t]he battle is not faultlessly conducted, nor are the motives of those who take part in it righteous or disinterested.'[350] The point that Holtby astutely makes in this

[347] Wohl, *Endangered Lives*, p. 3.
[348] Jim Turner (1985), 'Unemployment: Poor Relief and Unemployment in Middlesbrough', in J. W. Leonard (ed.), *Local History Experienced*, Teesside Polytechnic, Middlesbrough, p. 80.
[349] Wohl, *Endangered Lives*, p. 4. Sheffield 1801: 46,000 1851: 135,000. Leeds 1801: 53,000 1851: 172,000.
[350] Winifred Holtby (2011), *South Riding (1936)*, BBC Books, Reading, p. xix.

letter, and certainly has appeared to be the case in Middlesbrough, is that the local councillors and committees had the most impact on the lives of the community. Their decisions and resolutions affected the daily lives of the population in ways not considered by those in national government.

Still, there is a marked difference in the way epidemics were treated by those involved in confronting them within the town. It would appear that it largely depended upon the input of national government, usually the LGB. If there were any directives given by them, then the Middlesbrough authorities were much more likely to respond, and respond quickly and decisively, as was the case with smallpox. Unfortunately, this was often to the detriment of any other issues regarding the health of the town, as all available time and financial resources were diverted to what the government deemed to be of the highest importance. Were, therefore, the hands of the town's officials tied by the LGB? The answer in this case has to be no, the LGB worked in an advisory capacity and was meant to be a support mechanism for the local authorities when required. In Middlesbrough's case, the officials were far too reliant on the LGB to the point of it restricting their response to an epidemic if they did not feel that they had the complete approval of the Board. This situation can be readily observed in the case of pneumonia and the issue of its status as an infectious disease within the town. Middlesbrough, in the opinion of the LGB, was in the best position possible to determine the nature of the disease, yet it chose instead to stall, awaiting a decision from the government board that it could never have hoped to receive. As for pneumonia, the lack of cohesion and cooperation between the main groups involved meant that those at the heart of the situation, namely the MOH and the medical practitioners of the town, were effectively impotent as the profession struggled to deal with an epidemic situation.

The next chapter shall look at the key features of the early twentieth century. As the nineteenth century gave way, the 1900s proved to be a period of change within the town of Middlesbrough. The following section, therefore, shall look at the effect these changes had on infant mortality and conditions for workers in the north of the town, which

contemporaries considered amongst the worst in the Middlesbrough. It shall examine the impact of industry on health, and subsequently how a lack of foresight in terms of infrastructure and planning within the town negatively affected the wellbeing of the community. The chapter will also review the movements and interactions of the Middlesbrough's growing GP community, especially the MDMS, as the Society began to make demands on the established friendly societies and clubs within the town.

## Chapter II: 1900-1920: Resistance to Change

This chapter shall examine the early years of the twentieth century and how the town's growth began to affect the community in a variety of ways. The analysis of this period begins with a review of Lady Florence Bell's study of Middlesbrough, *At the Works: A Study of a Manufacturing Town*. This book, published in 1907, provided an insight into the lives of workers and their families at the turn of the century. Most importantly, it demonstrated the interactions the community had with their employers (industry), the town authorities and, perhaps the most pertinent to this investigation, the medical profession (GPs and works doctors). Additionally, and perhaps critically, Bell's work provided a rare opportunity to hear the voice of the workers in the late nineteenth century. A group whose opinions were seldom canvassed at this time, and certainly were not often considered significant enough to be consulted. It is usually the voice of public officials, or as would be expected in Middlesbrough, the industrial and medical hierarchy that received the most attention. The chapter shall also examine what was done to assist the workers in times of ill health as well as analysing how their social and living conditions altered at the start of the century, and what the subsequent impact on their health was. The analysis of the book shall be undertaken in conjunction with an examination of the corresponding role of the GPs at this time. Special attention shall be paid to the issues that Bells' study raised concerning friendly societies and sick clubs within the town, as well as the worker's interaction with the medical profession.

The second half of this chapter shall assess the impact all of this had on a one group within the town, namely the infants. Infant mortality was unusually high in Middlesbrough throughout the late nineteenth century into the middle of the twentieth century. The perceived reasons for this high rate are examined, and then challenged. In particular, the idea that there was a gain in terms of health and a lowering of the rate of infant deaths during the course of the First World War, an assertion reinforced by the historian Jay Winter, will be discussed. Disparaging claims regarding Middlesbrough and its community shall also

be scrutinized to assess whether the contemporary wisdom espoused as fact was correct, or whether the town's population during this period received unfair criticism and blame.

During this period, there was a steady increase in the number of GPs within the town, observable through Trade Directories. The GPs also begin to move around the town more than previously (*Table 11*).

*Table 11*

Number of General Practitioners listed In Wards Directory for Middlesbrough, 1898-1918

| Year | Surgeons (or General Practitioners) |
|---|---|
| 1898-9 | 25 |
| 1902-3 | 30 |
| 1904-5 | 34 |
| 1906-7 | 34 |
| 1910-11 | 37 |
| 1917-18 | 34 |

Source: Wards Directory of Darlington, Hartlepool, West Hartlepool, Stockton, Thornaby and Middlesbrough, R Ward and Sons, Newcastle-Upon-Tyne, editions running from 1898-1918

There is not a significant difference in numbers of doctors listed from 1904 onwards. However, the figures do drop again in 1917-8, most likely due to the First World War and a percentage of younger GPs being drafted into the forces, usually the medical corps. *Table 12* provides the locations of doctors in Middlesbrough during the first two decades of the twentieth century.

*Table 12*

Location of GPs in Middlesbrough Wards, 1898-1918

| Wards | 1898-99 | 1902-3 | 1904-5 | 1906-7 | 1910-11 | 1917-18 |
|---|---|---|---|---|---|---|
| Acklam | 1 | 1 | 1 | 1 | 1 | 1 |
| Ayresome | | | | | 1 | |
| Cleveland | 7 | 7 | 6 | 6 | 7 | 3 |
| Exchange | 5 | 5 | 7 | 10 | 7 | 13 |
| Grove Hill | | | 1 | 1 | | |
| Linthorpe | | 1 | 2 | 1 | 3 | 4 |
| Newport | 3 | 4 | 4 | 3 | 2 | 3 |
| Ormesby | 3 | 7 | 7 | 4 | 2 | 1 |
| St. Hilda's (Marsh) | | 1 | 1 | 2 | 1 | 1 |
| Vulcan | 3 | 2 | 4 | 2 | 7 | 6 |
| Other (not identifiable) | 3 | 2 | 1 | 4 | 6 | 2 |

Source: Wards Directory of Darlington, Hartlepool, West Hartlepool, Stockton, Thornaby and Middlesbrough, R Ward and Sons, Newcastle-Upon-Tyne, editions running from 1898-1918

The figures are not the number of actual surgeries but the number of GPs listed in Ward's Trade Directory, presumably some of the doctors were in practice together so there are more doctors accounted for than surgeries. Additionally, some of those listed did not necessarily practice as GPs, or at least not full-time. This is in comparison to the 1944 map of GP surgeries in Chapter III; this does give the actual location of surgeries rather than GPs. The figure in 1944 ostensibly appears smaller but by this time, GPs had begun to form partnerships and the number of single-handed practices had begun to decline. There is significant movement towards the Exchange area of the town in 1917/18; this is due to a number of GPs moving towards premises located on the Linthorpe Road at the edge of the Exchange and Cleveland Wards. This is still a popular area for GP surgeries within Middlesbrough today, primarily due to its central location and closeness to the main public transport hubs of the town. The Maps below (*Fig 3-5)* graphically demonstrate the movement of GPs around the town from the end of the nineteenth century until the end of the First World War.

*Fig. 3*
Location of GPs in Middlesbrough Wards, 1898/1899

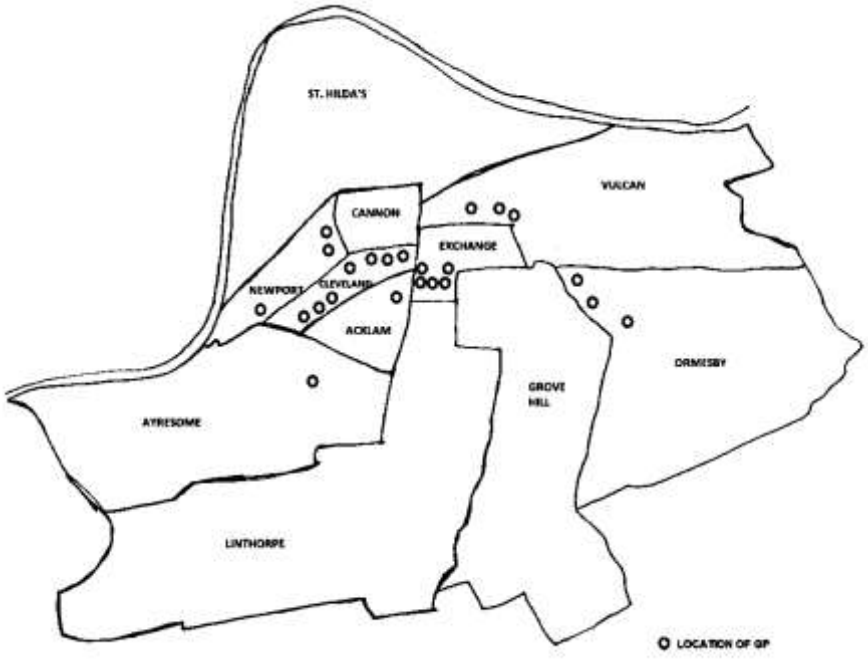



*Fig. 4*
Location of GPs in Middlesbrough Wards, 1906/1907

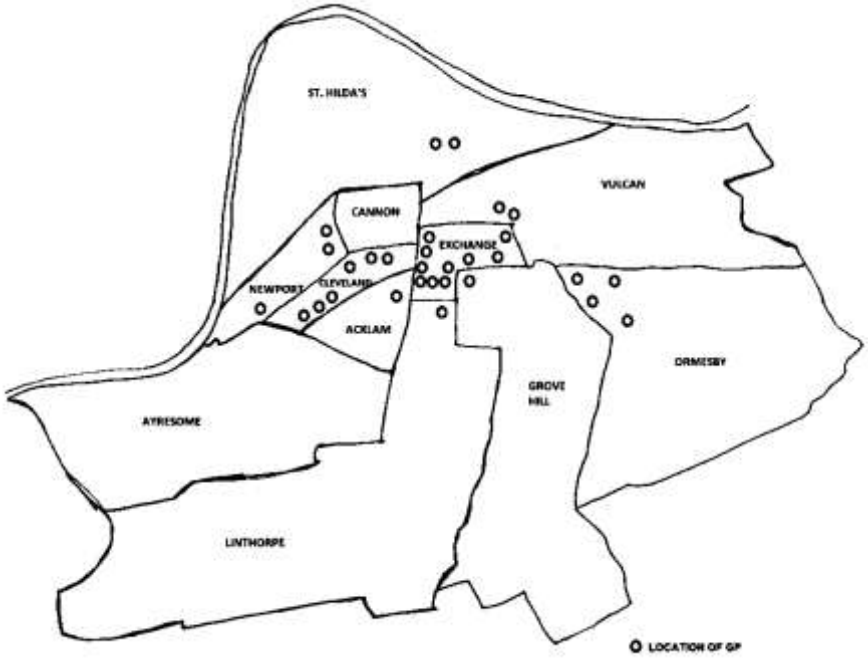
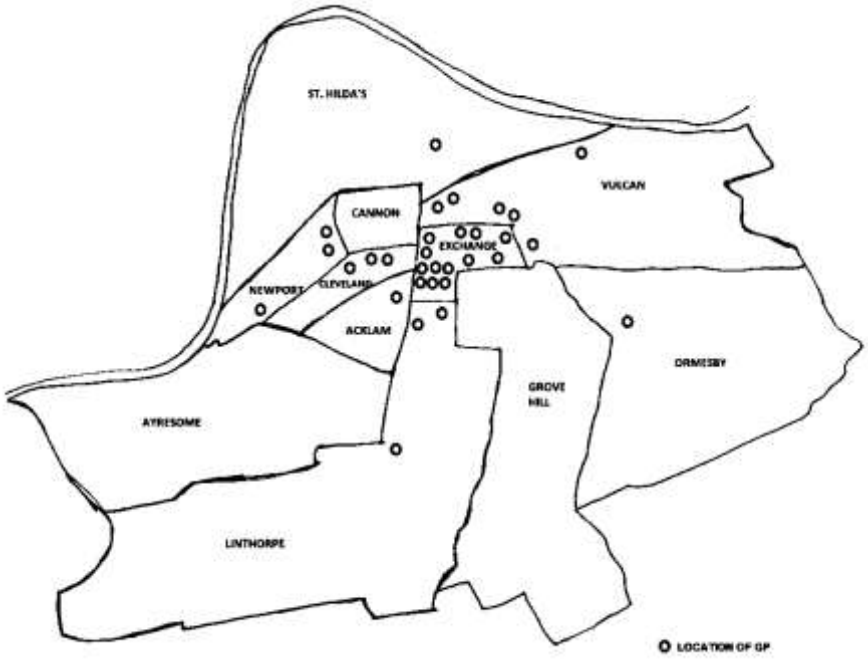


*Fig. 5*
Location of GPs in Middlesbrough Wards, 1917/1918




*Figs 3-5* Source: Wards Directory of Darlington, Hartlepool, West Hartlepool, Stockton, Thornaby and Middlesbrough, R Ward and Sons, Newcastle-Upon-Tyne, editions running from 1898-1918

## '*At the Works*' and in the Home

Lady Florence Eveleen Eleanore Bell (1851-1930) was the wife of the Middlesbrough ironmaster, colliery owner and three-time mayor of the town, Sir Hugh Bell (1844-1931).[351] Lady Bell's interest and attachment to the iron and steel workers within Middlesbrough grew through her husband's close involvement with both the town and its industry. Bell took inspiration for her study from the work of philanthropists such as Charles Booth (1840-1916) and Seebohm Rowntree (1871-1954) in bringing the plight of the poor in London and York

[351] Sir Hugh Bell was mayor in 1874, 1883 and again in 1911. Peter J. Keating (1976), *Into Unknown England, 1866-1913*, Manchester University Press, Manchester, p. 285.

respectively to light.[352] Indeed, the dedication at the beginning of *At the Works* reads 'T*o Charles Booth of wise and sympathetic counsel*'.[353]

Such a study was to become increasingly commonplace throughout the early decades of the twentieth century. The working classes were subject to scrutiny in the 1937 publication *The Road to Wigan Pier* by George Orwell.[354] In this instance, coal miners rather than the men of the iron and steel industry took centre stage. *Wigan Pier* looks not only at the working conditions of the miners but also their living and social situations, similar in many respects to Bell's study of Middlesbrough (although Orwell perhaps employs a slightly more poetic account than Bell).[355]

Written and published in 1907, Bell's book explored the life of those who lived and worked in the iron works of Middlesbrough. It was based on a survey Bell undertook over a thirty-year period, interviewing men and women within the community and observing their day-to-day life and practices.[356] Bell claimed that she and a large group of volunteers, predominantly female, canvassed and studied the working class of Middlesbrough (again principally female).[357] Rather than centring on Middlesbrough as a whole, the historian Jim Turner contests that Bell, most likely, focused on the Port Clarence area of the town. This was where the Bell Brothers' employees tended to reside in company owned cottages.[358] However, this is not to suggest that this was not a valid surveying strategy. Bell's position as the owner's wife would have afforded her, and her team of volunteers, access to the workers in a way that she might have struggled to achieve elsewhere in the town. Additionally, she

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[352] Charles Booth (1902-1904), *Life and Labour of the People in London*, Macmillan, London. Seebohm Rowntree (1901), *Poverty: A Study of Town Life*, Macmillan, London.
[353] Bell, *At the Works*, p. V.
[354] George Orwell (1937), *The Road to Wigan Pier*, Victor Gollancz, London.
[355] Furthermore, the publisher Victor Gollancz commissioned Orwell's survey in 1936, whereas Bell's *At the Works* was a much more personal endeavour.
[356] Bell, *At the Works,* p. 8.
[357] Florence Bell (1997), *At the Works: A Study of a Manufacturing Town,* University of Teesside, Middlesbrough (original published in 1907), p. X-XIV.
[358] *Ibid*. Tuner provided the forward to the 1997 edition of the publication and looked at the veracity of the claims Bell made in the book as well as trying to assign the value of the Bell's work in terms of an historical, social survey. The 1985 edition has a forward by Angela V. John, focuses on Bell and her background and connections with those she came to study. The 1985 edition is used for all other references, unless specified otherwise.

looked at their recreational habits, housing and women within the community (often a neglected group at this time). Bell also investigated the kinds of illness and accidents the working class population of Middlesbrough encountered, and examined the steps workers took to protect themselves in times of hardship.

## Relationship with Illness

The experience of those living and working within the Ironmasters District of Middlesbrough was a complicated one regarding health. The men who worked at the iron and steel mills had to be, by necessity, fit and healthy to be able to cope with the manual nature of their work. Their days were long and physically demanding they worked in extremes of heat for eight to twelve hours a day. The men may well have started their working lives as strong, comparatively healthy men, but the work soon took its toll. The workers were acutely aware that they needed to stay fit to be able to work, and they felt uneasy at the prospect of approaching a doctor in times of sickness.[359] This was especially so in the case of the works doctor, for fear of being laid off and all the ramifications of such a situation. The pay received in times of ill health was dependent upon the position held at the works.[360] For example, a foreman would receive full pay for the first two weeks of any sick time. Whereas an ordinary worker would not, even taking into account any contributions he might receive from any 'sick club' he paid into, it would not be equal to his usual wage.[361] This, of course, came at the worst possible time as extra food and additional remedies would be required for recovery. This was not to mention the fact that the majority of the workforce also had a family to support. The family would also feel the burden of the illness, with the women of the household having to add the role of nurse to the list of their already considerable duties.

At this time in Middlesbrough, as was the case in many areas of the country, overcrowding was an issue. Bell recounts the experience of a family of thirteen living in a

[359] Bell, *At the Works,* pp. 85-6.
[360] *Ibid*., p. 86.
[361] *Ibid*.

four-roomed house with an invalid child to support (the young man in question was twenty and had an unnamed incurable disease).[362] This placed not only extra strain on family resources but also was not conducive to the well-being of the invalided young man. The family freely discussed the prospect of being able to move to a larger house once the he had died.[363] This highlights not only the harsh reality of these families who had members suffering from a long-term illness but also the pressure for all to contribute and be useful to the family. Bell used this example to question how someone living in this situation with a curable illness would have fared. If recovery were possible, would a noisy, overcrowded house be the ideal environment for this to occur?

The issue of men returning to work before they were fully fit was also a concern, linked once again to the finances of the families.[364] This often led to relapses extremely quickly after their return and certainly a susceptibility to other illness and passing epidemics. Bell attempted, throughout the book, to encourage the reader to set their own personal experiences aside and try to imagine the motivations of the lower class workers she is describing. This is something that she largely manages to achieve with aplomb. A review of the book in 1907 accurately described the empathy that Bell tried to engender whilst ensuring there is an '…absence of that pitying patronage which is worse than any class prejudice.'[365] She urges her readers to consider that in time of sickness, especially one that might have required hospitalization or surgery, the least of the issues concerning the workers was the actual illness but what it meant to their income and their families.

Bell is acutely aware of her background and upbringing as well as her current social status as the wife of a leading industrialist within the town. Bell's own father, Sir Joseph Oliffe (1808-1869), had been a physician; thus, Bell was conscious of the demands that were placed upon the medical profession. This may well have stood her in good stead when

[362] *Ibid*., p. 87.
[363] *Ibid*., p. 88.
[364] *Ibid*.
[365] Henry W. Macrosty (1907), 'At the Works: A Study of a Manufacturing Town: A Review', *The Economic Journal*, **66**: p. 258.

reviewing the interactions of the community with their local GPs.[366] The middle and upper class readership that Bell aimed for had at their disposal the necessary means to deal with ill health quickly, and without the same financial worries as their working-class counterparts. Bell commented that even the use of the telephone to contact the doctor by the privileged was a luxury the iron workers did not have.[367] Indeed, they were often not even aware of how or where they could contact the doctor. This led to them seeking the help of other medical practitioners such as 'herbalists'. Bell described such a shop located in the town that sold books and remedies at a relatively low cost. The workers would buy a book from the herbalist and the recommended ingredients to make the 'prescribed' concoction themselves.[368] This was acceptable perhaps in the case of minor complaints, coughs, and sickness and so forth, but it was not so effective for serious conditions that truly required medical expertise. If anything, it retarded the healing process and often led to the workers being away from work for longer periods. Herbalists were to remain a visible presence within Middlesbrough throughout the late nineteenth and early twentieth centuries. The herbalists, like the doctors, advertised their services and addresses in the local trade directories. The number of premises within the Middlesbrough remains consistent between 1898 and 1918, at around nine, only beginning to decline significantly by 1917/8. *Table 13* gives the number of herbalists listed in Ward's Directory during this timeframe.[369] Self-diagnosis and treatment endured, with individuals seeking herbalists and the use of home remedies as an alternative to a visit to the GP. Additionally, if it was a particularly embarrassing complaint, further discomfort could be avoided by self-medication rather than seeing a practitioner.[370]

[366] However, Sir Joseph Oliffe was no ordinary physician; he had practised in Paris acting as President of the Paris Medical Society and eventually being appointed as physician to the British Embassy. Anon (1869), 'Obituary: Sir Joseph Oliffe M.D. Paris, F.R.C.P. London', *The British Medical Journal*, **429**: p. 274.
[367] Bell, *At the Works,* p. 86.
[368] *Ibid*., p. 90.
[369] Wards Directory of Darlington, Hartlepool, West Hartlepool, Stockton, Thornaby and Middlesbrough, R Ward and Sons, Newcastle-Upon-Tyne, editions running from 1898-1918.
[370] Digby, *Evolution of British General Practice*, p. 99.

*Table 13*

Number of Herbalists listed In Wards Directory for Middlesbrough, 1898-1918

| Year(s) | No. of Herbalists |
|---|---|
| 1898/9 | 9 |
| 1902/3 | 6 |
| 1904/5 | 9 |
| 1906/7 | 7 |
| 1910/11 | 8 |
| 1917/18 | 5 |

Source: Wards Directory of Darlington, Hartlepool, West Hartlepool, Stockton, Thornaby and Middlesbrough, R Ward and Sons, Newcastle-Upon-Tyne, editions running from 1898-1918.

This reliance on alternative forms of medicine raises the question why the men, when sick, did not go to see the works doctor, who was available to them free of charge via weekly contributions paid directly from their wages each week. Married men paid 3*d* a week, and single men 2*d* a week provided their earnings were more than 18*s* a week.[371] For their part, the employers supplemented this amount directly to the doctor to allow this benefit to take place. The workers could not argue that medical consultation was unavailable to them; through their weekly subscriptions, it would have been logical to see a GP in times of ill health.

However, if the doctor felt they were not fit for work, the resulting strain and stress was far greater in terms of financial loss than continuing to work and either ignoring or hiding the complaint. An accident at work was something that the men could not conceal; an illness was entirely another matter. Bell talks about men concealing long-term and degenerative conditions from doctors and their employers for fear of losing their jobs.[372] One man had a cataract over one eye and concealed the fact from his employers. The man's wife was heavily pregnant and needed to continue working in order to provide for his family.[373] These men worked at the best of times in dangerous circumstances, where accidents were an everyday possibility. To have men working, concealing serious medical conditions, was asking for trouble in Bell's opinion, and it must have been something that the men in

[371] Bell, *At the Works,* p. 55.
[372] *Ibid*., p. 89.
[373] *Ibid*.

question recognised. However, when destitution was the alternative it was a risk most seemed prepared to take. The men were effectively paying for a service each week that they were reluctant to use. Even poor law cases required an order from a relieving officer to gain free access to a GP. In the early years of the twentieth century, the poor law medical officers in Middlesbrough did tend to stay extremely faithful to the terms of the law and refused to see even the neediest case without an order. Without an official order, the GP would not receive reimbursement for treatment provided. As Mr Edmund Beabey, a scripture reader at a church in Middlesbrough, noted, people had to be in extreme distress before they would even consider going to a relieving officer.[374]

During this period, significant attention was paid to food and nutrition and its effect upon health. In the case of Bell's study, this is most likely due to the fact she spent a large proportion of her research time examining the role of women within, not only the home, but also the community in general.[375] Therefore, almost by default the issue of food and its preparation would become a central one. Indeed, one woman, when questioned, commented that trying to come up with meals for her family, her husband in particular, meant a good deal of 'brain-thinking'.[376] The role of homemaker was one the women of Middlesbrough assumed. However, it did not necessarily follow that it came naturally for all of them, a point that is not lost on Bell. She acknowledged that some wives did not know how to cook at all and

> '...get their food from an eating-house or a fried-fish shop; and some of the others who do cook in the home do it so badly that it might be almost better if they did not attempt it.'[377]

The impact was that precious money was wasted on expensive readymade food, food that was not necessarily nutritious or provided for the entire family outside of the male breadwinner. Women had to be, or quickly learned to be, proficient organizers. There

[374] *Royal Commission on the Poor, 1909*, p. 154.
[375] *Bell, At the Works,* p. 92.
[376] *Ibid*., p. 95.
[377] *Ibid*., p. 92.

appears to be an implied resentment amongst the women, or at least the inexperienced among them, that the roles of wife, mother, carer and cook were thrust upon them.[378] They might well have been resentful, but they were also resigned to the situation.

It was not only cooking but also issues concerning hygiene that were a cause for unease within the town. In 1900, the idea of using women as Sanitary Inspectors was one that had been adopted in towns such as Glasgow, Sheffield and some parts of London.[379] The theory was that women were more likely to take advice on matters of hygiene and cleanliness from another woman than they were from a man. It was felt that female sanitary inspectors would take no excuses or poor attitudes from the women they visited.[380] MOH Dingle felt that this might be a beneficial scheme in Middlesbrough, to have at least one female inspector.[381]

The daily routine of the women of the town was a cycle of preparing, baking, cooking and cleaning, all of which was focused around the male head of the house. This meant preparing his breakfast, food taken to work, lunch, dinner and supper. All these meals suggest that families were eating more than might be imagined. In reality, portions were small, and it was a distinctly unvaried diet. Potatoes and a poor quality cut of meat was the staple evening meal. The rest was usually a composite of homemade bread, cold meat or cheese, eaten with cold, weak, sugary tea.[382] Bell compared the quantities consumed by a working class family to that of a middle class family. She found that what was expected to last the poorer family a week served the better off family less than two days.[383] Indeed, many of the cuts of meat consumed in the working class household would not even have been

[378] Women in Middlesbrough tended to marry at a young age, due in part to the lack of any other opportunities for them, especially in terms of employment. Doyle, 'Competition and Cooperation', p. 343.
[379] Anon (1900), 'Housing of the Working Classes', *Northern Echo*, September 5th.
[380] Celia Davies (1988), 'The Health Visitor as Mother's Friend: A Woman's Place in Public Health, 1900-14' *Social History of Medicine*, **1(1)**: pp. 39-59.
[381] *Ibid*.
[382] *Bell, At the Works,* pp. 93-5.
[383] *Ibid*., pp. 47-84. Bell looked in detail at the 'Expenditure of the Workman'.

considered in the middle and upper class homes.[384] There was also a considerable reliance amongst the poorer families on the use of condensed milk. The positives for those using the product were that it lasted substantially longer than fresh milk, and meant less expenditure in the long term for something that was used daily and frequently. The negative was that it was a poor nutritional substitute, especially when given to infants as their supply of milk.[385] In 1894, manufacturers of condensed milk were forced to label the product as unsuitable for infants, this, however, did not deter poorer families from using it.[386] Fresh milk rarely lived up to that epithet, left as it was to stand in shops, often for days, in warm and unsanitary conditions before being purchased, nor was it a cheap alternative to tinned milk. Money was not at a premium amongst the working class families of Middlesbrough, and by necessity meals would often be repetitive with the same staple products being consumed throughout the week. This would not have been at all unusual for the workers of industrial Britain. However, it would have seemed that way to the middle and upper class observers. These two social classes would have been used to a more varied and nutritious diet than that reportedly found amongst the workers.

The lack of variety in the preparations, especially those taken to work by the men, often meant they got bored with what they had to eat. Some of the men reported on occasion not eating their packed lunch and instead going without for the duration of their shift.[387] This was not ideal considering the amount of heavy, physical work they had to do. Bell suggested that it might have been beneficial to provide an onsite catering facility for the men, to ensure they received nutritious food during their shift. This idea was not a universally popular one amongst the workers. Some felt that the idea was sound in principle as long as the men could go in and eat in their working state without washing or changing their clothes first. Others thought it was simply a waste of time, and it was easier and quicker simply to

[384] This echoes the findings of Ballard in the case of the 1888 pneumonia outbreak, where he considered the poor cuts of bacon widely consumed by the lower classes to be a possible source of the outbreak.
[385] *Ibid*., p. 94.
[386] Wohl, *Endangered Lives*, pp. 20-2. Condensed milk was lacking in essential vitamins (A & D) and was considered by the medical profession to be of no positive benefit to infants.
[387] Bell, *At the Works,* p. 96.

eat packed meals where they worked without delay or fuss.[388] Men working eight-hour shifts received a quarter of an hour for their meals, whilst those working twelve-hour shifts had a quarter of an hour for breakfast and half an hour for lunch. With this in mind, it is perhaps understandable that time was valuable to them and even walking to a canteen area would have consumed a considerable portion of their allotted break. They also cited some resentment over the suggestion that outside agencies could somehow organize their dining habits better than they did themselves.[389] As will next be examined, this was not the only area of working life where the men felt there was too much outside interference.

## Sick Clubs and Benefits

Accidents were a constant threat in such a hazardous environment as the iron and steel mills. In a town like Middlesbrough, there were few families whose lives had not been affected in some way by an accident, either directly or by association. The issue of industrial accidents and compensation has been extensively reviewed in Bartrip and Burnam's publication, *The Wounded Soldiers of Industry* (1983). The study mainly focused on industrial accidents and compensation made to workers within the coal and railway industries.[390] However, many of the acts and directives introduced during the period examined, namely 1833-1897, were relevant and applicable to the industrial workers of Middlesbrough, at least in the case of the general Employer Liability Acts.

Any worker injured during the course of his work was entitled to be paid fifty per cent of his average earnings, up to one pound a week.[391] The reality was that injury was the least of the family members' concerns; injury gave the hope of life eventually returning to normal at least. A death, however, did not. After the initial period of mourning and the rallying of

[388] *Ibid*., pp. 98-9. The issue of catering being available to the workers is one that resurfaces during the Second World War within Middlesbrough and is discussed further in chapter three of the thesis.
[389] *Ibid*., p. 97.
[390] Peter Bartrip and Sandra Burman (1983), *The Wounded Soldiers of Industry: Industrial Compensation Policy 1833-1897*, Clarendon Press, Oxford.
[391] Bell, *At the Works*, p. 101.

neighbours and fellow workers, the family was left to their own devices. If a widow had no one else within the family living with her under the employment of the works, then she was forced to surrender her home so that another worker and their family could occupy it.[392] Those not fatally injured at the works were put to work if possible in other occupations, sometimes within the works but also within the community. This was often an attempt to keep them active and useful, and it distracted them from both their injuries and what they had subsequently lost.[393] Unlike the widows, these men were allowed to remain in their homes as means of compensation for the injury sustained. The strain, however, on the family was substantial, it fell once again to the women of the household to act as carers to those injured, and as worried mothers as their sons often continued to work at the same mill as their injured father.[394]

As Jim Turner has noted studies such as the one by Bell, and even within official reports, seem to suggest that the working class population of Middlesbrough were passive in their response to hardship.[395] However, as shall be demonstrated, the workers were more proactive than contemporary reports might suggest.

The first friendly society established in Middlesbrough was the Oddfellows Order (Manchester Unity), originally founded in 1835 with nine members, by the turn of the century the figure stood at nine lodges with a membership in excess of 2,500.[396] There were numerous other affiliated orders established within the town over the course of the nineteenth century, with Bell placing the figure at around two hundred friendly societies by the early twentieth century.[397] Additionally, there was a large number of yearly clubs formed by the workers, whereby members paid contributions and disbanded at the end of each year,

[392] *Ibid*., p. 106.
[393] *Ibid*.
[394] *Ibid*., p. 107.
[395] Jim Turner, 'The Frontier Revisited: Thrift and Fellowship in the New Industrial Town, *c*. 1830-1914', in Pollard, *Middlesbrough Town and Community*, p. 84.
[396] *Ibid*., pp. 85-86. Turner does not discuss the role of the medical profession or their interaction with such societies.
[397] *Ibid*., p. 86.

dividing the surplus money equally.[398] It was easier to obtain membership to these clubs if elderly or in poor health.[399] Ostensibly, lodges gave working class members status and respectability to middle class observers, thrift was considered a noble, Christian and honourable pursuit.[400]

Not all of those employed paid into the various 'sick clubs' and 'benefit societies' that existed within the town; a perhaps surprising fact given the nature of the work and the risk of accident or serious injury. Bell asked 700 workers whether they were in any of these clubs, of which 380 responded to the positive, 270 to the negative.[401] She then suggested that rather than this being an indicator of carelessness or disregard on the part of the men who chose not to pay into a club; it was merely an example of procrastination. That these men meant to join but, whilst there had been no personal experience of illness or hardship, they kept putting it off until another day.[402] In essence, it was a lack of forward planning rather than not caring about the consequences. Many of the men were also innately suspicious about the motivations of those in authority. The men were wary of undertaking the physical examination required. However, they were even more suspicious of the official forms they had to complete. Therefore, they avoided the clubs. There was another issue raised in regards to these clubs, and that was their association with public houses, a large proportion used such establishments as their meeting place.[403] Indeed, an extra annual contribution of between 1*d* and 3*d* was taken, in addition to their weekly subscription, this being known as 'wet rent'. Those members that attended the yearly meeting had the total divided amongst them in the form of drink.[404] Alcohol and socializing seemed to play a large part in the life of the societies but was in many ways counter-productive to the aims of saving and securing against ill health. This led to groups of men banding together to form their own clubs to avoid this scenario. This seems to indicate that the overreliance on alcohol as an integral part of

[398] *Ibid*., p. 89.
[399] *Ibid*., p. 90.
[400] *Ibid*., p. 94.
[401] Bell, *At the Works*, p. 119
[402] *Ibid*.
[403] *Ibid*., p. 122.
[404] *Ibid*., pp. 122-3.

the societies was a concern not only to middle class observers but also to the men in question. However, Jim Turner has noted that those societies that held meetings in public houses often did so due to a lack of available, affordable meeting places in the town.[405] Additionally, publicans (who were also usually members) regulated the amount of alcohol consumed, even imposing fines for drunkenness.[406]

The elected committee of these breakaway societies came from inside in the workers' own ranks, and this included the 'sick visitors'.[407] The 'sick visitor' was tasked with assessing the veracity of claims of incapacity. This led to a certain amount of mistrust and resentment amongst members, at least towards the criteria used to judge claims of ill health. One person interviewed described how '...he was found lifting a kettle from the fire, and was therefore pronounced not ill enough to be entitled to the benefit of the money.'[408] The emphasis appears to be on physical symptoms and there is no mention of the 'sick visitor' having any medical training, at least not in this individual case. This appeared to the workers to be tantamount to spying, although they were equally as distrustful of inspection by medically trained men. The final resort, therefore, for those so mistrustful, was to save the money themselves, in their own homes a plan inherently flawed, as this usually led to the money being 'borrowed' when occasion saw fit.[409]

This, according to Bell, was the experience and viewpoint of the workers, but what of the doctor's perspective. One of the earliest debates of the aforementioned MDMS that punctuated monthly meetings throughout 1899 and into 1900 was the issue of friendly societies within the town. Specifically the question of women, and subsequently juveniles, being permitted to join and the impact this would have on the doctors expected to treat them. The issue also illustrated how the Society grouped together to exclude outsiders from coming in to take up positions within the friendly societies, and even made sure that those within their own ranks did not act contrary to the MDMS' collective wishes. The Society was

[405] Turner, 'The Frontier Revisited', p. 90.
[406] *Ibid*. This was an attempt to safeguard funds above anything else.
[407] Bell, *At the Works*, p. 124.
[408] *Ibid*.
[409] *Ibid*., p. 125.

concerned with women being admitted into the lodges of friendly societies that their members were acting as doctors for.[410] The argument against women and juveniles being admitted to friendly societies was that they were usually private patients of the doctors. This was elucidated by Dr Levick who

> '…pointed out the mistake it would be to admit members of families into any Friendly – saying one took a Friendly Society not because it paid but because it gave an introduction which often led to the family becoming <u>private</u> members.'[411]

The debate was, therefore, not merely the issue of women and children being admitted but rather the amount that the doctors stood to lose by them no longer being private, fee-paying patients. To ensure the cooperation of all members the motion was proposed and carried:

> '[t]hat in future no member of this Society shall accept a Friendly Society at less than four shillings per head per annum except by permission of this Society.'[412]

This appears to have not been enough, however, to have arrested the disquiet about the admission of female members into lodges, regardless of whether 4/- per head was secured or not. The example of Mrs (Dr) Levick can be used to demonstrate the situation within the Society.[413] Mrs Levick had accepted a position ('medical officership') to a Lodge that was already accepting women she had even agreed terms of 4/- per head per annum before this figure was decided as the appropriate rate by the MDMS.[414] However, despite this there was still some unease amongst the Society hierarchy about one of their number attending women at all. Therefore, despite the President admitting that '…the Society had no power to interfere' in this instance, displeasure at the situation was made quite clear, so much so that at the following meeting, Mrs Levick sent word, in her absence, that she had turned down the position after due consideration. The issue appeared to have moved on from securing a

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[410] TA/Accession 3034, Box 3, Minute Book, Meeting September 12th 1899.
[411] *Ibid*. The word 'private' is underlined as it appeared in the minutes.
[412] *Ibid*., Meeting October 20th 1899.
[413] Mrs Levick was married to Dr Levick, he was a well-respected member of both the Society and the medical profession within Middlesbrough. Mrs Levick was also a qualified MD but chose to go the moniker of Mrs rather than Dr so as not to cause any confusion between herself and her husband.
[414] TA/Accession 3034, Box 3, Minute Book, Meeting October 20th 1899. The position was at a Lodge of the Manchester Unity Order of Oddfellows.

rate of 4/- to requiring a 'wage limit' be instituted to regulate the admission of women into friendly society lodges.[415] It would appear that the issue was much more about attending women than securing a realistic, reasonable payment for doing so. This was not necessarily the response of all GP communities to friendly societies. In Leicester, for example, GPs were heavily involved with both friendly and provident societies, embracing the concept rather than resisting it.[416] The GPs of Leicester were also much more proactive that those in Middlesbrough in trying to secure adequate medical provision for women, children and the unemployed after the arrival of the NHI Act, forming the Leicester Public Medical Service.[417] In Middlesbrough, the GPs wanted to keep women and children as private patients, or if possible, draw them into their own family clubs. This was even the case prior to the NHI when the MDMS all but canvassed for members of its family clubs amongst the iron and steel workers uninsured wives. There continued to be few female clubs in Middlesbrough, only three lodges accepted woman prior to 1914.[418]

The reasons behind the stance the GPs in Middlesbrough took seem to be manifold, an almost innate reluctance to treat family members, specifically women, outside of the usual setting. These included a fear of losing income, the worry that juveniles would be next and further loss as married men and women would now pay a lower combined rate than as individuals. Therefore, it did not matter if a position could be secured for a certain rate; there were other key issues and obstacles for the doctors as to why women should be excluded from treatment within friendly societies. Additionally, by keeping together as a Society, which effectively consisted of all the doctors of Middlesbrough, they could demand whatever they wanted from the friendly societies. The doctors seem almost to resent being controlled by the friendly societies; in fact, despite being a reasonably regular source of income for the GPs, they appear to want to pull away from them as much as possible (especially the

[415] *Ibid*. Meeting November 14th 1899. The 'wage or income limit' they wanted was to ensure that the combined wages of husbands and wives did not exceed a pre-agreed rate, a rate that would have meant that they were not entitled to 'free' medical care but instead would have been private patients.
[416] Welshman, *Municipal Medicine*, pp. 278.
[417] *Ibid*.
[418] Turner, 'The Frontier Revisited', p. 91.

Medical Aid Association). They seemed to prefer being doctors for works clubs, perhaps because they had much more control over the regulations of such groups and could act far more autonomously than within the friendly societies. This position did backfire on the group somewhat, as the friendly societies tried to bring in doctors from outside the area to fill the vacancies that the town's GPs refused to take. That is not to suggest that the MDMS allowed themselves to be bullied into submission by the friendly societies. In 1900, Dr John Thornhill was appointed the full-time medical officer of the friendly societies (medical aid association) for Middlesbrough. There was an immense amount of opposition to the placement from members of the MDMS, so much so that Dr Thornhill left the town almost immediately.[419] The Society felt so strongly about interference from those outside of their number and the potential threat it posed to their respective livelihoods that in late 1900 they amended their rules to reflect this, declaring:

> 'That in the event of any club, association of clubs, medical aid association or other such body obtaining the services of a medical practitioner outside the Society, or any kindred Society, no member of this Society shall hold any professional relations with such practitioner.'[420]

In the case of family clubs, the Society compiled an extensive list of rules (twelve in total) that outlined everything from charges to attendance stipulations to the requirements of admitting an individual into the club.[421] Members (patients) had to have paid into the club for six consecutive months before they could receive any treatment. Therefore, the doctors had to ensure that the general health of potential members was good before they were admitted.[422] The Society wanted to ensure that they had control over who was admitted and demanded that the doctor had the final say as to whether the individuals were permitted

[419] TA/Accession 3107, Box 7, Miscellaneous Papers concerning Medical Societies in the Middlesbrough District, Teesside Archives. Reference is also made in an undated letter in the BMJ Supplement, circa 1901, of a case being brought with General Medical Council by the Medical Society against an unnamed medical man who took up a position related to the Medical Aid Society. The man left Middlesbrough prior to the trial and the case was subsequently dropped, it is unclear as to whether this is Dr Thornhill or not.
[420] TA/Accession 3034, Box 3, Minute Book, Meeting October 9th 1900.
[421] TA/Accession 3034, Box 3, Minute Book, Meeting April 10th 1900.
[422] *Ibid*.

entry or not. There were a number of extras charged on top of the weekly subscription for confinements, surgical operations and vaccinations.[423] Members also had to attend the GPs surgery wherever possible rather than request a home visit. The works clubs were similar to the family clubs in their mechanism, seemed to be another way of the doctors distancing themselves from the friendly societies, and related medical aid associations.

Medical aid associations are also referred to in the MDMS minutes as Medical Aid Societies. These associations, established in the 1870s, were born out of a desire to make the contract between patient and doctor less complex, eliminating the bias towards the GP.[424] The associations acquired subscribers from the local area (which was sometimes quite a wide geographical region) and then provided medical attendance for them, the members were often drawn from existing societies and clubs.[425] The medical aid associations received the full backing of the friendly societies who felt that they provided a much needed service for the working classes, especially the neglected groups such as women and children.[426] The friendly societies did not particularly like either the family or works clubs. The former were set up by a doctor or group of doctors and ran by them, the latter was established predominately in industrial areas, such as Middlesbrough. The friendly societies resented the works clubs as these employer-led Clubs would often not allow their members to join a Society.[427]

The associations were the result of the collaborative efforts of the various friendly Societies that would exist in a given area.[428] Prior to the formation of the associations, these cooperatives had worked to promote First Aid amongst laymen (usually with the assistance of the St. John's Ambulance) and had been instrumental in developing convalescent homes

[423] *Ibid*. Patients were even expected to supply bring their own bottles if medicines were to be administered then and there, if not they were charged for their supply.
[424] There were only two Medical Aid Associations in the North East from 1874-1903, one in Teesside and one in the Newcastle area. James C. Riley (1997), *Sick, Not Dead: The Health of British Workingmen During the Mortality Decline*, John Hopkins University Press, London, p. 65.
[425] *Ibid*., p. 57.
[426] Workmen were often members of multiple Clubs and Societies to try and ensure they received full medical treatment for themselves, and often family members in times of illness. Also, different Clubs and Societies offered different services and terms.
[427] Riley, *Sick, Not Dead*, p. 58.
[428] *Ibid*., pp. 56-57.

in countryside and seaside locations to help working class individuals recuperating from disease and injury.[429] After their formation in an area, the medical aid association rented a surgery, stocked it with medicine and equipment and then employed its own doctor, midwife and dispenser.[430] So the question is why were the medical aid associations so unpopular with the GPs of Middlesbrough? At a meeting of the MDMS in February 1900, the issue of medical aid societies was raised by Dr Considine, there were, at that time, three GPs who held positions with the medical aid association, Drs Considine, Scanlan and Steel.[431] Dr Considine considered it the right time to remove themselves from the connection with the association, especially after the General Medical Council had condemned the aid societies. The other two Drs agreed that they too would be willing to resign their posts, but would like some reassurance that no other positions would be taken up in the town and Medical Aid Associations would effectively be removed from Middlesbrough.[432] Therefore, all members of the MDMS approved the resolution that '…no Medical Aid Societies would continue within Middlesbrough.' So what were the reasons for this action by the GPs of the town?

The medical aid associations were perceived as a threat to the autonomy and control of the doctors. The GPs could not determine the fees they charged. The fees could not be or raised, at least not in the same way as family or works clubs.[433] Therefore, either within Middlesbrough at least, the GPs chose not to engage with them in the first place, or if they did, it was short-lived. The associations were constrictive and encouraged the working class to move away from private practice or the doctor-led family clubs, and this meant income drifted away from the GPs as their patients deserted them. The friendly societies and in turn the collaborative medical aid associations, tried to include the local GPs as much as possible in their plans. However, this approach was unsuccessful in the case of Middlesbrough, and despite publically claiming that the MDMS was on good terms with the friendly societies in

[429] *Ibid*.
[430] *Ibid*.
[431] TA/Accession 3034, Box 3, Minute Book, Meeting February 13th 1900. Drs Scanlan and Steel were in practice together.
[432] *Ibid*.
[433] Ironically, the raising of fees for both private patients and those within Clubs was one of the key reasons behind the foundation of the Medical Aid Association. Riley, *Sick, Not Dead*, pp. 59-61.

the town, privately their meeting told a different story.[434] The aid associations were also unpopular with the BMA, of which the majority of GPs in Middlesbrough were members and several were representatives for the Cleveland Branch. The BMA refused to allow any medical aid associations to advertise vacant positions in their publications.[435] There was also the accusation that the aid associations canvassed for members, quite aggressively and actively within Middlesbrough according to the MDMS.[436] They felt that they were taking patients away from them whilst intimidating people into joining. The Society itself, in the case of family clubs, made it a rule not to canvass for members at all.[437] It would seem that the GPs perceived the association as a threat to not only their livelihoods, but also their status and made the decision soon after their formation to distance themselves as a group and effectively work to drive any potential association from the town.

The MDMS meetings seem to be largely concerned with matters regarding the various societies and clubs in the town, almost to the exclusion of all other topics. The Society worked hard to unite the doctors of Middlesbrough. However, the overriding impression that remains is that the Society was formed at the height of the crisis in relations with friendly societies and doctors in the town. Formed to negotiate terms for the towns doctors and once this objective was achieved the Society was effectively surplus to requirements. The medical aid associations were also, in the eyes of the GPs in direct competition with the established family and works clubs of the town. This was an argument that was to spill over into the pages of the *BMJ* in late 1902. The problem centred on the case that the MDMS had requested the General Medical Council bring against a medical man in the town employed by the medical aid association. The charge being brought against the individual was that of advertising and canvassing, something that was strongly

[434] TA/Accession 3107, Box 7, 'Miscellaneous Papers concerning Medical Societies in the Middlesbrough' and TA/Accession 3034, Box 3, Minute Book, Meeting November 14th 1899. There was a suspicion that someone within the group was informing the Friendly Societies of what was discussed at the meetings. Dr Knott had found out that they seemed to know 'all that was said and done in these meetings.' This was the last thing the group wanted given the nature of their discussions concerning Friendly Societies and Medical Aid Associations.
[435] Riley, *Sick, Not Dead*, p. 60.
[436] TA/Accession 3107, Box 7, Miscellaneous Papers concerning Medical Societies in the Middlesbrough.
[437] TA/Accession 3034, Box 3, Minute Book, Meeting April 10th 1900.

discouraged within the medical profession. Dr John Ellerton, a GP from Middlesbrough, wrote to the *BMJ* expressing his concern about family clubs within the town.[438] Ellerton could not see the difference in the way that members were solicited to join the family clubs in Middlesbrough and the alleged canvassing of individuals to join the medical aid association, the latter of which had led to the current action by the General Medical Council. Dr Ellerton felt that the key difference was that the family clubs had the backing of the local medical society. The Society, in his opinion, endorsed the use of a 'club card' to advertise for more members.[439] Ellerton concluded that since the General Medical Council was to investigate an individual for advertising then surely they should also intervene to end the scenario he had outlined. The doctor within his correspondence had also expressed the opinion that Middlesbrough was overrun with clubs and societies, with half the town being members of at least one. He also felt that there were '…persons well able to pay a reasonable amount for their medical attendance' within these clubs, which was counterproductive to the survival of the profession.[440]

This led to a swift rebuttal by the then Secretary and former President of the MDMS, Dr Howell.[441] He strenuously denied that people who could afford to pay fully for medical attendance were members of the family clubs within the town that the Society had adopted quite strict and extensive rules for, including the issuing of a club card and the outlawing of canvassing for new members. Howell stated that if there were any persons who were unjustly members they were the exception rather than the rule, and it was due to one of two reasons. Either the persons in question had raised themselves, through thrift and care, to a level where they could reasonably pay, having been legitimately eligible previously. Alternatively, the attending doctor had neglected to inform the member that they were no

[438] John Ellerton (1902), '"Family Clubs" and Advertising', *British Medical Journal*, **2188:1**, p. 1802.
[439] *Ibid* They were issued to members and had the name and address of the doctor and collector on them as well as the 'intimation that the husband can join his wife's club for 1½*d*. a week.'
[440] *Ibid*.
[441] R.E. Howell (1902), '"Family Clubs" and Advertising', *British Medical Journal*, **2190:1**, pp. 1926-1927.

longer entitled to medical attendance at the contract rate.[442] Dr Ellerton was a member of the MDMS, but not one, it would appear, that regularly attended meetings, otherwise, as Dr Howell pointed out he would have been well aware of the rules the Society had implemented.

This was not to be the end of the matter, in early 1903 Ellerton wrote another piece for the *BMJ* re-addressing the issue of family clubs in Middlesbrough.[443] This time he had produced further reasons as to why he disliked and mistrusted such clubs. Through this article, it becomes clear that his stance is extremely personal. Ellerton had been a surgeon at one of the Iron Works in the town and had received an ultimatum from his employers, either he established his own works club or forfeited his position. He considered the situation unjust to medical men; not only in terms of lost income but also in terms of that the clubs encouraged "quackery" and the practice of second-rate medicine.[444] Workmen would rather spend their money on the cheaper option of bonesetters or herbalists than pay the doctor. One rather interesting notion that Ellerton highlighted was that these cheap clubs somehow disrupted the balance that existed between the doctor and the patient. Ellerton remonstrated that the ladies who joined family clubs got too familiar with their GP, referring to them as "Jones" or "Robinson" rather than "Mr" or "Dr".[445] Ellerton called for subscriptions to the clubs to be raised so that the medical care provided would be of a higher standard. From this, it would appear that Dr Ellerton resented the clubs due to what he had personally lost by their introduction, namely income and social status. However, he ensured that he mentioned that his opinion of the MDMS had been revised, and Ellerton no longer was under the misconception that they approved of such clubs. Three doctors had held the post of President by 1903. Ellerton claimed that two of the doctors considered that the town would be better off without such clubs and felt they degraded the profession.[446] Whilst it was true that members expressed this opinion of friendly societies and the medical aid association,

[442] *Ibid*.
[443] John Ellerton (1903), 'Cheap Family Clubs', *British Medical Journal*, **2192:1**, p. 43.
[444] *Ibid*.
[445] *Ibid*.
[446] *Ibid*. Ellerton had not spoken to the third President so could not ascertain that individuals thoughts.

the minutes of their meetings tend to suggest that attitude did not extend to family and works clubs, which they all but ran and dictated their course and shape.

The Bell study depicted work clubs as being directed by the workforce itself rather than by Industry itself. However, the evidence presented by the GPs seems to suggest that this was not necessarily the case. Within the Iron and Steel industry, at least, the employers had much more control than Bell implies. Such an example can be seen in the case of Dr Ellerton, where his industrial employers demanded that such a club be established for the employees. This would also appear to be in contrast to the situation within the Coal Mining industry at this time, where clubs and Relief Funds were often created by the workers, usually with the support of their employers after the event rather than before it.[447] However, the success of such societies and clubs, at least in the case of Middlesbrough, was at the mercy of the medical practitioners of the town. In forming the MDMS at this time, the doctors' managed effectively to control the number and types of Clubs that were established within Middlesbrough. There was no external pressure applied by either the local authorities or the industrial employers to change the situation. It would also appear from the available evidence that the Friendly Societies were unable to exert any pressure upon the GPs to comply with their wishes. Rather the GPs held all of the power within that relationship by sticking together as a relatively harmonious, united and autonomous group.

## Development of the Town and Housing the Community

The basic requirement of an ironworker was physical strength and their health. This led to many men seeking employment being drawn to the area, to such an extent that the initial planned community of only 5,000 was quickly exceeded.[448] This meant housing was one of the first areas to be compromised. Homes were built rapidly and were poorly constructed, in an attempt to keep up with demand. It did not matter how and where the houses were built,

[447] John Benson (2003) 'Coalminers, Coalowners and Collaboration: The Miners' Permanent Relief Fund Movement in England, 1860-1895', *Labour History Review*, **68:2**, pp.181-94.
[448] Bell, *At the Works*, p. 2.

just as long as construction took place. Factors such as aesthetics or sanitation were of little concern at this time. Most of the housing consisted of four rooms, two on the ground floor and two upstairs. There were often up to twelve people living in these houses, sleeping in the kitchen and any area with space.[449] Many of the homes were located close to the works, which was advantageous to the workers as the proximity meant a reduced travelling time, but this was in turn to the detriment of their health. The workers appeared to be resigned to living in this convenient location next to their place of work, rather than pay higher rents for superior housing conditions. This was perhaps because the housing further south was only marginally better, but involved a much-increased distance to travel.[450] Convenience was the paramount concern to the workers, as time away from their work was premium to them and not to be wasted.[451] The town of Middlesbrough was such a new town at this time that there was no existing structure or pre-existing community, so that there was little guidance or support forthcoming to its new inhabitants. There was also little attention paid to providing leisure activities, especially for the working classes. The *raison d'être* for Middlesbrough's existence was solely due to industry. The measure of a successful man, therefore, was one who could afford to move out of the busy industrial centre and into the nearby countryside. However, dominated as it was by the working class, it retained the presence of a small middle class society. This included doctors, clergymen and retailers, people whose skills were required by those serving industry.[452] The individuals who lived within the town tended not to view their surroundings with the same critical and prejudicial eye that an outsider might. They did not dwell on Middlesbrough's lack of history or grand architecture; instead, they focused on what it did provide them, work and a home. Those who lived in the centre of the industrial heartland may have done so in comparatively squalid conditions, but they appeared to have still done so with more than a little pride in the place they lived.[453]

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[449] *Ibid*., p. 4.
[450] Those who resided to the south of the town tended to be those in better-paid employment, including GPs and managers of the iron and steel works.
[451] Bell, *At the Works*, p. 4.
[452] *Ibid*., p. 8.
[453] *Ibid*., p. 15.

In 1907, a Royal Commission took place to look at the poor, poor law and poor rates within the North Eastern counties. A housing agent from Middlesbrough, Mr Randall Gray, gave evidence about the situation within the town.[454] He was also a member of the Middlesbrough Board of Guardians and sat on the Middlesbrough Distress Committee. Randall presented information to the commission that he considered drinking, gambling, pawnshops and 'contempt for thrift' the primary causes of pauperism within the district.[455] He went on to point out that there was a reluctance to save when working, leading to hard times when a sudden shortage of work or a reduction in income occurred. However, Gray did not consider there to be any problem with overcrowding in the town. Indeed, if there were any to be found he firmly believed it be unnecessary and the fault of the occupiers.[456] Given his multifarious roles and that one of them was as a housing agent, it is of little surprise that he failed to acknowledge any serious housing problems amongst those he visited. In the same report, another member of the Middlesbrough Board of Guardians disagreed with Gray's assessment. This individual instead considered the social conditions of those in the town as poor. They went on to remark that the 'housing accommodation for the lower paid class of workmen is very bad.'[457] There was, however, no explanation given as to why the workers' housing was as dreadful as intimated. There appeared to be a lack of responsibility or ownership as to the problem within the town from both sides of the community. No one was willing to address the causal factors, therefore, it was merely dismissed as the problem of the workers that they caused and brought about their own misfortune.

A meeting of the Sanitary Committee in 1904 was held to discuss the situation at Nile Street in the north of Middlesbrough.[458] The area had long been a cause for concern, deemed unsanitary, and it had a death rate above the rest of the town. Considering the mortality figures for Middlesbrough were already well above the national average, the statistics for Nile Street would have been worrying indeed. Therefore, the recommendation

[454] PP 1909 XLI (Cd. 4888), *Royal Commission on the Poor, Poor Law and Poor Rates, 1909*, p. 146.
[455] *Ibid*., p. 147.
[456] *Ibid*. p. 149.
[457] *Ibid*., p. 297.
[458] Anon (1904), 'A Middlesbrough Housing Scheme', *The British Architect*, **62:4**, p. 23.

was made to purchase the houses located there for demolition. However, the local authority officials first had to agree on the financial aspects of the enterprise. The Sanitary Committee was not prepared to pay above £60 per house despite the owners having responded that they would be willing to sell for £127.[459] As some 700 people were to be re-housed, this meant quite a considerable expenditure, at least £12,955 was estimated.[460] The offer of £60 would have reduced the cost by £5,000, making the overall estimated cost, including the acquisition of land and erection of new housing, around £36,500, with the rents payable covering building costs.[461] After much deliberation, the Sanitary Committee finally agreed to declare the area insanitary and condemn the properties located there. This was not the end of the matter, and as Councillor Carey pointed out, at the same meeting, there were streets in the same area with an even worse record. Washington Street, for example, had a death rate at least ten per cent higher than that of Nile Street.[462] The issue of slum clearance was one that continued to trouble the authorities of Middlesbrough well into the 1930s and 40s. Indeed, the projected slum clearance of Nile Street was not completed until the mid-1930s.

The Middlesbrough Corporation and Sanitary Committee had tried to persuade those who owned the houses in Nile Street to improve them. As the houses were mainly owned by landlords, there was no real incentive for them to do so. The rents in this area could in all likelihood not be increased, as the inhabitants would not have been able to afford them. The tenants were not in a position to object and were likely to put up with the insanitary, dilapidated conditions of the houses as a consequence. If the community wanted improved housing, then they had to be prepared to pay increased rents, a situation that arose in the 1920s. This, in turn, led to families cutting back on other essentials. The first of the cutbacks were often to food and then hygiene. Municipal building of estates on the outskirts of the town began in the 1920s; there had been a decrease in the overall size of families in the

[459] *Ibid*.
[460] *Ibid*.
[461] *Ibid*.
[462] *Ibid*.

twentieth century in comparison to much of the nineteenth century.[463] Slum clearance began in 1910 and from 1920 to 1940; the Middlesbrough Corporation demolished 775 houses. However, demolition was halted in both the First and Second World Wars.[464]

The Middlesbrough town council had sent representatives to the North of England Housing Reform Conference, held in Newcastle in 1902. At this time, the Garden City Movement was a popular response to the urban problems that a large number of Victorian industrial towns and cities were battling.[465] This conference aimed to persuade councils to build cottages to re-house their poor rather than erect more rows of houses with cramped yards and narrow roads.[466] This information must have been worrying for the Middlesbrough representatives, as the latter was precisely what they had planned for the redevelopment of their slum areas.[467] The Garden City Movement ideas were eventually to have some impact on the plans for housing in Middlesbrough.[468] The ideas included roads and houses in built-in crescents with a limit imposed on the number of houses or cottages placed along them. Most of this new development was to take place towards the south of the town. Equally integral to the plan was the incorporation of green, open spaces, a feature that Middlesbrough had previously been lacking due to its design and subsequent sprawling growth. All of this planning, however, was put on hold in 1914 with the outbreak of the First World War. Unfortunately, for Middlesbrough the slum problem of the northern sector of the town was to persist further.[469]

Factored into all of the proposals was the issue of rates, a deeply contentious one within Middlesbrough.[470] Planners were acutely aware that the communities to the east, who might have been drawn into the town's jurisdiction under any expansion plans, might not

[463] John W House and Brian Fullerton (1960), *Teesside at Mid-Century: An Industrial and Economic Survey*, MacMillan and Co Ltd, London, p. 400.
[464] *Ibid*.
[465] L. Polley, 'Housing the Community, 1830-1914', in Pollard, '*Middlesbrough Town and Community'*, p. 170. Stanley Buder (1990), *Visionaries and Planners: the Garden City Movement and the Modern Community*, Oxford University Press, Oxford.
[466] Polley, 'Housing the Community', p. 171.
[467] This type of terraced housing with the aforementioned cramped yards built on narrow streets was the traditional style of accommodation found within Middlesbrough.
[468] Polley, 'Housing the Community', p. 171.
[469] *Ibid*., p. 170.
[470] S.E. Burgess (1911), 'Town Planning for Middlesbrough', *The Town Planning Review*, **2(3)**: p. 201.

have been keen to pay exorbitantly high rates. The rates for the Borough were high, but those involved felt it necessary to point out what they felt was a vital consideration, that '[a]ll the outlying parts have shared, and continue to share, in many of the works that have added to the debt and the rates of Middlesbrough.' That is to say that the outlying areas of Middlesbrough who benefitted from work taking place in town, for example, sanitation, also had to share the burden of paying for such renovation. This was even when they might not have, as was the case in this instance, directly profited. Those who were responsible for drawing up the plans felt confident that '[w]ith some tact and a little give-and-take, objections might soon be overcome.'[471]

The question of what to do with the slums would not go away, nor would the issue of overcrowding. There had been, by the late nineteenth century, severe overcrowding in Middlesbrough. The definition of overcrowding applied was a straightforward one, yet it was not defined until as late as 1935, namely 'More than two persons per room in a house.'[472] In 1891, 20% of Middlesbrough's population lived in overcrowded conditions; this was to fall to 12% by 1901, rising only slightly to 13% in 1911.[473] In reality, however, in the northern wards it was financial hardship rather than a lack of available housing that caused the majority of problems and stress. It should be noted that conditions in Middlesbrough were better than those in Newcastle, Gateshead and Sunderland, and were comparable to the neighbouring towns of Stockton and Darlington at this stage. To give an idea of the precise number of individuals involved, 20% of the population in 1891 equated to about 13,412 people; mainly located in the northern sector of the town.[474] This was where the real issue with overcrowding lay in Middlesbrough, as with most of the official figures of the time, those from the northern section of the town were prejudicially high.

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[471] *Ibid*.
[472] Alison Ravetz and Richard Turkington (1995), *The Place of Home: English Domestic Environments, 1914-2000*, Alden Press, Oxford, p. 68. This definition excluded bathrooms and sculleries but not kitchens, the definition had been loosely applied previously but the Housing Act of 1935 made it the official one.
[473] Taylor, 'The Infant Hercules and the Augean Stables', pp. 72-3
[474] *Ibid*., p. 72.

## GPs and the Panel System

Medical provision at this time was far from comprehensive. The National Health Insurance Act (hereafter, NHI) passed through Parliament in 1911 but only came into effect in 1913.[475] The act provided general medical care and sickness and maternity benefit to those engaged in manual labour by means of a small, weekly contribution taken directly from their wages. It only covered those aged over sixteen years who were employed (male or female), not their families. It all but excluded the middle and upper classes due to their employment being largely non-manual. The medical care and drugs were available to the insured person until retirement without charge or limit. Included in the scheme were a number of benefits related to treatment, this included free treatment in a sanatorium if any workers signed up to the scheme had TB, it also included their dependants.[476] It was up to the 'approved societies' that handled the scheme to decide which extra services they would allow, payment of which came out of any surpluses they had gathered.[477] These services included dental care, ophthalmic services and even a contribution towards convalescent care.[478] Of even greater significance was the payment of 'sickness benefit', this being 10s a week for men, 7s 6d for working women for a total of up to 26 weeks. This meant that families received payment even though they were incapacitated, and could still provide, albeit at a reduced rate, for their families. After this, it became 'disablement benefit' with the amount reduced to 5s a week irrespective of gender. The final component of the act was 'maternity benefit'; the wife of an insured person received a lump sum of 30s on the birth of a child.[479]

Since the late nineteenth century, the BMA had been fighting for an increase to the payments per head made to GPs by friendly societies.[480] The BMA considered that payments were too low based on the terms the doctors worked under, especially when some

[475] Honigsbaum , *The Division in British Medicine*, p. 9.
[476] Bernard Harris (2004), *The Origins of the British Welfare State: Social Welfare in England and Wales, 1800-1945*, Palgrave Macmillan, Basingstoke, p. 223.
[477] *Ibid*.
[478] *Ibid*., pp. 223-4.
[479] *Ibid*., pp. 10-11. This sum was doubled if the wife was registered as working too.
[480] Digby, *Evolution of British General Practice*, p. 307.

contributors to such schemes were frequent attendees. GPs wanted a new scheme that protected their status but increased their income.[481] However, there were concerns that the income threshold that the NHI would set for contributions would be so high that it would dramatically reduce the GPs number of private patients.[482] This was not the only problem that the BMA and its GP membership had with the NHI scheme; there was disagreement about the remuneration amount to be received. Lloyd George eventually offered the doctors a healthy inclusive package of 9s per patient, which was in excess of the average 4s 5d that the Plender Report of 1912 reported that GPs received.[483] The BMA did not consider the offer adequate and only after significant manoeuvring on the part of Lloyd George, in which he all but threatened to surrender control of NHI administration the GPs adversaries, the friendly societies, GPs began to sign NHI contracts.[484] Control now effectively passed to the GP and they could treat their panel patients almost in the same manner as their private patients.[485] Certification was a thorny issue, at least for the approved societies, who often felt that the GPs were not fulfilling their obligations in order to improve their own situation. This led to an increase in the number of referrals to medical officers.[486] There were also concerns that patients would now visit their GPs for any minor ailment, whereas they had previously been reluctant due to the costs involved.[487] This was combined with the concern that panel doctors did not treat their panel patients as well as their private ones. The capitation system meant that the GPs were paid a set figure irrespective of the quality of treatment that they might provide.[488] Indeed, it was not in the best interests of GPs to take on cases requiring expensive or lengthy treatment, as they would not receive full reimbursement for it. Thus the panel system, whilst undoubtedly providing enhanced access to medical services for working class patients, was also flawed and led to a reduction in the quality of treatment received.

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[481] *Ibid*., p. 309.
[482] *Ibid*., p. 310.
[483] *Ibid*.
[484] *Ibid*., p. 311.
[485] The GPs could still control their lists and patients could still choose their doctor.
[486] Digby and Bosanquet, 'Doctors and Patients', p. 86.
[487] *Ibid*., p. 87. This was also a popular accusation amongst the GP community post 1948 and the arrival of the NHS.
[488] *Ibid*., pp. 91-92.

Within the Stout Collection, there is a minute book of the Proceedings of the Middlesbrough Insurance Committee (1912-1919).[489] This book, whilst not directly discussing the work of the towns' GPs in considerable detail does provide an insight into the function of a panel doctor, as well as demonstrating the interactions they had with the Insurance Committee. GPs were often a representative on local and national insurance committees, in Middlesbrough Dr Howell was a representative on the State Sickness Insurance Committee, acting as one of the North of England reps.[490]

By 1912, the MDMS had dissolved and any communication with the towns GPs tended to be via the Cleveland Division of the BMA.[491] There was a meeting held of the Insurance Committee in 1912 where the Medical practitioners of the town agreed a scale of fees for the domiciliary treatment of tuberculosis (*table 14*).[492] This topic received the most attention at meetings although largely it did not concern the GPs but concentrated on administrative matters and the execution of its rules.

[489] TA/Accession 3107, Box 7, Minute Book of the Proceedings of the Middlesbrough Insurance Committee, 1912-1919.
[490] Alfred Cox and W. J. Brathwaite (1912), 'The Insurance Scheme: State Sickness Insurance Committee', *The British Medical Journal*, **2677:1**, p. 917.
[491] The inaugural meeting of the Cleveland Division of the BMA was held in April 1903, a number of the committee were from Middlesbrough including the Chairman, Dr Knott and the Secretary and Treasurer, Dr Howell. As these men also held prominent positions within the Medical Society it is perhaps understandable that the local Society became less important when compared to the prestigious BMA. Anon (1903), 'Cleveland Division Meeting', *Supplement to the British Medical Journal*, **2009:1**, p. lii. Unfortunately, there are no records of the meetings of the Cleveland BMA archived, the only information available about their proceedings is the limited reports contained with the *BMJ*.
[492] TA/Accession 3107, Box 7, Minute Book of the Proceedings, Meeting September 26th 1912. This topic received most attention at meetings of the Insurance Committee, and largely it did not concern the GPs but rather concentrated on administrative matters and the execution of its rules.

*Table 14*

Middlesbrough Insurance Committee Fees for Domiciliary Treatment of Tuberculosis, 1912

| | |
|---|---|
| For consultation at surgery | 2s 6d |
| For Visit | 2s 6d |
| For injection of tuberculin (local authority to supply the Tuberculin) | 2s 6d |
| For primary report | 5s 0d |
| For subsequent report | 5s 0d |
| For visit in response to emergency call between the hours of 8pm-8am | 5s 0d |

Source: TA/Accession 3107, Box 7, Minute Book of the Proceedings of the Middlesbrough Insurance Committee, 1912-1919, Teesside Archives, Middlesbrough.

At a meeting held January 12th 1914 a complaint was read that had been brought by an insured person (a member of the Ancient Order of Foresters Approved Society) against his panel doctor, Dr Walsh Benson.[493] The complaint concerned the attendance that the patient received and the subsequent prescription that was provided. The issue regarding the examination the patient received was swiftly dealt with, but the dispute about the prescription was to carry on long after the initial investigation and was to expose irregular practices in the professional relationship of Dr Benson and his dispenser, Mr Dale. The patient had attended the surgery of Dr Benson on December 3rd 1913 but was seen by Mr J.G. Dale, a chemist by profession, rather than Dr Benson.[494] After checking the patient's arm, he prescribed some ointment, what is unclear from the report is whether it was the prescription or the examination that the patient objected. However, what does become quite clear is that the matter that concerns the Insurance Sub-Committee the most is that of the issuing of a prescription by the chemist. Mr Dale had not only examined the patient and made a clinical judgement, but he had then prescribed a treatment using a blank prescription slip previously signed by Dr Benson. Not only that but he had not consulted with Dr Benson as to the course of action he intended to take at any stage. What was made clear to the Sub-Committee was that this was not the first time that this situation had occurred between the doctor and the chemist. Dr Benson clearly knew that Mr Dale had in his possession blank,

[493] *Ibid*., Meeting January 12th 1914.
[494] *Ibid*.

signed slips and was also permitted to examine minor cases and complaints. In this instance, Dr Benson was censured by the Insurance Committee and informed that any further irregularities would not be tolerated.[495] The physician was not removed from his post as a panel doctor. Nevertheless, his actions clearly unsettled the Insurance Committee, as two months later further irregularities involving Dr Benson and Mr Dale were uncovered.

The report was of irregularities involving prescriptions and the evidence gathered suggested some form of collusion between Dr Benson and Mr Dale.[496] They found that Mr Dale, coincidentally and importantly also a Panel Chemist, despite Mr Dale's premises not being near to Dr Bensons' patients residences, was dispensing a large percentage of Dr Benson's prescriptions. For the quarter ending January 11th 1914, Mr Dale was dispensing 65% of Dr Benson's prescriptions, and they accounted for 80.2% of the chemists business.[497] Not only was this the case but, Dr Benson's average cost per prescription was 9.009*d* which was considerably higher than the average for the other Panel Practitioners in the town, which stood at 6.6382*d*.[498] This was not the only anomaly that became known when Benson's practice and connection with Dale was reviewed; it also appeared that a patient of the doctor's had received seven similar prescriptions over three consecutive days.[499]

It was requested that Benson attend a meeting of the Sub-Committee to explain his actions. Perhaps unsurprisingly, the doctor blamed Dale for the identified problems, claiming that his dispenser had not informed him that his prescriptions were so costly, rather he had misled Benson into believing they were below average. Benson informed the Sub-Committee that he had dismissed Mr Dale as his dispenser and engaged another whom did not practice as a Panel Chemist. On the issue of multiple prescriptions being given to one patient, Benson admitted he had done this to recoup expenses after a private patient had

[495] *Ibid*.
[496] *Ibid*., Meeting March 31st 1914.
[497] *Ibid*. Benson had made out 1,081 prescriptions in the quarter and Dale had dispensed 650 for them.
[498] *Ibid*. Indeed, his average cost per patient was 8.6*d* compared to 5.2*d* for the rest of the panel doctors in Middlesbrough.
[499] *Ibid*.

died owing him money. The doctor had discovered the patient was also insured and, on the advice of the man in question's employer, he had informed Dale to copy and fill out prescriptions from his day book using Insurance forms, to claim a total of 4/-.[500]

The Sub-Committee, after considering Benson's evidence did little but admonish and warn him not to engage in such practices again, especially in the case of writing prescriptions to recoup losses. The Sub-Committee felt that the problem that had occurred between Dr Benson and Mr Dale was not the doctor's fault; rather it was because his dispenser had also been a Panel Chemist and a conflict of interest had arisen out of that. Their advisement to the General Committee was that Panel Doctors in the town, in future, must ensure that their dispenser was not also a Panel Chemist.[501]

The Insurance Committee did not appear to have a tremendous amount of power, or concern, over either the panel doctors or their actions. Notably, neither Benson nor Dale lost their positions, and other than a minor change in regulations, little was done about what can be considered quite a serious breach of procedures. Additionally, it is difficult to believe Dr Benson's claims that he was not complicit with Mr Dale regarding the supply of prescriptions and the rates. At worst it was verging on fraudulent, and at best it was neglectful and naïve on Benson's behalf.

Industrial areas had a higher number of panel doctors and prescriptions compared to their rural counterparts.[502] However, Anne Digby had argued that the demand for treatment and prescriptions was patient rather than practitioner driven. Certainly, the complaint against Dr Benson in Middlesbrough seemed to be more concerned with the prescription than whom the individual was treated by. The problems insurance committees encountered with GPs and prescriptions, such as in the Benson case, were not uncommon. The panel committees were often reluctant to deal with any doctors accused (and subsequently found)

[500] *Ibid*,
[501] *Ibid*.
[502] Anne Digby, 'The British National Health Insurance Act, 1911', in Martin Gorsky and Sally Sheard (eds.) (2006), *Financing Medicine: The British Experience Since 1750*, Routledge: Abingdon, p. 191.

to be guilty of excessive prescribing, and who should have been surcharged.[503] For example, the Salford Panel Committee, like the Middlesbrough one, had investigated cases and went back and forth between the doctors involved, the separate investigating committee and themselves before letting the doctors off with only a warning.[504] In Middlesbrough, Benson did not deny any accusations of wrongdoing, and not for the first time. It may have been that the Insurance Committee were reluctant to dismiss a panel doctor in such a predominately working class area. Anne Digby notes that a panel committee rarely upheld claims of medical negligence by patients. However, an accusation of "insufficient courtesy" by a doctor towards a patient was much more likely to be successful.[505] Concerning the chemist involved in this particular dispute, very little academic research has been undertaken on the role of panel chemists, especially their interactions with panel doctors and indeed their roles as dispensers.[506]

Competition for panel patients was fierce and despite the inevitable escalation in duties that the appointment brought, such as increased home visits, frequency of visits, prescriptions and administration demands, it was a position that practitioners sought.[507] Panel work was a regular, obtainable source of income, in so much, that a GP might feel it was beneficial to use the system when necessary and fees could not be secured in any other way. This was exhibited in the Benson case and his application for panel payments after the death of a private patient that still owed him fees. There are no available figures for the annual income of GPs from panel patients in Middlesbrough. However, Digby and Bosanquet place the average national income from 1922-1938 at £400-500 per practitioner, per annum.[508] If this average is indeed transferable to Middlesbrough, it is easy to understand why a panel appointment was attractive to practices, even if the role of actually

[503] Surcharging came about when a doctor was found to be over prescribing the regulated panel allowance, especially expensive drugs. If found guilty of this the doctor would be theoretically charged the excess. Digby, *Evolution of British General Practice*, p. 320. In the case of Benson in Middlesbrough, he was not surcharged despite being found guilty of over-prescribing.
[504] D S Lees and M H Cooper (1964), 'Payment Per-item-of-service: The Manchester and Salford Experience, 1913-28', *Medical Care*, **2:3**, p.154.
[505] Digby, *Evolution of British General Practice*, p. 320.
[506] *Ibid*., p. 321.
[507] Digby, 'The British National Health Insurance Act', p. 191.
[508] Digby and Bosanquet, *Doctors and Patients*, pp. 74-94.

treating the patients was subsequently passes on to a junior assistant. Whilst reviewing the number of extra positions that a GP took before and after the inception of the NHI, Digby found there was less financial pressure on GPs to seek out the range of appointments they had before.[509]

The medical profession was also deeply involved in the war effort, especially those doctors who remained within the town from 1914-1918. Medical practitioners worked for free, the figure provided being at least 12, at Hemlington Hospital to inspect the wounded soldiers. The GPs were given cars to travel between the hospital and their surgery, and presumably to see the soldiers in their own homes after discharge. The author of a review of Middlesbrough's war effort in 1920 stated that Hemlington Hospital had been commended by the war office for its effort in the recovery of wounded soldiers, being cited as 'one of the best'.[510] This so-called special treatment for the soldiers inevitably had an impact upon medical provision in the town, as it further overextended already stretched resources.

Middlesbrough according to Robertson also had numerous members of its medical ranks serve in the war. This included the frontline and accordingly '[v]aluable practices being temporarily surrendered in order that the armies of the country might have the succour which medical service can provide.'[511] This concurs with comments made about practices being left short-handed or men returning from the war only to find that they had no position open for them. It also resonates with the fact that in the Second World War special provision made to avoid this scenario, by getting older GPs to cover practices so that the men who returned still had a practice to come back to and a position within the practice.

The War also brought different kinds of health issues to the attention of the town's authorities. For example, in 1917, there was a sub-committee formed, under the direction of the Middlesbrough Sanitary Committee, to deal with the problems that an escalation in the number of venereal disease cases in the town had caused. It was considered that there had

[509] Digby, *Evolution of British General Practice*, p. 103.
[510] William Robertson (1920), *Middlesbrough's Effort in the Great War*, Jordison and Co, Middlesbrough, p. 18.
[511] *Ibid*.

been a proliferation in the numbers reported due to the wartime conditions. The Mayor of Middlesbrough announced, at the same meeting, that the Sanitary Committee had proposed a campaign of educational programs alongside the formation of a local committee of the National Council for Combating Venereal Disease.[512]

During this time, there was also the 1918/19 outbreak of Influenza, widely known as 'Spanish Influenza'. Little is made of the outbreak in this reflective piece, perhaps because it was not directly linked to the war, other than the spread of the disease due to the unprecedented movement of men across Europe and beyond. Influenza appeared to be at its height in Middlesbrough from June to July 1918, then recurring in the autumn in a much less virulent form.[513] This is not directly mentioned within official reports indeed deaths in the town were often attributed to pneumonia in the MOH records, as discussed in chapter I.

The problems outlined in this section were to have a direct impact upon the health of the community, particularly the infant population. It is this part of society that shall be examined next, and more specifically how and why the IMR fluctuated over the early decades of the twentieth century. Infant mortality is a strong indicator for health in general, revealing the social implications of not creating 'future healthy citizens', additionally it highlights the role, or perceived role, of the mother during the early part of the century.[514]

## Infant Mortality in Early Twentieth Century Middlesbrough

The situation in Middlesbrough with its reliance on heavy industry meant that it was predominately the male workforce who were insured, and protected in times of ill health. This led to the women and children of the town being woefully overlooked, and their health

[512] *Ibid*., p. 77.
[513] *Ibid*., p. 94.
[514] Wohl, *Endangered Lives,* p. 10.

consequently suffered. *Table 15* and *graph 2* illustrates the pattern of infant deaths in Middlesbrough and the average for England and Wales from 1900-1930.[515]

*Table 15*

Average Infantile Death Rate per 1,000 live births for Middlesbrough, England and Wales 1909-1928

| Era | Years | Ave. IM per 1,000 live births (Middlesbrough) | Ave. IM per 1,000 live births(England & Wales) |
|---|---|---|---|
| Pre-War | 1909-13 | 149 | 109 |
| War Years | 1914-18 | 144 | 99 |
| Post-War | 1919-23 | 118 | 79 |
| Depression (1920s) | 1924-28 | 101 | 71 |

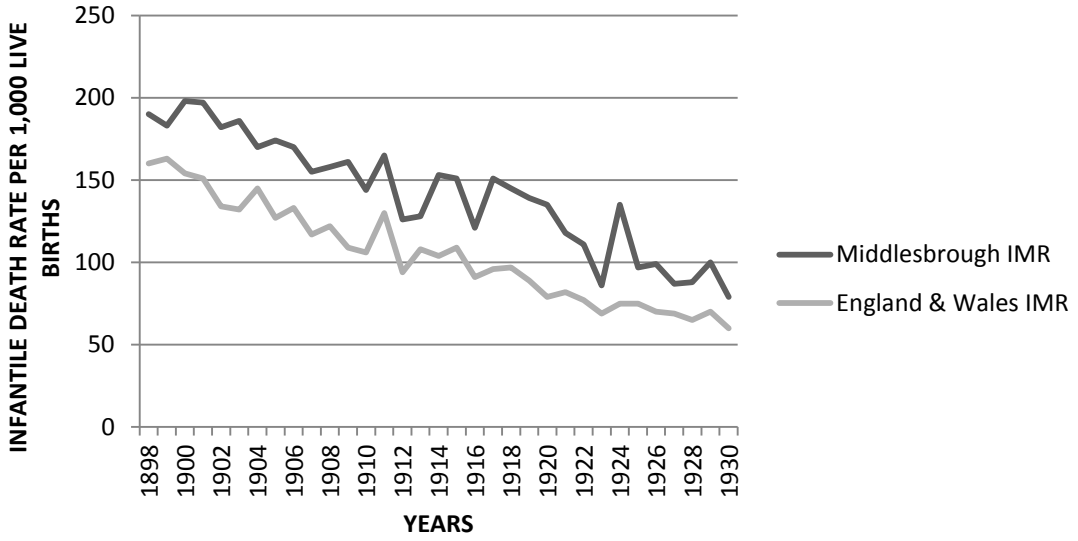
Source: CB/M/H/11, Medical Officer of Health Annual Report for 1930, 'Abstract of Medical Officer of Health Reports from 1898-1930', Teesside Archives, Middlesbrough.[516]

The IMR was significantly higher than the national average at all points from 1909-28.[517] This was especially so during the war years, where the drop was nowhere near as dramatic or noticeable as the rates cited in other comparative industrial towns (such as Oldham or Sheffield).

[515] TA/CB/M/H/11, Medical Officer of Health Annual Report for 1930, 'Abstract of Medical Officer of Health Reports from 1898-1930', Teesside Archives, Middlesbrough.
[516] *Table 1* and *table 2* use the dates 1909-1928 to demonstrate the distinct demarcations between the years and events. For example, pre-war, wars years, post-war and depression. These are split up into five-year periods for the consistency and to make for a more viable comparison. The infant statistics in this instance are defined as those under one year of age, this shall be the case unless specifically declared otherwise. The other reference for infant mortality occasionally applied in annual reports and LGB investigations was the death rate amongst children aged under five.
[517] TA/CB/M/H/11, Medical Officer of Health Annual Report for 1930.

*Graph 2*

Infantile Death Rate per 1,000 live births for Middlesbrough, England and Wales 1900-1930




Source: TA/CB/M/H/11, Medical Officer of Health Annual Report for 1930, 'Abstract of Medical Officer of Health Reports from 1898-1930', Teesside Archives, Middlesbrough

There was high IMR within Middlesbrough during the first thirty years of the twentieth century, especially when compared to that national average for England and Wales. The town did experience a steady decline until the middle of the 1920s. At this time, there was a sharp rise in infant deaths. Increased unemployment within Middlesbrough due to the effects of both the general strike and the coal strikes to the north, caused the rate to climb to around 140 deaths per 1,000 of the population. Thereafter a slow decrease, always above the national average, continued until the figures for the town eventually began to merge with those recorded for England and Wales in the 1950s. The decline in the rate does show a recognizable improvement in the health conditions of the town, the fact that it does not come too close to the national average during this period is of significant importance when reviewing the health of the town and the region throughout the hundred-year period in question.

Middlesbrough was often singled out within the annual LGB reports as a cause for concern with regards to its high IMR. Indeed, on more than one occasion

inspectors visited the town to try to ascertain why the situation existed.[518] The conclusions drawn were a mixture of the prevailing attitudes and reasoning of the day. These came to include; maternal neglect; poor living conditions; malnutrition and intemperance; climate and pollution. Unusually, Middlesbrough also had a high birth rate, especially when compared to the national average, as illustrated in the *table 16* and *graph 3* below.[519] A large proportion of young men inhabited the town, drawn there by the lure of industrial employment and the high wages it paid when compared to other industries. Young girls tended to marry young and raise large families, which helped push up both the birth rate and the infant mortality rate in Middlesbrough.[520]

*Table 16*

Average Birth Rate per 1,000 of the Living Population for Middlesbrough, England and Wales 1909-1928

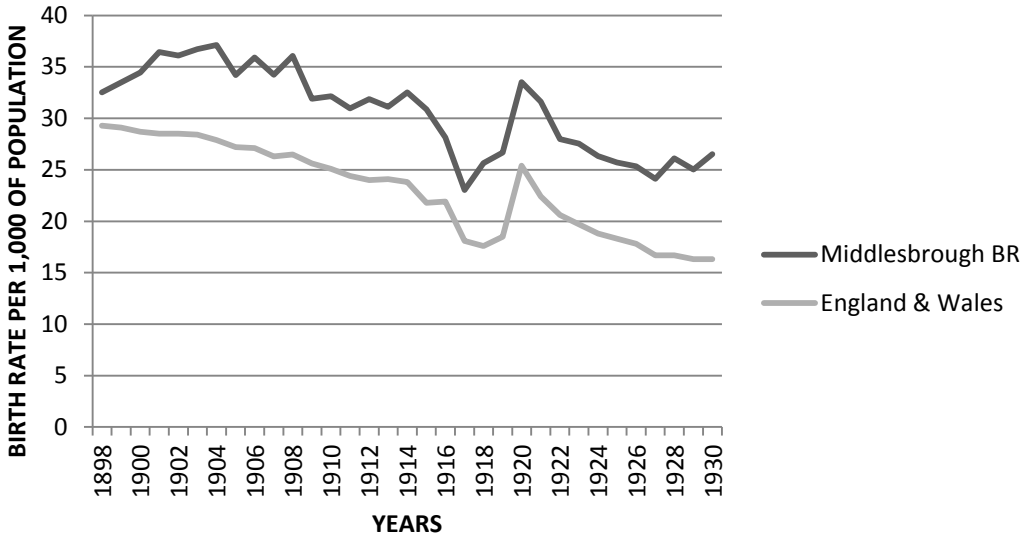
| Era | Years | Ave. Births per Year (Middlesbrough | Ave. Births per 1,000 living population (Middlesbrough) | Ave. Births per 1,000 living population (England & Wales) |
|---|---|---|---|---|
| Pre-War | 1909-1913 | 3,364 | 31.60 | 24.64 |
| War Years | 1914-1918 | 3,506 | 28.03 | 20.64 |
| Post-War | 1919-1923 | 3,936 | 29.46 | 21.32 |
| Depression (1920s) | 1924-1928 | 3,332 | 25.52 | 17.66 |

Source: TA/CB/M/H/11, Medical Officer of Health Annual Report for 1930, 'Abstract of Medical Officer of Health Reports from 1898-1930', Teesside Archives, Middlesbrough

[518] One such example is a report from 1910, directed by the chief medical officer, Arthur Newsholme. Dr. W W E Fletcher (1910), *Report to the Local Government Board upon the Sanitary Circumstances and Sanitary Administration of the County Borough of Middlesbrough, with Special Reference to the Persistently High General Death Rate and Infantile Mortality, and their Causes*, London, HMSO.
[519] TA/CB/M/H/11, Medical Officer of Health Annual Report for 1930.
[520] Doyle, 'Competition and Cooperation', p. 343.

*Graph 3*

Birth Rate per 1,000 of the Population for Middlesbrough, England and Wales 1900-1930




Source: TA/CB/M/H/11, Medical Officer of Health Annual Report for 1930, 'Abstract of Medical Officer of Health Reports from 1898-1930', Teesside Archives, Middlesbrough

The birth rate in Middlesbrough was higher than the national average throughout the period 1909-28, specifically so during the war years, when the focus nationally was how to increase the birth rate, as it had fallen significantly from the pre-war position.[521] In Middlesbrough, however, the actual number of births rose during 1914-18, although the infant mortality rate also did not decline within the town significantly. In contrast to this, the crude death rate for the borough did eventually begin to decline and eventually dipped below the national average for the first time in 1957.[522]

Authorities and medical practitioners did seem to be united in the opinion that intemperance was one of the key reasons poverty, and ill health were regular visitors to the workers of Middlesbrough. Dr John Hedley commented in 1907 that although intemperance throughout the town had improved, and in doing so had reduced the annual health bill, there

[521] TA/CB/M/H/11, Medical Officer of Health Annual Report for 1930.
[522] TA/CB/M/H/15, 'Annual Reports of the Medical Officer of Health, Middlesbrough, 1952-57', Teesside Archives, Middlesbrough, 1957 Report.

was still a tendency at this time to over indulge on the weekends by the workers.[523] This meant that the wives received less money to attend to matters of the home, such as buying food and clothes, and paying the rent and bills. Intemperance is an issue that arises repeatedly when studying the health records and publications related to the town and region. In relation to IMR, it is cited as one of the leading causes of high rates of mortality amongst those aged under one. A report published in 1917 supported this assertion the author had '...no hesitation in ascribing to this cause an important share in the causation of the excessive child mortality in such towns as Burnley, Wigan, Middlesbrough...'[524] In 1887, a Middlesbrough doctor, Dr Fraser (of North Riding Infirmary) gave a lecture on the matter of intemperance and the effects of alcohol to the Middlesbrough Temperance Society. He went into detail just how injurious to health the consumption of alcohol could be, concluding that tea and coffee were far better in their restorative powers than alcohol.[525] Women were considered just as responsible when it came to excessive alcohol consumption as the men. However, there is not much proof to substantiate this other than anecdotal evidence and casual remarks in local and national reports on the subject of health and infant mortality.

The local press in Middlesbrough were quick to criticise other towns within the northeast rather than address the issue in their own town. Sunderland had infant mortality rates comparable to those in Middlesbrough, certainly no worse, as suggested by the *North-Eastern Daily Gazette* in 1896.[526] The article commented on the potential reasons given for the rates in Sunderland and those outlined are comparable to those given for Middlesbrough.[527] Reportedly, women were harder drinkers than men were and there was an excess of public houses, the population married 'unhealthy' early, and there was high levels of overcrowding. The population of a town again is made to take responsibility for

[523] PP 1907 XXXIV (Cd. 3496), *Report of the Departmental Committee on Compensation for Industrial Diseases, 1907*, p. 87.
[524] PP 1917-18 XVI (Cd. 8496), *Annual Report of the Medical Officer of Health to the Local Government Board Supplement on Child Mortality at ages 0-5, 1918*, p. 66.
[525] Anon (1887), 'A Middlesbrough Doctor on the Temperance Question', *The North-Eastern Daily Gazette*, February 19th. The Temperance Society in Middlesbrough has endured and even published a brief history on the subject in 2000. Norman Moorsom (2000), *The Demon Drink in Victorian Middlesbrough*, Middlesbrough Temperance Society, Middlesbrough.
[526] Anon (1896), 'Appalling Reports from Sunderland', *North-Eastern Daily Gazette*, December 14th.
[527] Sunderland had 239.2 deaths per 1,000 live births.

mortality and morbidity rates. Within Middlesbrough the suggestion was something even more sinister that intemperance. Alderman Sadler, in 1892, connected the increase in infant mortality deaths in Middlesbrough with a rise in the number of children under five years of age being insured.[528] Indeed, he called for an investigation into, and a potential ban, on such schemes, convinced that the rate would fall.

One of the biggest threats to the life of those under five during the first decade of the twentieth century was measles. In 1907, there was a significant outbreak of the disease in Middlesbrough, although measles at this time, like pneumonia, did not require notification to the MOH.[529] It was due to the excessive number of deaths from the condition that the MOH and the Sanitation Committee became involved. There were 89 deaths registered in the first half of the year, compared to 19 in the previous six months. This led to the GPs of the town receiving instructions to send cases to the Borough Isolation Hospital when they considered that the isolation of the case at home was not working, and even then only on the approval of the parents. During the height of the outbreak, Dingle contested that the parents were often at fault, stating that:

> 'One of the greatest causes of this disease becoming epidemic is the firmly-rooted and widely prevailing idea of parents that their children must contract the disease sooner or later, and the little care they exercise in keeping children away from the disease.'[530]

With this in mind in June 1907, many of the schools in the town closed for a period of three weeks. This was not entirely successful, as by 1908 an estimated 80 per cent of children between 5-6yrs had contracted the disease.[531] The epidemic did eventually pass. The disease had most likely reached a saturation point, with most children of a susceptible age having already had the illness, and, therefore, being immune. There was a similar epidemic outbreak between 1917 and 1920. In 1919, deaths due to the disease were as high as 1.75

[528] Anon (1892), 'Middlesbrough County Council', *North-Eastern Daily Gazette*, May 11th.
[529] TA/CB/M/H/4, 'Annual Reports of the Medical Officer of Health, 1904-1909', 1907 Report, p. 85.
[530] *Ibid*., p. 87.
[531] *Ibid*., 1908 Report, p. 7.

deaths per 1,000 within the borough, compared to the national average for England and Wales of 0.10 per 1,000. It accounted for 3,048 out of 4,680 reported incidences of infectious disease to the MOH.[532]

In the first decade of the century, infantile mortality was a cause for national concern, as birth rates began to decline. In Middlesbrough, however, the birth rate was considerably higher than the national average, the figures for 1904 being 37.12 per 1,000 of the Middlesbrough population compared to the national average of 27.9 per 1,000.[533] Nevertheless, the IMR was also higher at 170 per 1,000 live births in comparison to 146 per 1,000 in England and Wales. Emphasis upon distinguishing types of infant deaths that were deemed preventable from those that could not be prevented is visible within the annual reports. In the case of preventable deaths, the mother received the majority of the blame, citing ignorance, carelessness and neglect as the reasons. In 1914, the government made allowances for the LGB and the Board of education to assist the various organizations involved in infant and maternal welfare; these included grants for clinics and infant dispensaries. [534]

From 1918, local authorities were required to establish a Maternity and Child Welfare Committee.[535] The aim was to tackle the ever-increasing IMR by educating mothers at welfare centres as to the correct diet for their infants, as well as basic hygiene and general childcare. The MOH for Stockton-on-Tees was Dr. George M'Gonigle, 'The Housewives' Champion'; considered a pioneer of public health policy amongst the poor and disadvantaged.[536] M'Gonigle worked tirelessly to implement welfare centres and clinics throughout Stockton. The ones he established in the early 1920s saw impressively high attendance amongst the working class mothers of the town. This is in direct contrast to

[532] TA/CB/M/H/8, 'Annual Reports of the Medical Officer of Health, Middlesbrough, 1914-1920' , Teesside Archives, Middlesbrough, 1919 Report.
[533] TA/CB/M/H/4, 'Annual Reports of the Medical Officer of Health, 1904-1909', 1904 Report, p. 70.
[534] Bernard Harris (1995), *Health of the Schoolchild: History of the School Medical Service in England and Wales, 1908-1974'*, Open University Press, Buckingham, p. 77.
[535] Susan McLaurin (1997), *The Housewives' Champion: Dr. G.C.M. M'Gonigle Medical Officer of Health for Stockton-on-Tees from 1924 to 1939*, Printability Publishing Ltd, Hartlepool, p. 6.
[536] *Ibid*., p. 5.

neighbouring Middlesbrough where attendance was much lower; even though the population was nearly double that of Stockton. His persistence and vision proved successful as the IMR fell between 1925 and 1934 from 92 per 1,000 live births to 62, only a fraction above the national average.[537] By contrast, in Middlesbrough's the IMR remained consistently in excess of the national statistics. In fact, between 1901 and 1910, Middlesbrough had the worst IMR of all the county boroughs in the country.

## '*Slaughter of the Innocents*': The War Years (1914-1918)

The issue of escalating infant mortality rates became a topic in the national press during the First World War. '*Slaughter of the Innocents'* was the damning title of an editorial in the *Weekly Dispatch*, May 1917, decrying the rising infant mortality rates in the larger, industrial towns and cities of Great Britain.[538] It was the northern towns of Burnley, Wigan, St. Helens, Barnsley, Sheffield and Middlesbrough, who were cited within the paper as amongst the worst cases for high IMR. The article places the blame, not as conventional wisdom espoused at the feet of neglectful parents, but rather at the low standards of living within these towns; despite, as the article contests, the magnificent buildings that adorned many of these "slum-ridden" cities. The press reported a different side of the story to that of the local authorities and national government, the latter tended to blame the individuals rather than their circumstances and surroundings. Briefly to address the claims of the newspaper article that 'magnificent buildings adorned these 'slum-ridden' cities', in the case of Middlesbrough this was not entirely so. At the end of the nineteenth century, some superfluous building did take place; in 1889, the new town hall was built at a cost of £130,000.[539] However, this took place via a 'civic loan' rather than at the expense of the ratepayers.

[537] *Ibid*., pp. 11-12.
[538] Anon (1917), 'Slaughter of the Innocents: Towns and Cities that Out-Herod Herod', *Weekly Dispatch*, May 20, p.2.
[539] Asa Briggs (1996), 'Middlesbrough: The Growth of a New Community', in Pollard, *Middlesbrough Town and Community*, p.30.

Thirteen years prior to the date of the *Weekly Dispatch* editorial, in his Presidential address to the Cleveland division of the British Medical Association in 1904, George Fulton also commented on the "mighty slaughter of the innocents" taking place throughout the country at that time, but perhaps most keenly exhibited in the Middlesbrough region.[540] In this address, he went on to outline the various alleged causes of infant mortality that appeared to be common to all locales (*table 17*).[541]

*Table 17*

List of Causes of Infantile Mortality Common to all Locales, 1904

i. Prematurity of birth and congenital defects
ii. Hereditary tendencies
iii. Inexperience and neglect of mother
iv. Industrial conditions
v. Social position
vi. Improper food and method of feeding
vii. Death from accidental and homicidal violence
viii. Age of parents
ix. Illegitimacy
x. Insurance
xi. Relation between birth rate and infantile mortality
xii. Density of population

Source: George CH Fulton (1904), 'Infantile Mortality: Its Causes and Prevention', *The British Medical Journal*, **2292**: pp. 1513

Regarding inexperience and neglect of the mother, Fulton called for infant mortality numbers to be broken down further so that statistics of first-born children who died could be accounted for separately.[542] Fulton was of the opinion that due to a mixture of inexperience and parturition difficulties, first time mothers were most likely to suffer a loss. Fulton, however, did not necessarily subscribe to the theory that women working and high infant mortality rates were connected.[543] He was the president of the Cleveland Division of the

[540] George CH Fulton (1904), 'Infantile Mortality: Its Causes and Prevention', *The British Medical Journal*, **2292**: pp. 1513-15.
[541] *Ibid*. The list is taken directly from the *British Medical Journal* (hereafter, *BMJ*) as it was published and printed in 1904.
[542] *Ibid*., p. 1513.
[543] *Ibid*.

BMA and was fully aware that Middlesbrough (and the surrounding district) had a high infant mortality rate despite not having large numbers of women in employment. Heavy industry was the dominant employer within the region and, therefore, women were effectively excluded. Fulton also compared infant deaths in the major cities of England and Scotland with those in Middlesbrough and found the industrial town to be the worst (*Table 18*).

*Table 18*

Infant Mortality Rates in the Major Cities of England and Scotland Compared to Middlesbrough for 1902, Deaths per 1,000 live births

| Town/City | No. Deaths per 1,000 live births |
|---|---|
| Glasgow | 128 |
| Edinburgh | 123 |
| Dundee | 143 |
| Aberdeen | 137 |
| London | 141 |
| Liverpool | 163 |
| Manchester | 152 |
| Birmingham | 157 |
| Middlesbrough | 182 |

Source: George CH Fulton (1904), 'Infantile Mortality: Its Causes and Prevention', *The British Medical Journal*, **2292**:**2** p. 1513.

However, this might well have been a case of choosing the locations to make his point as not all were comparable in terms of industry, population or history to Middlesbrough.

Middlesbrough was to be the subject of many reports over the following decade concerning infant mortality, both at a governmental level and as the ultimate example of all things negative in numerous journal publications. Diarrhoea, for example, was a central issue of many of the reports on infant mortality, especially amongst those under one year of age. This is highlighted in the case of Middlesbrough where the death rate per 1,000 of the population amongst the under ones was 30.8 (1904-08 figures). This is a high figure especially when one compares it to the national average at the time that stood at 8.9 per

1,000 for England and Wales,[544] as the table (*table 19*) below illustrates, comparing Middlesbrough to the nearby towns of Stockton and Darlington.[545]

*Table 19*

Number of Death for Infants and the Under Five Years Old in Darlington, Stockton and Middlesbrough due to Measles, Diarrhoea, TB, Pneumonia and Bronchitis, 1901-1910

| | | Under 1 Year | | Under 5 Years | |
|---|---|---|---|---|---|
| Town | Disease | Male | Female | Male | Female |
| Darlington (Pop c 62,000) | Measles | 23 | 10 | 69 | 54 |
| | Diarrhoea | 120 | 82 | 146 | 102 |
| | TB | 11 | 12 | 43 | 39 |
| | Pneumonia | 84 | 56 | 155 | 142 |
| | Bronchitis | 101 | 77 | 149 | 116 |
| | | | | | |
| Stockton (Pop c 67,500) | Measles | 45 | 30 | 160 | 166 |
| | Diarrhoea | 159 | 119 | 206 | 149 |
| | TB | 27 | 17 | 62 | 72 |
| | Pneumonia | 99 | 50 | 215 | 184 |
| | Bronchitis | 116 | 119 | 170 | 192 |
| | | | | | |
| Middlesbrough (Pop c 142,000) | Measles | 92 | 77 | 424 | 400 |
| | Diarrhoea | 699 | 602 | 920 | 804 |
| | TB | 99 | 76 | 255 | 185 |
| | Pneumonia | 513 | 402 | 1,109 | 1,008 |
| | Bronchitis | 344 | 248 | 470 | 372 |

Source: PP 1914-16 (Cd.8002) VIII, Supplement to Registrar General's Seventy-Fifth Annual Report, 1917, pp. 648-57.

The age group that suffered the most severely was those aged under one, in the case of diarrhoea this was the case in most large towns and cities. However, it was not to be the greatest threat to this age group within Middlesbrough; this was pneumonia for both sexes. Even taking into account the smaller population sizes of the different towns, Middlesbrough had a much higher death rate amongst the under ones and under-fives, especially in the case of diarrhoea and pneumonia. The other conditions were much more similar amongst the towns when one takes the respective population size of each into account.

[544] Anon (1911), 'Public Health', *The Lancet*, **177:4558**, p. 51.
[545] *Supplement to Seventy-Fifth Annual Report, 1917*, pp. 648-57.

Helen M. Blagg published a *Statistical Analysis of Infant Mortality* in 1910; the report gives an outline of what it determined to be direct and indirect causes of the high infant mortality rates in England and Wales.[546] Included are a list of possible remedies, amongst these were areas for consideration for the authorities as well as for the community itself. Direct causes were considered those of disease, namely diarrhoea, bronchitis and TB (these included pneumonia and other respiratory conditions). The indirect causes were, in the main, those that were deemed the responsibility of the parents (although even this was gender assigned, usually to the mother). These were ignorance of the mother; the surroundings of the infant; pre-natal causes; the industrial employment of the mother; and undefined causes such as illegitimacy. The final section of the report, prior to its conclusion, focused on possible remedies to the situation. These were education, aids to mothers, improved sanitation, milk depots and legislation. It also included a final remedy that had rather moralistic overtones to it. Namely, that section of the community that found itself most affected should be educated, not only in hygiene and care, but also in how to live a moral and godly life. The author felt 'anything which tends to raise the ideal and the spiritual side of life will tend to lower infant mortality.'[547]

Once again, the issue of female employment is a central, if somewhat overly dramatic, one. The potential hazards of women working are articulated most strongly by Blagg she considered that '…if the mother goes out to work, the baby is liable to be artificially fed, to be cared for by ignorant or neglectful persons, or to be left in danger of fire or starvation.'[548] She then went even further in the suggestion that no women should have to work, and that legislation needed to be employed to prevent their entering the workplace wherever possible. The report did acknowledge how difficult it would have been to be achieved, especially in how detrimental it would have been for widows who had to work to

[546] Helen Blagg (1910), *Statistical Analysis of Infant Mortality and its Causes in the United Kingdom*, P.S. King and Son, London. Blagg also went on to write *Who's Who in the English Church* (1911), *Women, and Prisons* (1912).
[547] *Ibid*., p. 27.
[548] *Ibid*., p. 19.

support their family.[549] However, this attitude regarding female employment would be forced to change after the outbreak of the First World War.

Female employment was blamed for high levels of infant mortality whenever it could be used as an explanation, especially in towns with high levels of female workers such as Oldham, Stoke, Bolton and Blackburn. In towns like Middlesbrough or Hull where high infant mortality rates persisted despite low female employment, other causal factors were sought in order to explain the figures. These included socio-economic conditions to explain away the differences between the two types of towns, despite their common link of high infant mortality. It was dismissed as 'regional variation', but only when 'regional variation' happened to occur in a town of low female employment and could not be used to reinforce the employment argument or be conveniently or easily explained. Subsequently there is little explanation in the post-World War One reports (and even more recent histories on the subject) as to why the mortality rate was so high in towns such as Middlesbrough. Even contemporaries could not successfully explain why there were these variations in towns with historically low female employment. Did it, in fact, mean that the question of women in the workplace was not as significant as considered, or that it was something distinct to those towns, were there other social conditions that these 'regional variations' shared? The most likely scenario is that the influence of female employment was overplayed in order to maintain the impression that it was an act of wilful neglect for women to work.

Ultimately, much of the blame for the infant mortality rates was still placed on the shoulders of the parents. In fact, disability was also the fault of the parents according to Blagg's report. The unhealthy lifestyle and surroundings of the child led to them becoming 'crippled' and 'feeble-minded'.[550] Blagg quoted then LGB President, John Burns, speaking at the 1908 National Conference on Infantile Mortality (held annually from 1906-1908 at Caxton Hall, London) that had inspired the collation of her report. Burns considered that the need for 'special schools' for disabled children was entirely due to a lack of foresight and planning. He

[549] *Ibid*., p. 24.
[550] *Ibid*., p. 28.

stated, 'if half the money expended now had been spent on the mother, the child, and the home, twenty, ten or even five years ago, our special schools would not be needed.'[551] The report by Burns seems to suggest that the government and local authorities were equally guilty of not supporting the community sufficiently. Perhaps unsurprising given Burns' socialist and trade union background. However, the LGB President was not above blaming the mother for all associated problems, especially married working women whom he felt not only endangered the lives of their children but lowered the standards of wages.[552]

The idea of 'damaged children' was a recurrent theme in the contemporary literature concerning infant mortality. Fulton had touched upon this very subject in 1904, namely that the parents were responsible for all the avoidable illness their child encountered, including disability. The eugenics movement also centred on the theme of what could be inherited from the parents as well as the environment in which the child grew up. Karl Pearson (1857-1936) a follower of Sir Francis Galton (1822-1911) and an exponent of eugenics felt that the parents were the real cause of a child's health problems. In an address to public health officers in 1912 he informed the audience that;

> '[H]ealth is a real hereditary character and the health of the parents is far more important than the question of back-to-back houses, one-apartment tenements, the employment of mothers or breast feeding.'[553]

This was a pre-war argument that whilst not eradicated by the outbreak of WWI was muted considerably during and after, as it became clearer that environment and social conditions were much more influential.[554] The Eugenics movement attempted to make its theory

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[551] *Ibid*., pp. 24-5.
[552] Carol Dyhouse (1978), 'Working Class Mothers and Infant Mortality in England, 1895-1914', *Journal of Social History*, **12(2)**: p. 259.
[553] Karl Pearson (1912), *Eugenics and Public Health: An Address to Public Health Officers*, Dulau, London, pp. 32-33.
[554] Richard Soloway, 'Eugenics and Pronatalism in Wartime Britain', in Richard Wall and Jay Winter (eds.) (1988),*The Upheaval of War: Family, Work and Welfare in Europe, 1914-1918*, Cambridge University Press, Cambridge, p. 371.

inclusive and open to the causal impact of environmental factors and somewhat reluctantly supported the establishment of a National Baby Week in 1917.[555]

The Blagg report also blamed urban living for what had happened with infant mortality rates. She cited rural Ireland and Scotland, with their 'primitive' habits as an example of how natural, simpler living could lead to lower infant mortality rates.[556] Middlesbrough had a higher death rate in 1908 than any of the other thirty-three towns Blagg's report cited, the figure for the town being 19.95 per 1,000 of the population. The birth rate was 36.06 per 1,000, with only Rhondda being higher at 40.3 per 1,000. As far as the infant mortality rate was concerned in 1908, only Rhondda (184) and Oldham (160) had higher rates than Middlesbrough (158). Middlesbrough, however, was not included in the report, as its population figures did not exceed 100,000 in 1908 as it only took into account the urban and not rural population of the towns.[557]

*Table 20* shows the different wards of Middlesbrough with their respective birth rates and deaths from the childhood diseases measles and whooping cough, the town's endemic ailments, bronchitis and pneumonia, and finally deaths from all causes. [558] The figures in the table are taken from a report published towards the end of the First World War that looked at the infant mortality rates in England and Wales. Middlesbrough played an integral role within the report due to its persistently high IMR.

[555] *Ibid*., p. 373.
[556] Blagg, *Statistical Analysis of Infant Mortality* p. 29.
[557] *Ibid*., pp. 34-5.
[558] *Supplement on Child Mortality at ages 0-5, 1918,* p. 57.

*Table 20*

Middlesbrough 1911-1914
Birth and deaths per 1,000 births at ages under 5 from all causes, from measles and whooping cough, and from bronchitis and pneumonia in certain wards of the town

| Ward | Births 1911-1914 | Measles and Whooping Cough | Bronchitis and Pneumonia | All Causes |
|---|---|---|---|---|
| Ayresome | 1,309 | 15.3 | 35.1 | 145.9 |
| Acklam | 1,194 | 33.5 | 49.4 | 206.0 |
| Cannon | 1,816 | 49.0 | 92.5 | 328.7 |
| Cleveland | 1,325 | 37.0 | 68.7 | 251.3 |
| Exchange | 818 | 19.6 | 39.1 | 205.3 |
| Grove Hill | 729 | 15.1 | 26.1 | 146.7 |
| Linthorpe | 863 | 19.7 | 44.0 | 190.0 |
| Newport | 2,008 | 50.3 | 67.7 | 302.8 |
| St. Hilda's | 1,748 | 69.2 | 83.5 | 369.0 |
| | | | | |
| Total for the Borough | 11,810 | | | |
| Average for the Borough | | 37.0 | 61.0 | 251.0 |

Source: 1917-18 [Cd. 8496] Annual Report of the Medical Officer of Health to the Local Government Board Supplement on Child Mortality at ages 0-5, p. 57.

The report not only provided statistics but also offered possible explanations and solutions to the problem. It listed industry, unsatisfactory housing and domestic cleanliness, carelessly prepared meals, heavy drinking within the town, a past time shared by the women of the town as well as the men, and excessive gambling. These were all features the writer of the report, Arthur Newsholme (1857-1943), the then Chief Medical Officer of Health, felt were specific to the town. This report compiled in 1915/16, for publication in the 1917/18 Annual LGB Report, declared that, in Middlesbrough, the 'complex causation of child mortality and its indirect relation to industrial occupation are fairly evident'.[559] In concluding his report, Newsholme made suggestions as to what could be done to improve matters within the town. He advocated both sanitary and social reform; he also put forward the notion that the vast proportion of those living in the inner and northern wards should be relocated to

[559] *Supplement on Child Mortality at ages 0-5, 1918*, p. 58.

the outer, southern wards to reduce overcrowding.[560] Rather unsurprisingly once again, the inhabitants of the town received most of the criticism. There was a feeling that the corporation was doing enough already by improving sanitation and implementing 'social agencies' as it was put, to help the town and the people improve. Newsholme felt that what was required was that the 'communal conscience and the conscience of each inhabitant of the town should be awakened'.[561] It is difficult to ascertain exactly what these 'social agencies' were doing within the town. Indeed, the town's own MOH, Charles Dingle considered the high infant mortality rates to be 'a social rather than sanitary question', the worst areas being the Cannon, Newport and St. Hilda's wards.[562] These are remarkably similar words to those of the MOH for Birmingham in 1893 who declared that the problems in that city were also 'social rather than sanitary'.[563] Similar language was used when an investigator for the LGB, Dr W.W.E. Fletcher, wrote his report on the health of Middlesbrough in 1910. Discussing endemic pneumonia in the town, Fletcher blamed insanitary conditions, the 'dirty habits' of the population, overcrowding, malnutrition and, in the case of adults, 'more or less intemperance' for pneumonia's presence.[564] Dingle in his report on smallpox attempts to redress the balance, as he points out that the health concerns of the town might be due to 'damp sewage-polluted ground, defects in construction of sewers, defects in excremental disposal, overcrowding...' amongst other possibilities.[565] These were all valid reasons. However, he went on to contradict himself by suggesting that the working classes have only themselves to blame by not adopting even 'the most elementary rules of sanitation, such as cleanliness and fresh air.'[566]

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[560] *Ibid*., pp. 59-60.
[561] *Ibid*., p. 60.
[562] TA/CB/M/H/4, Medical Officer of Health Annual Report for 1906, Teesside Archives, Middlesbrough, p. 5.
[563] Naomi Williams (1992), 'Death in its Season: Class, Environment and the Mortality of Infants in Nineteenth-century Sheffield', *Social History of Medicine*, **5:1**, p. 75.
[564] Dr. W W E Fletcher (1910), *Report to the Local Government Board upon the Sanitary Circumstances and Sanitary Administration of the County Borough of Middlesbrough, with Special Reference to the Persistently High General Death Rate and Infantile Mortality, and their Causes*, London, HMSO, p. 42.
[565] Dingle, 'Middlesbrough Small-pox', p. 174.
[566] *Ibid*.

The breakdown of figures for Middlesbrough's wards (*Table 20*) also resonates with Naomi Williams' study of infant mortality in Sheffield. Williams looked at the social and spatial influences that were exerted on infant mortality rates in the different wards of the city.[567] Within Sheffield, like Middlesbrough, the unhealthiest wards were situated in low-lying areas around rivers, with poor drainage and prone to flooding. The topography of these areas in Sheffield is comparable to those on Middlesbrough, namely the Cannon, Newport and St. Hilda's wards. Sheffield was also and iron and steel town, although unlike Middlesbrough it also manufactured secondary products such as cutlery and tankards (Sheffield plate) as well as heavy steel goods such as armaments.[568] Conversely, Middlesbrough produced steel as raw material for export both abroad and within Britain. Therefore, environmental problems were primarily in both Middlesbrough and Sheffield. Williams also concluded that the lower social classes (unskilled) predominantly occupied these areas and that they fared the worst during the months of July-September when diseases such as diarrhoea affected the infant mortality rates.[569] However, in Sheffield there was a mix of social classes living in the riverside area of the city, this was despite the unskilled class being worst affected. In Middlesbrough the distribution of classes was more distinct, the unskilled workers lived in the northern wards and the IMR in this area was almost double that of the southern wards of Grove Hill, Linthorpe and Ayresome. The MOH for Middlesbrough had picked up on this theme but little was dome to address the issues and given the knowledge of the topographical conditions of these wards (regarding flooding and drainage) it was disingenuous of Dingle to persist with the notion that this was purely social rather than sanitary. As Williams pointed out in the case of Sheffield, the conditions even

[567] Williams, 'Death in its Season', pp. 71-94. Williams used civil death registers, burial and cemetery registers and census enumerators' books to assess the social status and geographical location of families who experienced an infant death.
[568] David Reeder and Richard Roger (2000), 'Industrialisation and the City Economy', in Daunton, *The Cambridge Urban History of Britain: Volume III*, p. 579. Sheffield also had a considerably larger population than Middlesbrough, standing at 335,953 in 1881 and 543,446 in 1921.
[569] Williams, 'Death in its Season', p. 85.

within a given area could vary from street to street, although the perception in Middlesbrough was that these few wards were bringing down the health of the entire town.[570]

Although this was not universally accepted within the local council, for example, the President of the Sanitary Committee, Colonel Sadler, argued that the health of the north of the town was good, and no figures that he had been presented proved otherwise.[571] There is little question that the northern wards were the most problematic in the town, therefore, what figures Sadler had in mind compared to the rest of the Middlesbrough wards is hard to fathom. Health, by 1900, might well have improved incrementally since the mid-1800s, but the situation in the north was poor in the extreme and had the effect of prejudicing the figures for the whole of Middlesbrough quite detrimentally. Sadler appeared to infer that any adverse figures reported in the north had been more to do with the concentration of lodging houses in the area than endemic ill health.[572] The inference as to what Sadler meant by this was the figures were affected by a large number of transient workers passing through the area and bolstering the disease figures for the north in the process. Individuals that lived in lodging houses were treated with contempt, the character of people who lived in some establishments was considered questionable. The houses themselves were thought to be the foci for infectious disease, overcrowded and unhygienic.[573] Once again, this was a misleading statement as these individuals were least likely to report ill health, have a GP or be included in the town's mortality and morbidity figures. Additionally, as was the recurrent motif, the migrant workers within the community were held responsible for the elevated figures. The north of the town did have a large proportion of lodging houses there, but it also had the greatest concentration of workers and their families residing there too.

There was also a perceived divide between the rich and the poor, as Mooney and Tanner explored in their study of the Notting Dale Special Area of London during the late nineteenth century. This area was part of the Kensington district of London, considered a

[570] *Ibid*., p. 93.
[571] Anon (1900), 'Middlesbrough's Sanitary Problems', *Northern Echo*, June 7.
[572] *Ibid*.
[573] Feldmen, 'Migration', p. 196.

prosperous and relatively healthy place to live, especially when compared to London's East End.[574] Parental neglect, '…either wilful or in ignorance…' was the main cause of infant mortality, and a lack of knowledge as to what constituted food suitable for infants was largely blamed.[575] This same study addressed the issue of spatial problems regarding infant mortality, or at least the perception of it during the late nineteenth century. It was considered, at the time, that the social status of the parents and the community where they lived had the greatest effect upon infant mortality. Rather as the situation witnessed in Middlesbrough, it '[u]nderlined the distinctions between healthy, morally-upstanding citizens and their slovenly, unhealthy neighbours.'[576] As Williams astutely suggests in her Sheffield study, trying to untangle what the factors that drove up the rate in one area and down in another actually were is problematic. There are multiple causes and influences to be considered beyond just environmental and social status. However, it does seem that, as in the case of Sheffield and Middlesbrough, certain areas of a town paid a greater price in terms of infant deaths than others did.

Newsholme's work on infant mortality was to be used as ammunition in 1917 by the eugenics movement. Written in 1917, the same year as the newspaper article *'Slaughter of the Innocents'* had appeared, Eric Pritchard MD (1864-1943) reviewed recent reports and documentation on infant mortality.[577] Pritchard's article published in the *Eugenics Review* had its own bias and agenda for analysing the reasons behind the nation's high infant mortality rate. By the mid-1910s, those interested in the factors behind the soaring rates looked, not to the reasons why alone but to the 'relative importance' of these factors. Newsholme's report was just one that Pritchard examined and cited within his paper.[578]

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[574] Graham Mooney and Andrea Tanner (2006), 'Infant Mortality, a Spatial Problem. Notting Dale Special Area in George Newman's London', in Eilidh Garrett, Chris Galley, Nicola Shelton and Robert Woods (eds.), *Infant Morality: A Continuing Social Problem*, Ashgate, Aldershot, p. 170.
[575] *Ibid*., p. 176.
[576] *Ibid*.
[577] Eric Pritchard (1917), 'Some Recent Documents on the Subject of Infant Mortality, and Some Reflections Thereon', *The Eugenics Review*, **9:3**, pp. 223-30. Pritchard was well known for his work regarding infant welfare and child hygiene and was president of numerous paediatric and child welfare associations. Anon (1943), 'Obituary: Eric Pritchard, M.D., F.R.C.P.', *British Medical Journal*, **4332:2** pp. 591-2.
[578] Pritchard, 'Some Recent Documents', p. 227.

Newsholme had attempted to appraise the relative weight of the factors that contributed to high mortality rates amongst infants, and, in doing so, he tried to pinpoint the most crucial elements. Pritchard used Middlesbrough as the prime example of a town where the birth rate was unusually high but so was the infant mortality rate. Pritchard argued that although medical men such as Dr G.W. Hope considered high birth rates as being of more importance than a low infant mortality rate to the stability of a population, such theories did not take into account the quality of lives of those born into the squalid, overcrowded streets of Middlesbrough.[579] Hope had, in his 1917 report to the Carnegie Trust, implied that a town with a low birth rate and low infant mortality rate did not necessarily result in a higher population increase than a town with a high birth rate but a concomitantly high infant mortality rate.[580] Pritchard thought this was nonsense, encouraging the poor conditions of towns such as Middlesbrough and Sunderland to be allowed to continue at the detriment of the nation's overall population and the debasement of movements such as the Garden Cities, to improve living standards. This caused consternation from Pritchard who felt that such suggestions might lead to future problems for the nation as a whole.[581]

Pritchard went on to declare his lack of 'faith' in '…those which have proved their inferiority by remaining permanently submerged and who are content to live in crowded, insanitary areas.'[582] The insinuation in such a comment was that those were living in the slums of Middlesbrough did so by choice rather than circumstances beyond their control. It is difficult to accept that all the inhabitants had to do was move to a better home and live hygienically for a better way of life. Whilst the latter may well have been true, achieving that goal was not as straightforward as Pritchard's remark implied.

The 1913 annual report of the MOH to the LGB outlined the child welfare work being carried out in Middlesbrough and used vague terms to describe its work. For example, "*Practically* all births are notified", "*About* four visits are made by health visitors to each

[579] *Ibid*., p. 229.
[580] *Ibid*. The Carnegie Trust was formed in 1913 as a charitable organization to address the needs and well-being of the people of Britain. David Nasaw (2006), *Andrew Carnegie*, Penguin, London.
[581] Pritchard, '*Some Recent Documents*', p. 229.
[582] *Ibid*.

child", "*Some* lectures on infant care are given by various societies".[583] Throughout his reports, Middlesbrough's own MOH Dingle focused heavily on maternal neglect and familial responsibilities rather than any other possible factors such as industry, environment, disease or living conditions, many of which were beyond the parents' control. Unfortunately, what is harder to discern is the opinion of the GPs during this period, particularly in the case of infant mortality. The Middlesbrough Maternity and Infant Welfare Central Committee were instrumental in pressing for changes to the way in which the problem of a persistently high infant mortality rate within the town was challenged.[584] This was particularly so during the First World War when national initiatives to raise the declining birth rate led infant and maternal welfare to become an important issue. The Committee in Middlesbrough aimed to setup Maternity and Infant Welfare Clinics throughout the town, and encourage mothers, especially first time ones, to attend. Mrs (Dr) Levick was prominent in the formation of the Committee, which also received the full backing of MOH Dingle (who regularly attended its monthly meetings).[585] The centres were not particularly popular within the town and the members struggled to persuade mothers to attend in significant numbers. One of the earliest problems the Committee encountered was trying to identify and secure suitable locations. Roman Catholic mothers were worried about attending the clinics that were held in Church of England owned centres in case there was some kind of religious overture.[586] The Committee were heavily involved with setting up the events that constituted National Baby Week during 1916 and 1917, yet another national led scheme. The week had initially been postponed from July 1917 due to an outbreak of measles within the town.[587] The reason behind the postponement was to stop the spread of the disease, especially as the group that the baby week was aimed at were those most affected by the epidemic, namely the poorer classes. Therefore, to carry on with the promotion would have been somewhat

[583] PP 1913 XXXII (Cd.6909), *Annual Report of the Medical Officer of Health to the Local Government Board Infant and Child Mortality*, 1913, p. 278.
[584] TA/Accession 3076, Box 4, Minute Book of the Middlesbrough and Infant Welfare Central Committee, 1916-1919, Teesside Archives, Middlesbrough.
[585] *Ibid*.
[586] *Ibid*., Meeting June 2nd 1916.
[587] There were 4,650 notified cases and 159 deaths within the town during 1917.

counterproductive in its effect. When the week went ahead in October, five welfare centres within the town were opened to the public to try to educate them on the role they played, at least on an advisory level. This culminated in an address being given by Dr Caleb Saleeby at the town hall in Middlesbrough that promoted, amongst others, issues regarding hygiene and how its improvement could reduce infant mortality.[588] However, the meetings and much of the work of the Committee members centred around fund raising activities, exhibitions, lectures and the upkeep of the various centres. With the exception of Mrs Levick and MOH Dingle, other practitioners within the town did not become involved with the Committee, choosing instead to leave it to the women, as it were.[589] This might have been one of the agencies Newsholme was alluding to.

Additionally, Middlesbrough seems to have often been excluded from retrospective analysis of infant mortality within the County Boroughs, despite it persistently being amongst the highest rates in the country. This might have been because it was a strongly patriarchal system within Middlesbrough with women seldom working and therefore it does not fit neatly into either contemporary or historical perceptions as to the degree of maternal influences on IMR.[590]

[588] Robertson, *Middlesbrough's Effort in the Great* War, p.73. Caleb Williams Saleeby was a prominent eugenicist and social campaigner. Indeed, Saleeby was one of the committee members on the National Baby Week Council. Anon (1918), 'Medical News', *British Medical Journal*, **3013:2**, p. 363.

[589] This was not a mind-set that was to change significantly over the subsequent decades. Indeed, on the subject of midwifery in the 1930s the then Mayor of Middlesbrough, Councillor George Carter declared that when it came to issues of maternity '…men should learn to keep off the grass.' TA/Accession 3076, Box 4, Envelope 9, 'Where Women Excel: Middlesbrough's Mayor on Work of Midwives' April 19th 1937 [paper of origin not provided]. This might have been one of the agencies Newsholme was alluding to.

[590] Female activity levels in Middlesbrough were below 20%. A.A. Hall (1981), 'Wages, Earnings and Real Earnings in Teesside: A Re-assessment of the Ameliorist Interpretation of Living Standards in Britain, 1870–1914', *International Review of Social History*, **26**, p. 203. Middlesbrough was excluded from the Millward and Bell study of infant mortality in the County Boroughs. Robert Millward and Frances Bell (2001), 'Infant Mortality in Victorian Britain: The Mother as the Medium', *Economic History Review*, **54:1**, pp. 699-733.

## Health Gains and Infant Mortality during the First World War

The historian Jay Winter has published extensively on the gains that were made in terms of civilian health during the First World War.[591] Indeed, in his book, *The Great War and the British People*, he claims that the areas worst affected prior to 1914 exhibited the greatest gains in terms of health both during and after the war, using infant mortality data as one of the key factors of proof. He lists the towns and County boroughs with the worst infant mortality rate prior to the start of WWI. Middlesbrough is included in the list, appearing at sixth place among the county boroughs.[592]

Winter uses the 1911-1914 averages for the infant mortality rate prior to the war. These were taken from the 1917-18 annual report of the medical officer of health to the local government board on child mortality. He then looks at the infant mortality rate for the year immediately after the war period to ascertain the decline. In the case of Middlesbrough, he records a fall of only six deaths per 1,000 live births. Indeed if one takes an average of the 4 years after 1914 then the decrease stands at only two deaths per 1,000 live births. *Table 21* lists the eight worst performing County Borough towns prior to the war. As can be seen, Middlesbrough's decline is the least impressive; in fact, it is strikingly at odds with the rest.[593]

[591] Wall and Winter, *The Upheaval of War*.
[592] Jay M. Winter (2003), *The Great War and the British People*, Palgrave Macmillan, Basingstoke, p. 150. A County Borough was at the top tier of local authority hierarchy, there had to be a minimum population of 50,000, a figure that was increased to 75,000 in 1926. Taylor *et al*, 'Central and Local Government', p. 398.
[593] Winter, *The Great War*, pp. 150-153.

*Table 21*

Wartime Infant Mortality Decline in County Boroughs in 1911-1914, Deaths per 1,000 Live Births

| Areas of Highest IMRs in 1914 | IMR 1911-1914 | IMR Wartime Decline |
|---|---|---|
| Burnley | 172 | 31 |
| Stoke-on-Trent | 161 | 31 |
| Wigan | 159 | 29 |
| Barnsley | 151 | 19 |
| Preston | 149 | 32 |
| Middlesbrough | 144 | 6 |
| St. Helens | 143 | 26 |
| Blackburn | 143 | 19 |

Taken from J. M. Winter (2003), *The Great War and the British People*, Basingstoke, Palgrave Macmillan, p.150.

Winter's hypothesis that significant gains were made in terms of health during the First World War is one that does not stand up to scrutiny, especially in the case of Middlesbrough. The historian Linda Bryder all but demolished Winter's theories about the reasons behind the 'apparent' decline in mortality and the infant mortality rate during the First World War, especially concerning the rise in TB cases.[594] Winter considered the reasons behind the increase to be due to the transference of large populations to the urban centres and the deterioration of housing conditions, due primarily to the postponement of sanitary work by local authorities during the war. The latter was certainly found to be the case in Middlesbrough, as all plans for the slum clearance in the northern quarter of the town were put on hold. Bryder argued that it was disingenuous of Winter to dismiss the links between nutrition and TB, and continued to quote a range of contemporary sources, which considered poor nutrition to be a predisposing factor in TB mortality and morbidity.[595] Immediately after the war, E.L. Collis (a professor of preventive medicine at the University of Wales) cited the decline of TB related deaths in Britain as indicating that nutrition rather than

[594] Linda Bryder (1987), 'The First World War: Healthy or Hungry?', *History Workshop Journal*, **24:1**, pp. 141-57.
[595] *Ibid*., p. 146. There has also been an edited volume published on TB that includes Bryder's work. Flurin Condrau and Michael Worboys (eds.) (2010), *Tuberculosis Then and Now: Perspectives on the History of an Infectious Disease*, McGill-Queen's University Press, Montreal.

poor housing or overcrowding was the cause of the experience during the war.[596] Housing in Britain after the war was equally poor as it had been during the war years, yet nutrition improved compared to the situation previously. Bryder also refutes Winter's claims that the Second World War demonstrated the link between TB and poor housing, as rates of TB rose in the first two years of World War II despite improved rationing when compared to the First World War.[597] As Bryder contests, housing was even worse after 1941, due to bombing and existing issues, yet the TB rate fell from this point. She states that the decline was due to successful rationing and improvements in nutrition that it provided, particularly to the lower classes.[598]

Winter also cited disruption to the TB service as a possible reason for the wartime increase in cases. However, this was not an entirely accurate reflection of the situation during the First World War, the service had not yet become organised and was sporadic at best.[599] Therefore, any disruption to the service would have had a negligible impact on the rise in TB cases. In discounting the impact of nutrition on the spread of TB, it meant that Winter could explain the 'anomaly' of increased TB deaths during the war as being due to something other than diet. It was vital that the rise could be explained in some other way, or improved nutrition could not be heralded for the decline in mortality and infant mortality rates.

If we break down the figures for TB deaths in Middlesbrough from the period 1909-1928 into four sections, then we can begin to analyse the impact of factors such as wartime nutrition on the town (*table 22*). The four periods to be considered are the Pre-War era (1909-13), the War Years (1914-18), Post-War era (1919-23) and finally the era of the 1920s depression within the region (1924-28).[600]

[596] Bryder, 'The First World War', p. 146.
[597] *Ibid*., p. 149.
[598] *Ibid*.
[599] *Ibid*.
[600] TA/CB/M/H/11, Medical Officer of Health Annual Report for 1930.

*Table 22*

Tuberculosis Related Deaths in Middlesbrough from 1909-1928

| Era | Year | Deaths (TB) | Ave (5 Years) |
|---|---|---|---|
| Pre-War | 1909 | 203 | |
| | 1910 | 153 | |
| | 1911 | 184 | 177 |
| | 1912 | 172 | |
| | 1912 | 175 | |
| War Years | 1914 | 223 | |
| | 1915 | 230 | |
| | 1916 | 204 | 220 |
| | 1917 | 228 | |
| | 1918 | 217 | |
| Post-War | 1919 | 167 | |
| | 1920 | 178 | |
| | 1921 | 162 | 173 |
| | 1922 | 170 | |
| | 1923 | 190 | |
| Depression (1920s) | 1924 | 239 | |
| | 1925 | 222 | |
| | 1926 | 175 | 206 |
| | 1927 | 194 | |
| | 1928 | 199 | |

Source: TA/CB/M/H/11 - 'Annual Report of the Medical Officer of Health, Middlesbrough, 1930', Teesside Archives, Middlesbrough.

There is a marked rise in the number of deaths attributed to TB during the war years, a pattern that is somewhat replicated during the 1920s, at the time of the industrial depression and decline within the region. At the time of the general strike in 1926, Middlesbrough was beginning to be affected by the industrial slump. During this time, money was scarce and food, hygiene and standards of living poor. This might well suggest that, at least in Middlesbrough, conditions were similar to those of the depression era.

To some extent, this is validated by reports that Middlesbrough suffered from a serious shortage of food during the First World War. There was a shortage of tea, butter, meat (low quality), sugar and an escalation in the price of bread. People found it difficult getting hold of provisions, and this was especially so in the poorer areas of the town where distribution was weak. There appeared to have been an inadequate chain of supply between

the national and local level in Middlesbrough's case.[601] This may well begin to explain why the gains made in terms of health within the town were not as substantial as reported in other areas of the country. The authorities in Middlesbrough did endeavour to make sure that supplies were made available to the workers and the injured soldiers housed at Hemlington Hospital. The sporadic nature of the supply of food in Middlesbrough does not support Winter's hypothesis that nutrition improved during WWI due to a greater distribution of essentials via rationing. If anything, the supply of food may have been compromised by the onset of War in the case of Middlesbrough, making the situation worse than it had been previously.

Winter's argument that positive gains to infant mortality rates could be linked to improved nutrition is not entirely conclusive. Winter points to the lower rates of infantile gastro-enteritis as an indicator of improved nutritional content. Improved quality and availability of milk rather than better diet were what Bryder considered the true reason behind the enhanced rates.[602] Milk quality was notoriously inconsistent at this time and might have contributed to the high pre-war rates of infantile gastro-enteritis. During the war, there was a reduced supply of fresh milk, even more so in the case of poorer areas. This may well have proved advantageous to the infants born during this time, as the children were not fed contaminated or inferior quality milk. The supply of milk was certainly an issue within Middlesbrough during the war, as was the price. As Bryder points out, in 1917 fresh milk was set at 8d a quart (as a maximum); it was rarely sold below this price either. This was a price that was too high for poorer families to afford comfortably.[603]

Women during the war, Winter argued, had a greater entitlement to the families' share of food, due to their employment in the wartime industrial infrastructure. Bryder points out how contradictory this argument is, and how unlikely it was that the working class males would subserviently defer to women within the home now they were also in industrial employment. Indeed, Bryder refers to the fact that Winter even within this same argument

[601] Robertson, *Middlesbrough's Effort in the Great War*, p. 77.
[602] Bryder, 'The First World War', p. 150.
[603] *Ibid*.

recalls the difficulty with which the suggestion that females took over medical superintendent roles was received. Why then would Winter assume that working class males were more adaptable than their middle class counterparts?[604]

The war industries benefitted from higher wages and an increase in the availability of work, especially overtime. However, the downside to this was the long hours that those employed in these industries worked. This led to almost inevitable adverse health implications, combined with issues relating to safety as pressure mounted to complete orders on time to maximise the war effort. In addition, there were worries surrounding supply of food to the workers. The main concerns being that the workers would eventually go on strike due to grievances over the matter. The concern over the supply of food, especially tea and meat led the chief constable of the town to inform the food committee that there was a real risk of workers striking.[605] This did come to fruition, at least on a small scale, with a number of men refusing to work until the matter was resolved.

There is a case to be made that the negatives outnumbered the positive gains within Middlesbrough during the First World War. For example, Turner lists the positives of World War I for the town as including a reduction in vagrancy; a fall in the numbers in the workhouse; full employment and the movement of women into the workplace. He then went on to list the negatives, these he considered to be, inflation; food shortages; industrial unrest; the strain of wartime working conditions, such as long hours and an oppressive regime; and finally the strain war placed upon the pre-existing housing shortages.[606] The latter he noted could be blamed on the influx of casual (male) workers to the area, many of which remained in the town post-war and could then not find work. This placed a strain on the poor law resources, and as these men were often single, with no familial links in the area, this led to a long-term problem by the 1940s as to how to care for these men.

[604] *Ibid*., pp. 152-3.
[605] Robertson, *Middlesbrough's Effort in the Great War*, p. 77.
[606] Turner, *Unemployment*, p. 80.

## Conclusion

The first half of this chapter examined the life of the community, in particular of iron and steel workers at the beginning of the twentieth century. This was achieved primarily by a reassessment of the 1907 publication *At the Works: A Study of a Manufacturing Town* by Lady Bell. The book was well received by Bell's peers and still stands up to critical analysis today. *At the Works* strengths lie in its ability to connect with the lives and opinions of the workers and their families. It went beyond being a mere study of iron and steel workers' daily lives; it asked pertinent questions that had not previously been considered, particularly in the case of women's roles. Moreover, it examined the lives of the workers and their interests outside the workplace, seldom had this been investigated other than in the capacity to portray them as drunken spendthrifts. It acknowledged the undoubted hardship in which they lived but also applauded their spirit and resilience.

The community within Middlesbrough, at least the iron and steel workers and their families, appear to have viewed their health as secondary to their continued industrial employment. It was more beneficial for them to remain in work than tending to any illness that might befall them. This perception was amplified in the case of the male workers, who understood that their entire family relied upon the money they brought into the home. The experiences of the women of the household were profoundly affected by any ill health amongst the male breadwinners. Women, ultimately, took over the role of the pivotal member of the family, taking on the role nurse, in addition to their existing responsibilities. They also had to try to ensure that the meagre earnings that still came into the home (usually from the sick clubs the men paid into each week) stretched far enough to pay the rent, buy food, and other essentials.

Rather than the workers seeing industry as the enemy, it was their benefactor. Whilst they were acutely aware that the environment in which they worked and lived brought with it illness and disability, they saw it as a testament to their town and their personal resolve. The workers may well have trusted their industrial employers, but they appear to exhibit

something akin to mistrust when it came to the medical profession. This can be best explained by the lack of understanding and the lack of interaction between the two groups. The workers could seldom afford the services of their family doctor. Worst still was the implications of what the doctor might bring, namely an extended absence from work. This feeling was compounded by the presence of works doctors (in the direct employ of industry), and of 'sick visitors', sent to check on the veracity of claims for benefit societies and clubs. Either of these parties could bring, at least in the minds of the workers, more harm than good. Therefore, it can be seen that a hierarchy of trust from the workers' point of view developed. Workers held their employers in higher esteem than those officials both sides of industry employed to treat and counsel them.

The GPs had to deal with changes in the demands of working class patients, exacerbated by the doctor's complex relationship with the friendly societies and sick clubs of the town. The GPs also had to cope with changes in practice after the introduction of the NHI in 1911. This chapter has demonstrated that both of these issues were problematic for GPs within Middlesbrough, primarily as they threatened the doctors' status and level of control over patients and the fees they could charge. However, judging by the increase in GP numbers and the movement of doctor's around the town, away from the poorer northern wards, practices were flourishing despite the resentment that they held towards the various societies and clubs, and subsequently the NHI. During this time the GPs of Middlesbrough had much to deal with, the majority of their work not deriving from the epidemics as might be suspected but rather with minor, recurrent ailments, especially amongst the workers that did visit them. Watkin Edwards in his Presidential address to the Cleveland branch of the BMA in 1913, outlined the situation that GPs, prior to the First World War, worked under.[607] Middlesbrough may well have been a town frequented by various epidemics and serious illness but it was the minor complaints that accounted for much of the GPs workload. These, according to Watkin Edwards, included dyspepsia, sciatica and lumbago. These conditions can all be attributed in some way to the prevailing industries of the town but they also

[607] Watkin Edwards, 'An Address on Industrial Diseases', p. 97.

demonstrate the propensity of both contemporaries and retrospective reviewers to overlook the impact of minor illness in favour of the acute, epidemic outbreaks. This is usually by necessity as morbidity is much harder to define, even more so for the infrequently reported day-to-day conditions. However, it is important to reflect that these ailments were what the GPs dealt with most often, if not 'upon the visiting list [then] upon the consulting room list.'[608] This is a theory also reinforced by the populations' apparent reliance on herbalists and self-treatment of minor complaints for those reluctant to visit a GP.

The second part of the chapter evaluated the IMR of Middlesbrough at the beginning of the twentieth century, most crucially the impact that the First World War had upon the figures. Middlesbrough exhibited exceptionally high mortality rates amongst those under five years of age for at least the first five decades of the twentieth century. The rate for the town did not at any point prior to the 1950s drop below the national average for England and Wales. Additionally, Middlesbrough found itself at odds with the towns in closest proximity to it, such as Stockton and Darlington. The reasons behind this appear to have been manifold, and in essence compounded the town's problems in dealing with the high number of infant deaths. The town was also repeatedly singled out in national reports as having a worryingly poor record of infant mortality.

The possibility has to be considered that perhaps the town authorities looked in the wrong places for solutions, relying on the notion that it was the responsibility of the townspeople to address such issues and adjust their behaviour accordingly. This train of thought was one that was reinforced by several national reports, where the blame for high mortality rates was firmly placed at the parents' door. Financial resources in Middlesbrough were stretched, especially those reserved for healthcare, prone as the town was to epidemic disease outbreaks. Therefore, funds were bypassed from proactive health campaigns and were instead spent on addressing the most urgent and pressing needs. This lack of foresight

[608] *Ibid*. This is a concept that was revisited during the interviews with the retired GPs from the 1950s onwards in chapter IV.

probably prevented infant deaths from being significantly reduced.[609] The problem of infant mortality was also dependent upon the decisions of the MOH. In Middlesbrough, Dingle was far less focused on the issue of child welfare than his counterpart in Stockton was to be in the years following the war.[610]

However, the composition of the town during the early years of the twentieth century does suggest a level of inexperience amongst mothers. This was so much so that Dr Fulton cited it as a possible explanation for why the rates seemed to be so high. Therefore, the social composition of the town cannot be entirely discounted as a contributing factor. As with all towns during the First World War, medical provision in Middlesbrough was affected. The GP community was an aged one, with the younger members of the profession being sent to the frontline of the war. Those left behind had to attend to the returning wounded soldiers at Hemlington Hospital, almost to the point of prioritization over the rest of the community. The GPs did not feature heavily in contemporary debate concerning infant mortality in Middlesbrough. However, their professional counterparts' decades later would exhibit no ill will towards the community they served, placing no blame at the door of their patients. If this is a perception that was carried over through the history of the town then the judgements of the MOH of Middlesbrough and the local authorities might be based on the prevailing attitudes of the time.[611] This might have been born out of a desire to forfeit any responsibility themselves and appear blameless to the all-important ratepayers of Middlesbrough.

Levene, Powell and Stewart have recently looked at the inter-war choices of County Borough authorities in the provision of health services. They make the valid point that Boroughs that had poor housing or unhealthy wards had a greater requirement for health

[609] The point of spending to prevent deaths in the future had already been considered as a possible issue during the war years. Pritchard, 'Some Recent Documents on the Subject of Infant Mortality', pp. 223-30.
[610] McGonigle in Stockton was actively involved in child welfare and the implementation of clinics for mothers to attend. This interest eventually earned him the moniker 'The Housewives Champion'. McLaurin, *The Housewives' Champion*.
[611] Based also on the experiences of Birmingham, Sheffield and Leicester.

services than healthy Boroughs.[612] This would certainly have been the case in early twentieth century Middlesbrough, combined with the problem that these Boroughs often had the least money available to spend.[613] In the inter-war period, the national government placed emphasis on forcing local authorities to provide certain health services such as Maternity and Child Welfare.[614] Similarly local authorities in Middlesbrough during the early twentieth century felt pressurized by the LGB to respond to certain health threats above others. Therefore, if resources had to be prioritized in one area, it was inevitable that other health services or issues would be compromised.

The next chapter shall examine the plans to change the nature of healthcare in the wake of the First World War and the arrival of the Second. It shall also review the role of the GP in Middlesbrough during the 1920s and 1930s, and how they subsequently came to shape and influence healthcare provision in the town.

[612] Alysa Levene, Martin Powell and John Stewart (2005), 'Investment Choices? County Borough Health Expenditure in Inter-War England and Wales', *Urban History*, **32(3)**: p. 437.
[613] *Ibid*.
[614] *Ibid*., p. 456.

## Chapter III: 1920-1950: The Interwar Years and the Aftermath of World War II

This period charts the post-war position of the region. In Middlesbrough and the surrounding area, the war had been a period of furious industrial endeavour through the production of munitions as part of the war effort. This began to decline rapidly after the end of the war as demand, naturally, slumped. This led to a high unemployment rate within the district that continued throughout the 1920s leading into the depression of the late 1920s and early 1930s. This, in turn, had an enormous impact on the health of the region as many struggled to make ends meet, living in substandard conditions with an inadequate diet. In addition, as many were unemployed they could not contribute to the NHI or the various work-based societies and clubs that would have provided for them and their families in times of ill health. Clearly, this was a time of monumental change within the region. It provides the chance to observe the effect on both the community and their practitioners. Health was under threat from industry once more, but this time from the lack of it.

At the same time, numerous medical developments took place throughout this period. There were improvements and advancements as a direct result of the war. These included developments in surgical techniques, plastic surgery, orthopaedics and prosthetics.[615] These would have been particularly welcomed in a region dominated by heavy industry, and the subsequent accidents that it brought.[616] The development of drugs such as sulphonamides proved to be useful in the case of conditions like pneumonia, which was still a leading cause of death in Middlesbrough. Infectious disease had declined rapidly in the region, although non-communicable diseases such as cancer and coronary heart disease, both of which increased dramatically in the district during the post-war period, had replaced them.[617]

[615] Harris, *The Origins of the British Welfare State*, p. 220.
[616] Roger Cooter (1993), Surgery and Society in Peace and War: Orthopaedics and the Organization of Modern Medicine, 1880-1948, Palgrave Macmillan, Basingstoke.
[617] TA/CB/M/H/11, Medical Officer of Health Annual Report for 1930.

The 1920s and 30s saw a marked improvement in the health of the nation post war. There were noticeable advances too within the region, as mortality and infant death rates began slowly to decline. That is not to suggest that things improved to such an extent that towns like Middlesbrough now found experienced mortality and morbidity statistics anywhere near those of the national average. The improving situation suffered a blow in the late 1920s and early 1930s by an economic depression that left many without work or any source of regular income.[618] Even the arrival of the petrochemical industry in the form of Imperial Chemical Industries (hereafter, ICI) in the late 1920s did not influence employment in the region in the way developers initially anticipated.[619]

The Second World War meant the removal of large numbers of GPs from Middlesbrough to serve abroad, once again the population became reliant on the older members of the profession to serve and support the town. Then, perhaps most notably, after the war in 1948 came the arrival of the NHS. This provided the most dramatic changes in the provision of medical care since the NHI in 1911, as now all citizens could be included in the plan. GPs were the medical body most heavily affected by the scheme these doctors were the primary source of medical provision and interaction for most people, even in a town like Middlesbrough where hospital provision was exceptionally strong. One of the biggest medical advancements of the post-war period was the development of antibiotics in the late 1940s; penicillin first, quickly followed by streptomycin.[620]

This chapter will examine the work of the GPs within the community and identify them amongst the historical record, looking at obituaries, trade records, and the Medical Directory. Additionally, it shall assess the perceived positives of decline, especially amongst the practitioners, and most vocally the MOH, of the town, alongside plans to improve the structure of the town to maximise health and healthcare provision. Finally, this chapter will

[618] John Stevenson and Chris Cook (1994), *Britain in the Depression: Society and Politics 1929-1939*, Longman, London.
[619] Carol Kennedy (1986), *ICI: The Company that Changed our Lives*, London, Hutchinson.
[620] Anne Hardy and E. M. Tansey, 'Medical Enterprise and Global Response, 1945-2000', in William F Bynum, Anne Hardy, Stephen Jacyna, Christopher Lawrence and E. M. Tansey (2006), *The Western Medical Tradition 1800 to 2000*, Cambridge University Press, Cambridge, pp. 470-472.

begin to explore the impact of the arrival of the NHS in 1948, and the subsequent choices that the GPs within the region were forced to make, a theme which carried over long after the inception of the NHS.

## Jack-of-all-Trades or Master of None: Identifying the General Practitioner

One of the inherent difficulties involved in any review of a professional group is trying to locate their 'voice'. By this, we mean their identity, their opinions and indeed those things that categorized and punctuated their daily working lives. If one wanted to study the working practices of GPs today, one would simply go directly to them with an enquiry; in short, one could ask them. This, unfortunately, is not a viable option when trying to evaluate the same criteria for the interwar years. This opportunity has sadly passed, as the majority are no longer alive and their memories are inaccessible. They can only be retrieved through the reminiscences of others, or perhaps through a review, if applicable, of their published work. There are a number of ways in which a clearer picture of the profession during this time can be assembled and provide an insight into the GPs lives and roles within Middlesbrough.

Possible available sources include local trade directories, medical directories and obituaries. Historians Dupree and Crowther have assiduously reviewed the numerous issues raised by using these kinds of sources to gather a 'collective biography'.[621] Their work on the Scottish medical profession in the nineteenth and early twentieth centuries included a close and extensive study of both obituaries and the Medical Directory.[622] They comment on the 'invisibility' of the general practitioners in the medical literature; remarking that their presence

[621] Anne Digby and Helen Sweet used this term to describe the use of obituaries in General Practice. Anne Digby and Helen Sweet, 'Collective Biography and the History of General Practice' in Jonathan Andrews, Helen Bartlett and John Stewart (eds.) (1998), *Historical and Contemporary Perspectives on Health, Illness and Health Care Provision in Britain since the Seventeenth Century: Discussion Papers*, Oxford Brookes University, Oxford, p. 55.

[622] Marguerite W. Dupree and M. Anne Crowther (1991), 'A Profile of the Medical Profession in Scotland in the Early Twentieth Century: The *Medical Directory* as a Historical Source', *Bulletin of the History of Medicine*, **65:** pp. 209-33. Anne Crowther and Marguerite Dupree (1996), 'The Invisible General Practitioner: The Careers of Scottish Medical Students in the Late Nineteenth Century', *Bulletin of the History of Medicine*, **70**: pp. 387-413.

is best and most frequently observed 'en masse' in the medical journal, in relation to issues of legislation and working conditions. Also of concern is the problematic nature of obituaries, namely, who received one, who wrote it, and indeed the journal of publication. Similar problems arise when using the Medical Directory, as the practitioners almost had *carte blanche* as to what they could include.[623] This could lead to the inclusion of copious and somewhat spurious titbits of information, especially amongst the younger practitioners trying to make a name. Dupree and Crowther also note that the Medical Directory, whilst listing appointments and publications, did not specifically identify whether doctors were a GP. This concern can to some extent be dealt with by cross-referencing the GPs in local trade directories that list them as 'surgeons' or 'general practitioners'. This can in turn be clarified further by locating those same names in medical obituaries, found in journals such as the *BMJ* or the *Lancet*. Note should be made at this point that the number of obituaries found in the *BMJ* is greater than in the *Lancet*; however, these practitioners do appear to be those who were closely involved with the BMA.

Dupree and Crowther, publishing in 1991, alluded to the lack of detailed studies there had been using such historical sources within Britain, except for the work of Irvine Loudon and Hilary Marland, which tended to focus on the 1858 Medical Act.[624] In 1998, Anne Digby and Helen Sweet published a paper concerning the history of general practitioners, observable through obituaries.[625] However, other than this handful of studies, and a more generalized one by John Welshman in Leicester, there has been a discernible lack of interest shown in the area.[626] This sub-chapter aims to address the issues these publications raise and utilise their methodology to try to develop a clearer idea of the structure of general practice. In the case of Middlesbrough, there is also, rather fortuitously, the Stout archive that contains a number of interviews with retired practitioners in the early 1980s, many of which had been in practice from the 1920s through to the 1940s.

[623] Dupree and Crowther, 'A Profile of the Medical Profession', p. 213-4.
[624] Loudon, *Medical Care and the General Practitioner* and Marland, *Medicine and Society*.
[625] Digby and Sweet, 'Collective Biography'.
[626] Welshman, *Municipal Medicine*.

However, even with these interviews that Stout collected, there has to be an element of caution exercised when reading them. Some were recorded with surviving spouses or children rather than the actual GPs, so there is a tendency, as with the obituaries, to eulogise and overplay achievements. Nonetheless, they still serve as a useful source when used as only part of the wider examination. Medical obituaries and directories have tended to be used to track the career paths and educational histories of a group of cohorts. This study, however, is much more concerned with the roles, inter-connections and social duties of the practitioners within the town. Dupree and Crowther do not discuss the social roles of the doctors, whilst acknowledging the social status this conferred; they show interest only in their medical appointments.[627] In a town such as Middlesbrough, it is necessary to reflect upon civic duties, and the status and influence this would have provided the doctors, particularly concerning industrial and council based roles.

*Ward's Trade Directory* for Middlesbrough lists the surgeons and GPs of the town.[628] It is noticeable that many of Middlesbrough's GPs also held honorary consulting or surgical positions within one or more of the charitable hospitals. For example, GPs with a speciality could secure a position in more than one hospital. In Middlesbrough during the 1920s, Dr. J.P. Higham was not only a GP in the Linthorpe Road area but also an ophthalmic surgeon to the North Ormesby Hospital and North Riding Infirmary.[629] The same situation occurs with Dr. G.H. Lowe, working as a GP in the Newport Road district, whilst acting as an anaesthetist to the North Ormesby Hospital and an honorary anaesthetist to the North Riding Infirmary.[630]

Of those who received an obituary in the *BMJ*, most were active, long-serving and loyal members of the BMA. Indeed, of the 27 obituaries located within the journal (for those who had practised in from around 1900-1940), eight had at some time served as chair of the

[627] Dupree and Crowther, 'A Profile of the Medical Profession', pp. 223-26.
[628] *Ward's Directory 1898-99: Darlington, Hartlepool, West Hartlepool, Stockton, Thornaby and Middlesbrough*, R. Ward, Newcastle-Upon-Tyne. *Ward's Directory 1921-22: Darlington, Hartlepool, West Hartlepool, Stockton, Thornaby and Middlesbrough*, R. Ward, Newcastle-Upon-Tyne.
[629] *Ward's Directory 1921-22*, pp. 455-6.
[630] *Ibid.*

Cleveland Division of the BMA and numerous others had been secretaries or assistants. For example, Dr James Brownlee (1878-1943), was described as '[a] life-long member of the BMA and one of its severest critics, he had been President of the North of England branch…'[631] Dr James Donaldson (1876-1930), was recorded in his obituary as being a 'keen BMA man', whilst Dr Robert E. Howell (1866-1936), '…had rendered many and valuable services' to the association.[632]

The obituaries tend to be, understandably, biased and deferential in tone, usually written by a close friend and colleague, and even on occasion offspring who themselves were practising GPs. Despite this, obituaries do provide an opportunity to observe a whole generation of GPs and their various commitments, not only in terms of their professional work but also in relation to the wider community. The obituary of Dr Frank Mort (1873-1929) colourfully describes his memorial service, recalling how '…at his funeral men and women were seen weeping in the streets.'[633] The former mayor of Middlesbrough, Dr John Hedley (1843-1927), had an equally distinguished send-off; his obituary described how 'his funeral service was attended by the principal citizens of the county borough for which he had done so much.'[634]

There were a number of medical men (and women) over the nineteenth and early twentieth centuries that held post within the town such as Councillor, Alderman, Mayor and Justice of the Peace (*Table 23*). [635]

[631] Anon (1943), 'Dr J. Brownlee', *The British Medical Journal*, **4289(1)**: p. 366.
[632] Anon (1930), 'Dr J. Donaldson', *The British Medical Journal*, **3611(1)**: p. 571 and Anon (1936), 'Robert Edward Howell, M.B., C.M. Consulting Physician, North Ormesby Hospital, Middlesbrough', *The British Medical Journal*, **3913(1)**: p. 41.
[633] Anon (1929), 'Obituary: Frank Mort, M.B. Glasg.', *The Lancet*, **5501(213)**, p. 265.
[634] Anon (1927), 'Obituary: John Hedley, M.D. Durh., L.S.A., J.P.', *The Lancet*, **5398(209)**, p. 363.
[635] TA/Accession 3720, Box 10.5, Envelope 5, Medical Town Councillors 1853-1968.

*Table 23*

Middlesbrough Medical Town Councillors and Justices of the Peace, 1853-1968

| Medical Town Councillors | Justices of the Peace |
|---|---|
| • P.B. Considine<br>  ○ Marsh Ward 1902-1906<br>• H.D. Levick<br>  ○ Linthorpe Ward 1920-1938<br>  ○ Alderman 1938-1943<br>  ○ Mayor 1930<br>• Mrs H.M. Levick<br>  ○ Grove Hill Ward 1926-1932<br>• C.L. Elder<br>  ○ Park Ward 1957-1968<br>• John Richardson<br>  ○ Middle Ward 1853-1858<br>  ○ Alderman 1858-1872<br>  ○ Mayor 1858<br>• John Hedley<br>  ○ South Ward 1886-1898<br>  ○ Middle & Grove Hill Wards 1898-1904<br>  ○ Alderman 1904-1925<br>  ○ Mayor 1902 | • John Hedley (c1880)<br>• John Richardson (c1880)<br>• John Ellerton (c1890)<br>• F.O. Graham (c1950)<br>• H. Kay (c1960) |

Source: TA/Accession 3720, Box 10.5, Envelope 5, Medical Town Councillors 1853-1968.

The obituaries also highlight the numerous, medically related appointments that the GPs took on, even outside of their honorary hospital positions. Some worked at the turn of the century as public vaccinators, school medical officers, on education boards and insurance company panels. As Middlesbrough was an industrial town, GPs often found employment as medical officers for the various works scattered throughout the town. Such roles were often recorded as one of the individual's principle achievements within their obituary. For example, Dr William J. Williams (1841-1920), was recorded as being '…a Justice of the Peace for the Borough and a patron of most of the institutions of the town.'[636] Dr William Knott (1857-1931), 'was a public vaccinator and honorary medical officer to Dr Barnado's Home and to North Ormesby Orphanage.'[637] Not only high profile roles warranted a mention but also their involvement in panel practice. Dr Brownlee was a 'keen insurance practitioner, he was a

[636] Anon (1920), 'Dr W.J. Williams', *The British Medical Journal*, **3089(1)**: pp. 386-387.
[637] Anon (1931), 'Dr William Knott', *The British Medical Journal*, **3678(2)**: pp. 39-40.

member of the Middlesbrough Panel Committee from its formation and its Chairman.'[638] Dr Donaldson was 'the first secretary of the Middlesbrough Panel Committee, afterwards becoming its Chairman.'[639] The Freemasons also featured heavily within the obituaries during this time. Dr Harry Levick (1866-1958), was not only a President of the British Legion but also a 'past master of the local lodge of Freemasons.'[640] Likewise, Dr Donaldson was an 'enthusiastic Freemason'.[641]

The lives of the GPs outside public roles and medical appointments also received comment, usually if there was not a great deal other information available. Dr Arthur Bryans (d. 1933), had been the medical officer to Middlesbrough Football Club for thirty years.[642] His outside interests were recorded as 'many and varied' seemingly in spite of 'the demands of a large general practice'.[643] Dr Brownlee was described as an 'active man and fond of outdoor exercise and games'.[644] Even the wartime achievements of the doctor's would be included, sometimes at great length, listing their rank and service record. Dr Thomas M. Body (1876-1957), for example, served as a Captain in the R.A.M.C. during the First World War in France, Mesopotamia and India.[645] Rarely was any mention made of their medical achievements, but if it did warrant inclusion, it was usually to commemorate surgical milestones within the town's history. Dr George F. Longbotham was 'the first person in Middlesbrough to remove tonsils…' and Dr Levick performed '…the first abdominal operation in Middlesbrough and the first amputation without "laudable pus".'[646] The attitudes of the GPs towards their patients and the people of Middlesbrough are expressed throughout the obituaries. Dr Mort was said to be 'always gentle, always courteous, even when the stress

[638] Anon, 'Dr J. Brownlee', p. 366.
[639] Anon, 'Dr J. Donaldson', p. 71.
[640] Anon (1958), 'H.D. Levick, M.B., F.R.C.S.', *The British Medical Journal*, **5093(2)**: p. 454.
[641] Anon, 'Dr J. Donaldson', p. 71.
[642] Anon (1933), 'Dr Arthur Bryans', *The British Medical Journal*, **3771(1)**: p. 680.
[643] *Ibid*.
[644] Anon, 'Dr J. Brownlee', p. 366.
[645] Anon (1957), 'Dr T.M. Body', *The British Medical Journal*, **5015(1)**: p. 409.
[646] Anon (1958), 'G.F. Longbotham, M.B., C.M.', *The British Medical Journal*, **5094(2)**: pp. 516-517 and Anon, 'H.D. Levick', p. 454.

was great…'[647] Likewise, Dr Longbotham, 'showed some great kindness to his patients in the grim days of the Tees-side depression.'[648]

These men and women certainly approached their lives and careers vigorously, appearing to have actively collected roles and titles. It must be noted that this was during, in the main, the pre-NHS period, and patient list sizes could be in excess of 3,000 combined with long working hours, punctuated by home visits and night calls. The only puzzle within the picture painted is how these GPs found enough hours in their day to fulfil the needs of all their various commitments.

By using the Medical Directory, it is possible to identify women practitioners immediately, due to a peculiarity in the way they are listed in the publication. Unlike their male counterparts, women's first names were included in the reference list for each town. In the case of Middlesbrough, there were five women listed as practitioners in 1930, three of whom were actively involved in child and maternity welfare services in the town.[649] Of the remaining two, one had been an assistant MOH in West Ham and the other a former medical superintendent at the Holgate Hospital in Middlesbrough from 1920-23. As found in Dupree and Crowther's study, women tended to work for and with other women, finding their refuge often in child welfare.[650] Dr Grace Dundas was the Medical Officer for this division of medical care in the 1920s.[651] Mrs (Dr) H. 'Minnie' Levick was part-founder of the first voluntary child-welfare centre. She also served as the president of the Middlesbrough branch of the National Council of Women.[652] However, Mrs Levick was also married to an influential member of the profession, Dr Harry Levick, who would eventually go on to be mayor of the town. Minnie Levick also became chair of the Cleveland Division of the BMA from 1927-8, a prestigious role indeed, especially for a woman in a deeply male dominated environment. It

[647] Anon (1929), 'Dr Frank Mort', *The British Medical Journal*, **3553(1)**: pp. 275-276.
[648] Anon, 'G.F. Longbotham', p. 517.
[649] *The Medical Directory 1930*, J and A Churchill, London, p. 1273.
[650] Crowther and Dupree, 'The Invisible General Practitioner', p. 404.
[651] Anon (1933), 'Dr Grace H. Giffen Dundas: Obituary', *The British Medical Journal*, **3805**: p. 1097.
[652] Anon (1961), 'H. Minnie Levick: Obituary', *The British Medical Journal*, **5252:** pp. 652-653.Mrs Levick became involved with matters of education, maternity services and various insurance panels within the town. Stout, 'Three Eminent Middlesbrough Women', pp. 40-41.

is clear from both of their obituaries that the Levicks' were admired and respected members of the community, holding numerous high profile roles in the town, quite outside of their medical positions.

If we compare the location of surgeries from the directory of 1898/99 with the one of 1921/22, we can see a perceptible shift towards the south and central districts of the town.[653] The table below (*table* 24) compares these two periods and how the GP surgeries moved within the town.

*Table 24*

Location of GP Surgeries in Middlesbrough 1898/99 & 1921/22

| Wards | 1898-99 | 1921-22 |
|---|---|---|
| Vulcan, Cannon, Newport, St. Hilda's | 1 | 1 |
| Linthorpe | 4 | 17 |
| Ormesby | 0 | 0 |
| Ayresome | 0 | 0 |
| Acklam, Cleveland, Exchange | 19 | 19 |
| Grove Hill | 1 | 0 |
| Other (not identifiable) | 5 | 6 |

Source: Ward's Directory 1898-99: Darlington, Hartlepool, West Hartlepool, Stockton, Thornaby and Middlesbrough, R. Ward, Newcastle-Upon-Tyne. Ward's Directory 1921-22: Darlington, Hartlepool, West Hartlepool, Stockton, Thornaby and Middlesbrough, R. Ward, Newcastle-Upon-Tyne

In the early 1920s, the immediate post-war period, the number of GPs increased from 24 to 38, and the number of premises grew from 30 to 43.[654] Obviously, the implication of these figures was that some doctors now resided at more than one surgery, additionally there had been the development of two-man practices. There was a move from the northern wards towards the centre of the town, namely into the lower Linthorpe Road area. There was now only one GP surgery in the Vulcan, Cannon, Newport and St. Hilda's wards. Whilst even at the turn of the century there had been a negligible number of surgeries in these wards, many more had been located just below in the Acklam, Cleveland and Exchange Wards. By the 1920s, this trend had begun to change, as more surgeries emerged in the central wards.

[653] *Ward's Directory 1898-99* and *Ward's Directory 1921-22*.
[654] *Ibid*.

The figures seem to suggest that any new practices that opened between 1898 and 1921 tended to do so in the Linthorpe ward, specifically, on the southern end of Linthorpe Road. This would have been an ideal choice for the GPs as it was the arterial road through the main complex of the town at the time. Additionally it was far enough away from the industrial zone to offer superior accommodation to the doctors' and their families. Ultimately, the effect was further deterioration of the links between the deprived areas and access to medical care. Understandably, the doctors wanted to live in more salubrious surroundings, especially as their surgeries often also doubled as their homes. This meant that they would be moving further away from their patients a point not lost upon town surveyors, observable by the mid-1940s when the problem became even starker. This consequently led into further disputes by the late 1960s and early 1970s with the arrival of health centres.

This section of the chapter has examined the location of the medical profession within Middlesbrough as well as doctors' varied roles and commissions. The next step, therefore, is to assess the health of the community and evaluate how the depression of the late 1920s and early 1930s affected this industrial town.

## Depression and the Positives of Decline

MOH reports within Middlesbrough at the start of this period have a generously optimistic tone to them. IMR, mortality rates and the incidence of infectious disease had all begun to decline after the end of WWI. Social historian Katherine Nicholas pointed out, during the early 1920s Middlesbrough's MOH Dingle was so relieved to see improved health amongst the population of the town that he focused on that rather than the larger issue of to what extent health was improving, especially when compared to the national situation.[655] Dingle even went as far as to describe health conditions in the town as 'exceptionally good'; this was somewhat misleading. However, given the distinct lack of opportunities to 'celebrate' in

[655] Nicholas, *The Social Effects of Unemployment*, p. 80

previous annual reports over his twenty years in charge, this exuberance is understandable if a little misplaced. Dingle, at times, was not beyond turning the negative into the positive by using what we would now call 'spin'. The decline in industry and the increase in unemployment that began to manifest itself within the region during the early 1920s were factors Dingle came to regard as a plus in terms of health. He contemplated that the reduction in industrial production meant less pollution and improved wellbeing for the community. The lack of ready income, he contested, meant that there was not as much available to be spent on alcohol, something which was always viewed as a positive.[656]

There was now a tendency in the MOH annual reports to compare mortality statistics for Middlesbrough with other areas of the country rather than the previous health record.[657] MOHs now started to ask pertinent questions, namely why were things not improving to the same level that appeared in the rest of the country. This question doggedly persisted in Middlesbrough throughout the first half of the twentieth century. There were improvements, but when placed in direct comparison with elsewhere the mortality statistics were still excessively high. This may well explain why any self-congratulating on behalf of the MOHs was short lived. Conditions in Middlesbrough had been so severe that even a small positive seemed like good news and possibly delayed serious questions being asked and addressed.

Dingle provided two potential positives derived from the industrial decline; firstly, he cited lower atmospheric pollution as a potential reason for health gains. Secondly, the lower IMR observable at the time of his report in 1923 was potentially due to a decrease in wages reducing alcohol consumption amongst mothers.[658] However, he did not mention any negative effects that the economic downturn might bring in terms of health. Was this merely an attempt by Dingle to put a positive spin on an otherwise negative situation perhaps? There was a fall in death rates and IMR in 1923, but it was short lived, and IMR increased

[656] *Ibid*., p. 81.
[657] *Ibid*., p. 83.
[658]TA/CB/M/H/10 'Annual Report of the Medical Officer of Health 1923, Middlesbrough', Teesside Archives, Middlesbrough.

again in 1924.[659] The IMR had declined but it was still much higher than the national average at almost twice the rate for England and Wales by 1924. The employment situation had not significantly improved. Therefore, following Dingle's logic there should have been a further reduction rather than a jump from 86 infant deaths per 1,000 to 135 deaths per 1,000.[660]

The medical profession of Middlesbrough felt that they were experiencing a marked decline in cases of infectious disease.[661] In reality, if the period 1920-1930 is compared with 1909-1919, the decline is not as significant as assumed. Scarlet fever increased in the number of notifications when taken as an average, although there was a decrease in the number of deaths due to diarrhoea, enteric fever and whooping cough. This may well feed into the idea that infant mortality was declining as these were among the key causes of death. In the case of TB, there was no change between the two periods, at least in the number of deaths. It is difficult to compare notifications, as TB only became a disease requiring notification to the MOH in 1912, although the number of notifications does appear to rise significantly from 1912 to 1930.[662] Measles notifications steadily rose from 1920 to 1930, although deaths due to the disease did drop by nearly a third in the 1909/1919 period, probably as a direct result. There are some obvious gains between the two periods, but closer inspection of the 1920-30 interval reveals little significant decline in morbidity but improvements in mortality. In fact, at the beginning of the 1930s notifications had risen for scarlet fever, measles and TB. Therefore, whatever gains were made during the First World War and the period immediately afterward, appear to have been lost during the 1920s. Perhaps the medical profession within the town had become somewhat desensitized to the magnitude of the diseases they dealt with on a daily basis.

Respiratory conditions continued to be problematic. One sentence within Dingle's report best illustrates the tone as a whole: 'With regard to treatment of Respiratory Disease,

[659] *Ibid.*
[660] TA/CB/M/H/11, Medical Officer of Health Annual Report for 1930.
[661] *Ibid.*
[662] TA/CB/M/H/11, Medical Officer of Health Annual Report for 1930.

it is probable at present that much less is done than could properly be done.'[663] There is though, no suggestion as to what this might be or might mean in terms of combating the disease. The MOH pointed out the problems and deficiencies of the town's health but had little or no suggestions for improving the current situation. This appears to be a trend within the MOH reports for Middlesbrough at this time. In the annual report for 1926, Dingle noted that:

> One most unsatisfactory fact in relation to the health of this town at present is the high mortality from Respiratory Diseases due to the number of fatal cases of Pneumonia, which are approximately twice as many per 1,000 of the population as they are in other towns in the North East Coast Area.[664]

Once again, there is a tendency to state what is, in all likeliness, already known to the medical community within the town, offering, once more, little in the way of advice. During the 1930s, there was a slump in production and the worst affected areas tended to be those that were heavily industrialized, the North East of England was amongst the most ill affected. In Middlesbrough at the time of the General Strike in 1926 male unemployment stood at 45%, compared to a national average of 14%.[665] The situation in Middlesbrough was in a constant stage of change as the fortunes of the iron and steel industry fluctuated. The mere fact that this situation occurred may well explain the decisions behind the town not being included in the government's 'Special Areas' scheme.

One of the provisions included in this policy was that quotations for contracts coming out of these areas received preference. This placed Middlesbrough at an immediate disadvantage, as it struggled to compete with the rest of the country and its competitors. A supplement entitled *Teesside and its Industries*, which accompanied the *Daily Telegraph* in 1935, proclaimed, rather erroneously, 'The association of the heavy industry in Middlesbrough in no way affects the health of the population, the standard of which is, in

[663] TA/CB/M/H/11, 'Annual Reports of the Medical Officer of Health, 1926-1930', 1925 Report, p. 11.
[664] *Ibid*. 1926 Report, 'Address to the Chairman and Members of the Sanitation Committee', p. 5.
[665] Elizabeth Porter (1973), *Pollution in Four Industrialised Estuaries : Studies in Relation to Changes in Population and Industrial Development: Four Case Studies Undertaken for the Royal Commission on Environmental Pollution*, H.M.S.O., London, p. 5.

fact, exceptionally high.'[666] This somewhat overstates the situation this was, however, a nationally distributed publication with a wide readership, therefore, authors of the publication were unlikely to highlight Middlesbrough's deficiencies, when the aim was clearly to promote the area in a time of crisis.

The Special Areas had been defined in 1934 by a government commission. The aim was to bring work to regions that had been markedly affected during the depression.[667] In 1934, these areas were initially named as Tyneside, Glasgow, South Wales, Durham and West Cumberland.[668] The North Eastern division of the depressed areas did include Middlesbrough, Stockton and Thornaby in the primary survey.[669] However, they were excluded from the list whilst Newcastle, Durham, Hartlepool and Sunderland managed to be included. There was, at this time, an overriding perception that the steel and iron industry was relatively prosperous, especially when compared to the coal and shipping industries.[670]

It was contrary to the remit of the Special Areas Commissioner to assist private industrial concerns.[671] Therefore, given the nature of industry in Middlesbrough it is understandable why the town was overlooked, it was not a question of necessarily attracting new employers to the town but supporting existing ones. John Mohan has reviewed hospital provision in the designated Special Areas and they were general found to be lacking due to their dependence on the voluntary sector for contributions.[672] The situation regarding the allocation of Special Area grants impacted heavily on the wider north east region, even compromising the establishment of the Poole Joint Sanatorium. The sanatorium, for the treatment and convalescence of TB sufferers, was a joint endeavour between the councils of

[666] *Ibid*., p. 15.
[667] William R. Garside (1990), *British Unemployment 1919-1939: A Study in Public Policy*, Cambridge University Press, Cambridge p. 251-6.
[668] There appears to be a strong link with coal mining areas and the declaration of a Special Area, although in the case of West Cumberland this was iron. Therefore, it seems to be a case of prioritising one industry over another.
[669] Hansard: HC Deb 05 March 1936 vol 309 cc1534-8.
[670] Hansard: HC Deb 23 July 1935 vol 304 cc1669-793.
[671] John Mohan (1997), 'Neglected Roots of Regionalism? The Commissioners for the Special Areas and Grants to Hospital Services in the 1930s', *Social History of Medicine*, **10(2)**: p. 246.
[672] *Ibid*., pp. 248-49.

Middlesbrough, West Hartlepool, Sunderland, South Shields, Darlington and Gateshead.[673] Middlesbrough, unlike the other collaborative authorities, was refused a grant, even though its rates were higher than West Hartlepool, which did receive a grant.[674] Mohan makes the case that using rate poundage (it was considered that lower rates would attract industry) was problematic, as although it indicated financial stress it did not necessarily measure economic stress.[675]

Unemployment in the region had always been a contributing factor to the problems associated with health. The main problem was that the area had tended to exhibit an extreme relationship with employment levels. Specifically, enduring either high unemployment rates, with all the associated issues of poverty, deprivation and inequality of services, or, periods of unparalleled prosperity, when industry flourished and above average wages were commonplace. In Middlesbrough, where the iron and steel industries were dominant until the 1930s, wages were above those of their neighbours working in the County Durham coalfields.[676] The metal industry was not prone to strikes in the same manner associated with the coal industry. It was only in the General Strike of 1926 that the metal industry became involved in widespread industrial action.[677] Knowles attributes the lack of dispute within the industry to 'the sober character of the leadership on both sides of a well-organised industry'.[678] Wages paid to the workers were dependent upon the tonnage they produced, therefore, even when the price of iron and steel collapsed, men were still better paid compared to those industries that were flourishing.

There was also a much more diverse array of industry in Middlesbrough than in these other areas.[679] However, it was still used to both regular short-term unemployment as well as

[673] Taylor *et al*, 'Central and Local Government', p. 418-23. When no agreement could be reached between the councils in the early stages of negotiations, it was the Ministry of Health that the councillors looked to, to add weight and persuasion behind the scheme
[674] Mohan, 'Neglected Roots of Regionalism', p. 253. West Hartlepool rates were 10s 6d in the pound, Middlesbrough rates were 13s 6d in the pound.
[675] *Ibid*., p. 254.
[676] Knowles, *Strikes: A Study of Industrial Conflict,* p. 172.
[677] *Ibid*.
[678] *Ibid*.
[679] By the 1930s the petrochemical industry and retail and manufacturing trade was also beginning to expand.

the longer-term experienced in the 1920s and early 1930s.[680] Particularly affected were men over fifty and those with little skill or training in their early twenties. After the First World War women had tentatively found their way into the workplace, often on a part-time basis as cleaners or seamstresses, especially as the number of clothing factories in the town began to rise. Women were the first to be laid off, especially if the position the woman held could be given to a man. In addition, societal pressure came into play; there was a stigma for a married woman to be seen to be the breadwinner, at least for the males of the family.[681]

Pollution was at this time a significant concern within the region, not solely in the form of atmospheric contamination. A report dated 1932 outlined the apparent pollution of the River Tees due to raw sewage deposited into it at ebb tide. The area affected was extensive and included Stockton, Billingham, Hartlepool, Middlesbrough and Redcar.[682] The MOH concluded, after conducting bacteriological tests on shellfish from the river at various points that they had been so badly contaminated that they were unfit for human consumption, and particularly dangerous if eaten raw. In an area susceptible already to high rates of diarrhoea and vomiting, this was a cause for serious concern. Therefore, a clean-up of the river was required, additionally, the source of the sewage entry needed to be determined. This had been a recurrent feature in the town from the early 1900s onwards, featuring in MOH reports and even the subject of a paper in 1912 by the then Assistant MOH, R.J. Ewart, questioning the cleanliness of the River and Tees and the prudence of consuming shellfish from the estuaries.[683] This increased interest coincided with national debate concerning the link between typhoid and sewage-contaminated shellfish during the same period.[684]

Industrial pollution continued its reputation as one of the leading factors as to why respiratory illnesses had been a prolific killer for over a hundred years within Teesside. Pneumoconiosis affected workers, due to the inhalation of heated dusts containing silica,

[680] Nicholas, *The Social Effects of Unemployment*, p. 32.
[681] *Ibid.*, pp. 26-7.
[682] TA/CB/M/H/13 'Special Reports of the Medical Officer of Health, Middlesbrough, 1930, 31 & 32'. This is taken from a letter to the Sanitation Committee dated February 6th 1932.
[683] Doyle, 'Managing and Contesting Industrial Pollution in Middlesbrough', p. 148.
[684] Anne Hardy (2003), 'Exorcizing Molly Malone: Typhoid and Shellfish Consumption in Urban Britain 1860–1960', *History Workshop Journal*, **55(1)**: pp. 72-90.

causing lesions in the lungs.[685] Workers found themselves exposed to extremes of temperature, especially within the iron and steel foundries. During the day, they worked in extreme heat, sweating profusely, only to leave the mines and workshops at dusk thus being exposed to the cooler temperature of the evening air. The combination of these two factors left workers susceptible to developing pneumonia.[686] Additionally, accidents were naturally a feature within the region, especially as many of the industries that had developed there involved heavy machinery and harmful substances. In 1924, there were 6,541 recorded work-related accidents with 65 fatalities, amongst the highest in the North East region.[687]

The arrival of the chemical industry on Teesside, heralded as a possible successor to the now ailing iron and steel works, brought with it new health complications. The land purchased at Billingham, near to both Stockton and Middlesbrough, by ICI, was to build a plant capable of producing ammonium nitrate, the basic component of fertilisers.[688] The area of land coincidently happened to be rich in anhydrite, a material required for production of the nitrate. Unfortunately, during the 1930s, due to the rapid expansion of the chemical fertiliser industry throughout the world and empire, the market collapsed, meaning diversification of the plant was required for its survival. The vision for the Billingham plant was now to produce oil using the coal readily available from just further north. The petrol plant opened in 1935 providing a welcome employment boost to the region.[689] Ultimately, however, this venture would never prove as successful as planned, and ICI at Billingham would have to develop strategies involving production and research in other areas, including dyestuffs and explosives to remain operational.

As late as 1945, came the production of the North East Development Area Outline Plan, in the case of Teesside, it stressed the need to support the chemical industry in the

[685] Donald Hunter (1959), *Health in Industry*, Harmondsworth, Penguin Books, p. 193.
[686] *Ibid*., p. 251.
[687] James Hadfield (1980), *Health in the Industrial North-East 1919-1939*, Patrington, International Institute of Social Economics, p. 167.
[688] Kennedy, *ICI: The Company that Changed our Lives*, p. 17.
[689] *Ibid*., p. 56.

region.[690] It emphasized the importance of ensuring the prioritisation of all male labour in the area be made to ICI. Thereby, suggesting that there should be no diversion of labour into other industries considering moving into the area. In doing so, like their Victorian counterparts, officials within Middlesbrough chose to 'put all their eggs in one basket'; once again, migrant labour was positively encouraged into the town. Once more, the policy makers were setting the area up for potential social and economic disaster.

The chemical industry, like its predecessors, was also associated with conditions pertaining to the lungs and respiratory tract. Inhalation of often corrosive materials could cause lesions and burning of the sensitive lining of the lungs.[691] Not only that, but irritating skin conditions, due to direct contact with the chemicals, now increased in occurrence, particularly on exposed parts of the body such as the hands and legs. ICI, however, developed a radical approach to occupational health, especially compared to the standards within industry at that time. The Billingham plant had full-time medical services by 1933, including a medical officer who was a fully qualified doctor.[692] One of his tasks was to examine employees returning to work after an extended period of absence, on behalf of the plant management. Close monitoring of the handling of hazardous substances took place to ensure that accidents, and injury, were minimised. Implementing such measures reduced the amount of working hours lost through sickness, whilst also constructing a healthy workforce. In the 1925 annual report, MOH Dingle called for increased vigilance of local authorities, and those with a 'commercial vested interest'.[693] However, he seemed to feel it was up to the individual to prevent illness from occurring by paying attention to, amongst other things, his or her own hygiene, cleanliness and domestic ventilation. During the inter-war years, emphasis was placed upon personal responsibility for the individuals' health. During this time, there was also the link between such responsibility and good citizenship, a

[690] Discussed at length in Huw Beynon, Ray Hudson and David Sadler (1986), *The Growth and Internationalisation of Teesside's Chemical Industry*, Durham, University of Durham, pp. 12-13.
[691] Donald Hunter, *Health in Industry*, p. 251.
[692] James Hadfield, *Health in the Industrial North-East*, p.169.
[693] TA/CB/M/H/11, 'Annual Reports of the Medical Officer of Health, Middlesbrough, 1926-1930', Teesside Archives, Middlesbrough.

concept cultivated during the First World War.[694] The New Health Society, established in the early 1920s to promote health and wellbeing and 'bodily discipline', led the movement.[695] The then Chief Medical Officer of Health, George Newman (1870-1948), was also a proponent of the idea of instilling 'hygienic habits and self-discipline' into all citizens.[696] However, these debates were often divisive as opponents argued that they failed to observe the link between poverty and ill health by effectively blaming the entirely individual for their personal circumstances.[697]

The region had experienced accelerated growth from the mid-nineteenth century onwards due to the expansion of industry. This resulted in much of the area experiencing an extreme housing crisis by the early part of the twentieth century. There was in 1930 the passing of a housing act to deal with the issue of slum clearance that was a widespread problem in Britain at the time. This piece of legislation freed exchequer funds to allow slum clearances to take place. Middlesbrough waited as many other towns and cities did, until after 1930 to begin to address the problems they had with housing. Not only did the act mean financial assistance and reimbursement but also much needed guidance on matters such as relocation and dispersal of larger families.[698]

The reports of the Sanitation Committee in 1932 regarding the proposed slum clearances in the Nile Street area of the town best illustrate this case.[699] A survey carried out showed that most of the houses in this area were in a poor condition. Indeed, in Brougham Street the description of number 34 is 'A BAD HOUSE'. The general fabric of the house was inferior bedrooms were damp, in both the front and back, as well as having a poor roof and yard for drainage.[700] This is not to suggest that such reports and decisions received universal approval. Indeed, these visits took place after the local community raised

[694] Ina Zweiniger-Bargielowska, (2007), 'Raising a Nation of 'Good Animals': The New Health Society and Health Education Campaigns in Interwar Britain', *Social History of Medicine*, **20(1)**: p. 76.
[695] *Ibid*., p. 74.
[696] *Ibid*., p. 84.
[697] *Ibid*., p. 79.
[698] Harris, *The Origins of the British Welfare State*, pp. 250-51.
[699] TA/CB/M/H/13 'Special Reports of the Medical Officer of Health, Middlesbrough, 1930, 31 & 32', Teesside Archives, Middlesbrough. Taken from a report entitled, 'Survey of houses petitioned against being included in the clearance scheme.' January 1932.
[700] *Ibid*.

objections to the demolition of the houses. These were, after all, people's homes; they did not want to leave their residence, which would ultimately mean separation from neighbours, family and friends. Such resistance, however, proved to be futile, the clearance going ahead, even against their wishes. However, by the post-war period this began to change, with families desiring a move away from the area to the newer housing estates, regardless of whether or not it removed them from their friends and community.[701]

The reports also highlighted the housing conditions of those suffering from TB; those with the illness tended to form clusters around the overcrowded wards of Newport, Canon, Cleveland and St. Hilda's.[702] Overcrowding assisted the spread of TB, and in these areas, it was already virtually impossible to separate anyone with the disease from the rest of their family and neighbours. Conditions across the whole of the region were not tremendously different, although due to Middlesbrough's unusual and rapid development it tended to have more pronounced problems than neighbouring towns. The slum clearance, whilst improving living conditions, only served to exacerbate the problem of poverty. Rents in the new housing estates were higher than those the inhabitants had previously been paying. This meant that families who moved into them may well have been experiencing better sanitation, ventilation and all round living environments, but it also meant that the largest percentage of their income was now used for paying the rent, leaving little available towards a substantial, nutritional diet or for fuel bills. Because of the slum clearance, a greater number of families found themselves living in poverty and consequentially suffering ill health. Rents, for example, in Stockton during the 1920s and 30s, ranged from 10s per week for a small street house and up to 12s 6d for a larger one. The council houses built during the 1920s proved almost prohibitively expensive at 17s 6d a week.[703] Additionally, the high rates in Stockton meant in the region of 3s a week needed adding onto the weekly rent. The removal of diseases and health implications that poor housing had produced quickly found themselves

[701] Dennis Chapman (1945), *A Social Survey of Middlesbrough: Part I*, HMSO, London. By the time of the Lock survey, a third of those living in the northern wards wanted their homes demolished and to be re-housed.
[702] TA/CB/M/H/13, 'Special Reports of the Medical Officer of Health'.
[703] McLaurin, *The Housewives' Champion*, p. 40.

replaced with new ones. Considering that even by the late 1930s, wages rarely exceeded £3 a week, a substantial proportion of even well paid workers' income was devoted to paying rent.

The remainder of their wages tended to be allocated to purchasing food for the family. The average working class diet at the turn of the century was not overly varied, and in a large percentage of cases, not adequately nutritious. In 1933, the BMA determined that the caloric requirement to keep the average man healthy and able to work was 3,400 calories per day (the figure is now nearer 2,500, but in 1933, the basis of this figure was for those in heavy manual labour).[704] The BMA also calculated that the weekly cost of this would be 5s 10½d (although the costing of the diet was criticised as being ridiculously unrealistic). A family of five, based on two adults and three children, it was calculated would require 22s 6½d a week. At a time of heavy unemployment, most keenly felt in the North East, this was beyond the means of most families. As John Pemberton pointed out in his 1934 article 'Malnutrition in England', the statutory unemployment benefit was 29s 3d a week for such a family, leaving them only 6s 8½d available to spend on rent, fuel, clothes and other sundries.[705] It was unrealistic to believe that families would be spending this figure on food, in reality often this figure was halved if they wanted to survive. It is not difficult to see how quickly compromised health could become in these situations. In the same article, Pemberton commented on the health of those in industrial regions. Analysing MOH reports from the northern counties he cited malnourished children with retarded physical development, low resistance to infection and slow recovery from childbirth as just some of the consequences arising from a poor diet.[706]

There were comparable issues observable within the region, in their 2011 study of municipal medicine; Levene *et al* examined the nearby port town of West Hartlepool,

[704] John Pemberton (2003). ''Malnutrition in England' University College Hospital Magazine 1934, Some reflections in 2003 on the 1930s', *International Journal of Epidemiology*, **32**: p. 494

[705] *Ibid*.
[706] *Ibid*., p. 494-5.

considered a parsimonious "stinting" council in the 1930s.[707] The collaborative group considered the factors that led to the actions, or rather inactions, of the town's council, especially their interactions with other local authorities, GPs and hospital services. The study aimed to investigate the 'competing interests of other health service providers", a comparable aim to this thesis.[708] However, the conflicts within Middlesbrough are more pronounced in the late nineteenth and early twentieth centuries than the late 1930s onwards. The reported involvement and interaction of GPs in West Hartlepool with the council is marginal, mainly concentrating on maternity services.[709] The local branch of the BMA passed a resolution in 1931 aimed at preventing municipal involvement in antenatal care. The GPs felt they should control this service and did not want the council to encroach. This was a typical response to such proposals, driven primarily by the BMA and witnessed nationwide.[710] There was little interest in antenatal care until the 1930s. GPs did not feel the need to be involved with this service until they felt threatened.[711] The BMA promoted the idea of GPs being the natural provider of advice to mothers post-partum, a concept embraced by some practices that went on to establish their own antenatal clinics.[712]

In the case of West Hartlepool, the local council agreed to the GPs effectively retaining control of antenatal care as it meant that they did not have to provide staff and in doing so saved money. This is a typical example of how such groups could work relatively harmoniously within a town, especially if both parties felt they had ultimately won. The situation was similar in Middlesbrough and if it was in the best interests of both groups, agreement could usually be reached. It was only when either party felt undermined that communication and relations deteriorated, as can be seen with notification of pneumonia in early twentieth century Middlesbrough.

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[707] Alysa Levene, Martin Powell, John Stewart and Becky Taylor (2011), *Cradle to Grave: Municipal Medicine in Interwar England and Wales*, Peter Lang, Oxford.
[708] *Ibid*., p. 200.
[709] *Ibid*., p. 220.
[710] *Ibid*.
[711] Digby, *Evolution of British General Practice*, p. 203.
[712] *Ibid*.

There are commonalities that the findings in West Hartlepool share with Middlesbrough. The slum clearance in both towns did not substantially take place until the 1930s, despite numerous housing acts encouraging such development.[713] The two towns were also treated prejudicially during the allocation of Special Area grants in the 1930s. Hartlepool was granted "Special Area" status during this time, unlike Middlesbrough. However, West Hartlepool was awarded a lower level of grant that the rest of the area due to its perceived relative prosperity.[714] West Hartlepool also differed to Middlesbrough in crucial ways, industry was diverse and unemployment was lower. However, like Middlesbrough, West Hartlepool was slow to work towards improving the lives and health of the poorer, working class sections of the population.[715]

The study concludes that in the case of West Hartlepool, responsibility for delaying improvements to health care lay equally with groups such as the GPs, MOH and the hospitals as it did with the town's council.[716] The same could be said for Middlesbrough, it was not all due to the inaction or obstinance of the council, the GPs could be equally obstructive, especially if they felt their position was threatened. This is not to suggest that positive outcomes were not possible from such interactions, just that they usually only came about after long fought debate and to the mutual benefit of all parties.

Dingle's assertion that the depression was advantageous for health appears to have been overly optimistic. Things had not improved as dramatically as perhaps estimated, and towards the end of the Second World War steps were urgently required to correct the situation. The war was to bring a new array of problems pertaining to health with it. However, in the case of Middlesbrough it was also to inspire a renewed vigour and determination within the town's officials to change conditions for the.

[713] Levene *et al*, 'Cradle to Grave', p. 199.
[714] *Ibid*., p. 201. The town council denied such claims and considered West Hartlepool as impoverished as the rest of Hartlepool.
[715] *Ibid*., p. 221.
[716] *Ibid*., p. 222.

## Local Plans and Healthcare Provision

There was little improvement as the depression of the 1930s gave way to the war years. The Middlesbrough Corporation, in a moment of extreme forward thinking, commissioned a detailed survey of the area three years before the Town and County Planning Act of 1947.[717] This act encouraged the use of many of the groups who were utilised in the Middlesbrough survey. The man tasked with this was Max Lock. Cecil Max Lock (1909-1988) was born in Watford in 1909, trained as an architect he became interested in the public and social aspects of town planning. He had initially been involved in a wartime survey of Hull and after Middlesbrough went on to helm similar surveys' in West Hartlepool, Portsmouth and Bedford.[718] Max Lock saw the social element of the survey as vital, the cooperation and involvement of the community were fundamental to the plan's success. Lock commented on this subject extensively in his introduction to the plan, placing the people of Middlesbrough at its heart.[719]

The survey consisted of a variety of different groups including town planners, architects, geographers and social scientists. The survey was broken down into four stages, starting in April 1944, and was presented eighteen months later to Middlesbrough Council, in October 1945.[720] As part of the initial fieldwork component, surveyors interviewed 1,400 families, this equated to roughly one in twenty-three households within the town. Questions included topics such as housing, shopping, transport, recreation and town improvements.[721] There was a division of work into three areas. Physical planning factors were under the supervision of Max Lock. A.E. Smailes carried out a geographical and economic survey, and finally Ruth Glass and Griselda Rowntree carried out the social survey, which we shall

[717] Ruth Glass (1948), *The Social Background to a Plan*, Routledge and Kegan Paul Ltd, London, p. xiii.
[718] For a brief history of Max Lock, see the website of the Max Lock Centre based at the University of Westminster http://www.wmin.ac.uk/builtenv/maxlock/HISTORY.HTM. Accessed on June 15 2011.
[719] Max Lock (ed.) (1946), *The County Borough of Middlesbrough: Survey and Plan*, Middlesbrough Corporation, Middlesbrough, pp. 11-17.
[720] *Ibid*., p. 17.
[721] *Ibid*., p. 11.

now look at in detail. The social survey was then broken down further into neighbourhood structure, retail trade, and health and education services.[722]

Middlesbrough, for the purposes of the survey, found itself divided into four zones based on housing and living conditions located there. Zone one was the poorest area, mainly located in the north of the town next to the industrial zone, along the banks of the River Tees. Zone four was the prosperous districts, consisting of private housing, building of which had largely taken place during the interwar years.[723] The worst areas were in the north, with the better areas located on the periphery of the town and to the south. Even the new housing estates did not offer a better standard of living for all they had poor access to healthcare and amenities. They may have been located in a geographically distinct zone, but socially they were no different to those living in zone one. The report even goes as far as to suggest that if the habits of the current population did not alter or improve dramatically, then despite the new, comfortable surroundings the population found themselves in, it would not take long at all before the situation previously witnessed in the northern wards would be replicated within these new estates.[724]

An area highlighted in the plan was the apparent disparity in the levels of healthcare for the different age groups within the town. Provision traditionally tended to be centred on the male workforce, the backbone of the town in terms of its productivity in such an industrialised area. With most of the healthcare located within the town developed around them, it followed then that those who were not in employment found were overlooked.[725] These usually consisted of women, the young and the elderly. Middlesbrough not only had a historically poor record of infant mortality but also, due to the nature of the industry in the area it had a large proportion of elderly males drawn to the area at the turn of the century, when industry was flourishing. Many had not married and had no support system or

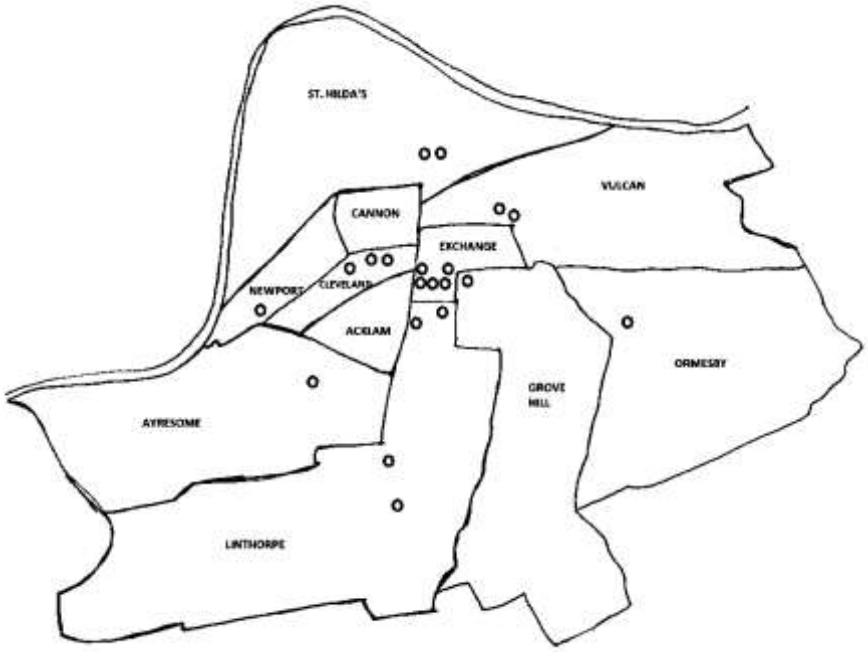
[722] Glass, *Social Background to a Plan*, p. 53.
[723] *Ibid*., pp. 54.
[724] *Ibid*., p. 50.
[725] Doyle and Nixon, 'Voluntary Hospital Finance', pp. 4-19.

adequate accommodation.[726] This is just one example of an area for improvement highlighted within the report, as were gaps in the provision for adolescents and adults who did not work.

One of the areas investigated was the provision of existing health services in the Borough, including the location and availability of general practices. The survey highlighted the shortcomings of the existing services, demonstrating the shortage of surgeries throughout the town but especially in the poorer northern wards (Cannon, Newport and St. Hilda's), and perhaps most worryingly of all there was almost a complete absence of practices in the new housing estates located to the south (*Fig 6*).[727]

*Fig 6*

GP Surgery Locations in the Wards of Middlesbrough (c1944)




Source: Max Lock (ed.) (1946), *The County Borough of Middlesbrough: Survey and Plan*, Middlesbrough Corporation, Middlesbrough.

[726] Glass, *Social Background to a Plan*, p. 69.
[727] Lock, *County Borough of Middlesbrough: Survey and Plan*, pp. 340-1. There had been issue with this dating back almost to the origin of the town, as highlighted in chapter one and again at this beginning of the current chapter.

During the 1930s, these new estates were developed to re-house those communities removed after the slum clearance within the northern wards. Slum clearance within Middlesbrough had been stalling since the early twentieth century.[728] There was a comparable situation in Leicester where slum clearance was delayed in the 1930s by the attitude of the MOH, Dr Millard did not feel clearance was the answer; rather efforts should have been made to improve existing housing.[729]

These already disadvantaged communities found themselves in surroundings that were salubrious but still experiencing the same inequalities in terms of health care they always had. This was combined with the fact that it was now even more expensive for them to travel to see their GP than before, due to their isolation. The study noted the 'social distance' between the doctor and his patients.[730] The vast majority of GPs in Middlesbrough lived in the affluent parts of the town, located in the south.[731] This resulted in the doctors not having much insight into the lives of the people that they treated. Additionally, as the doctors' home often doubled as their practice surgery, not only social but also spatial isolation developed. This increased distance, in all likelihood, added to the perception that the doctor should be consulted only if it were thoroughly unavoidable.

The issue of the lack of provision of GP surgeries in the new estates was to continue to be a problem into the 1950s. A meeting of the Middlesbrough Local Medical Committee was held, in 1954, to discuss the provision of primary care to the new housing estates in the town.[732] The consensus was that doctors needed to be located within the new estates and the local authority should expedite the process. It was difficult to find suitable premises within the estates; they either had to be a sublet council house or a specially built site. The problem with the latter solution surrounded the question of cost and who should incur the expenditure. The GPs wanted the local authority to construct surgeries then rent them out to

[728] Polley, 'Housing the Community', p. 170.
[729] Welshman, 'The Medical Officer of Health in England and Wales', p. 444.
[730] Lock, *County Borough of Middlesbrough: Survey and Plan*, p. 340.
[731] Glass, *Social Background to a Plan*, p. 78.
[732] Anon (1954), 'GP Services in New Housing Estates: Middlesbrough Practitioners' Views', *The British Medical Journal*, **4901:2**, pp. 224-5.

the doctors, but have no further involvement. The GPs would run the practice without the interference of the authorities.[733] It was also agreed at the meeting that any new doctor's moving to the town should be encouraged to set up practice in the new estates, rather than in the centre of town. However, this was negotiable, and the GPs did not want to make this a mandatory stipulation.

The effects of pollution became a key and critical area of the survey. In an area with heavy and clustered industry, it is not difficult to understand the immense problems the town had with atmospheric pollution. This survey came at a time of development of vast new chemical plants in the area. Indeed, the main questions asked by those interviewed were 'will smoke and smell again be allowed to pollute our homes?' 'What steps are being taken to prevent this in time?'[734] Assistance in this portion of the survey came from local schoolchildren, who helped to collect the raw data and information. The boys of nearby Acklam Hall School placed petri dishes at locations throughout the town; after removal, measurement of the pollution content took place by weighing the dishes. The pupils were involved in both stages of this process, demonstrating once again the close community involvement Max Lock and his planners tried to engender.[735]

There were two chief conclusions drawn by those involved in the survey, the first being that Middlesbrough's chief difficulty was the difference in conditions from one part of the town to another. Secondly, that its phenomenal growth meant it had tended to specialise industrially at the expense of providing and developing adequate social services.[736] These two observations are problematic in so far as the inference is that the issues Middlesbrough faced were endemic, not just in reference to health but also poverty, housing and education. That said it would be difficult to overhaul the town based on these points alone. Middlesbrough, at this time, was still dependent upon industry for much of its income and employment, and due to the nature of the town's development, it was difficult to see the

[733] *Ibid*.
[734] Lock, *County Borough of Middlesbrough: Survey and Plan*, p. 344.
[735] *Ibid*.
[736] *Ibid*., p. 38.

development of any successful strategy to rectify these apparent spatial inequalities. Throughout the history of Middlesbrough, there had been frequent debate surrounding the differences experienced within the town, particularly in connection to health. The link between the infant mortality rate and the northern wards had been established in the early 1900s.[737] Acknowledgement of this fact may well have taken place, but there was little observable proof of positive steps taken to address the situation. Indeed the same issue was to arise once more in the wake of the Lock survey.

There were a number of proposals made as to what improvements were needed, and what the key causes of the problems were. The proposals highlighted in particular the need for a universal health service (this all occurred prior to the arrival of the NHS). Attention to maternity and infant services, improving standards of nutrition and establishing grouped hospitals and health centres were amongst those mooted.[738] The general opinion expressed seems to have been that the most crucial factor in trying to attain better health in the town was to improve the living and working conditions. Of the proposals listed, those delivered, did so, mainly thanks to the inception of the NHS rather than through the work of local initiatives. For example, it was not until the late 1960s, for example, that health centres, at least on the level described in the survey, were to be developed.

Reporting the findings of the survey back to the community was a key component of the plan and took place most effectively. Pamphlets produced for each of the main summary areas of the plan were sold throughout the town at a penny each. In addition to this, there was a public exhibition in the Town Hall, alongside numerous public meetings.[739] The exhibition proved to be an enormous success, with over 10,000 people visiting in one week alone. The overriding ambition of those involved, especially Max Lock, was that the public would not only be pivotal in the collection of data but would also be able to be involved in commenting on and witnessing what the redevelopment proposals were. This is reminiscent of the aims of the Scottish planner, Patrick Geddes (1854-1932) in the early twentieth

[737] *Supplement on Child Mortality at ages 0-5, 1918.*
[738] Glass, *Social Background to a Plan*, pp.81-2.
[739] Lock, *County Borough of Middlesbrough: Survey and Plan*, p. 17.

century. Geddes. Like Lock, wanted the involvement of the community, to play an active role in planning and creating their environment.[740] The Lock survey involved the community at all stages, whether that was data collection or dissemination of the results back to them via public meetings. That is not to suggest that there was implementation of all of the proposals discussed, but at least the community felt valued, that their opinions mattered. In respect to health services within Middlesbrough, there were decade long legacies that affected its provision and widespread inequalities throughout the town, dependent upon social status and location. As the Lock survey pointed out, this was perhaps the most decisive factor determining people's experience in the town.[741]

Before the Lock survey, the mass observation study based in the fictional town of 'Worktown' (which had been the industrial North West town of Bolton) had begun in 1937.[742] It looked at all aspects of community life, based on oral interviews, observational studies and requests for diaries and correspondence from the population. The study soon expanded into other regions of the country as the government used the project to assess the morale of the public during wartime. In 1940, two of its researchers came to Middlesbrough and spent three months observing the town and its people for a direct comparison to the findings in Worktown.[743] In their report, Middlesbrough received a favourable review; they concluded that the inhabitants were happier, wealthier and even better dressed than those in Worktown. The observers thought the streets in Middlesbrough were cleaner, less polluted, and housing was preferable to Bolton. The findings of the group are a direct contrast to those of the Lock survey of 1944, which was highly critical of the living standards and amenities of the town, indeed the mass observation report would have been unrecognisable to those involved within the Lock group. It does raise the question of different agendas when

[740] Abigail Beach and Nick Tiratsoo, 'The Planners and the Public', in Daunton, *The Cambridge Urban History of Britain: Volume III*, p. 529.
[741] Lock, *County Borough of Middlesbrough: Survey and Plan*, p. 325.
[742] Mass-Observation (1970), *The Pub and the People: a Worktown Study,* Seven Dials Press Ltd, Welwyn Garden City. In addition, the Mass-Observation archive housed at the University of Sussex, largely has now been digitised and is available online. The study looked, anonymously, at the daily lives of working class people throughout the country over a number of decades, predominately around the time of the Second World War.
[743] Mass-Observation Archives, University of Sussex, *General Report on Middlesbrough*, 1940, pp. 1-13.

reading such vastly different evaluations of the same place. In terms of health, there was not a vast difference between the two towns, Middlesbrough had a significantly worse IMR, but Bolton had a sustained, higher overall death rate.[744]

Perhaps the most illuminating section of the Lock plan was the social survey that took place, starting in the summer of 1944. It was informative due to the extensive canvassing and opinion gathering from ordinary members of the community prior to the report's publication the following year. Those surveyed were selected randomly from a list of all Middlesbrough dwellings; every 23rd address was taken, resulting in a sample size of 1387.[745] The interviewers were instructed primarily to target housewives, followed by any other available adults. The rationale was that, in an industrial town such as Middlesbrough, there would be variable shift patterns making it difficult to access working adults of either sex. However, wherever possible attempts were made to do so, and there are numerous instances in the collected material of comparisons between the two groups being made. For the purposes of this study, the data collected directly related to health issues and concerns will be examined. Although no section was dedicated to the subject in the survey questions, it is an area touched upon repeatedly in regards to housing, location, neighbourhoods and public amenities.

The first part of the survey looked at where people wanted to live compared to where they resided.[746] It was found in the poorer wards (Acklam, Cleveland, Exchange, Cannon, Newport, St. Hilda's and Vulcan) that the majority of the community would ideally like a move to one of the newer housing estates, either that or to one of the southern wards such as Linthorpe or Grove Hill. Unsurprisingly those already housed in these desirable areas were happy where they were, with little to no desire to move. In addition to this, the reasons they gave for wanting to move were recorded and varied between wards. In the northern districts of Cannon, Newport, St Hilda's and Vulcan, 30% of housewives and 42% of husbands

[744] Registrar Generals Annual Reports 1911-1920 and the Registrar General's Statistical Review 1921-1954.
[745] Chapman, *A Social Survey of Middlesbrough: Part I*, pp. 3-4.
[746] *Ibid.*, pp. 1-86.

wanted the old buildings and houses demolished.[747] Yet only 5% and 2% respectively felt anything needed to be done about smoke emissions and the nearby factories. Considering how close these wards were to the industrial zone this is somewhat surprising and demonstrates that their immediate concerns were about their living conditions. The further we get away from the northern area the observable response is one of contentment with their surroundings, at least with their homes. Issues such as transport and better facilities for the children become the main contentions.[748] Interestingly the survey does not extend to interviewing those already living on the new estates; perhaps there was an assumption that they were already wholly satisfied with their surroundings and conditions.

The second element looked at attitudes to Middlesbrough, what people considered to be the greatest problems they would face in the post-war era and what amenities, if any, they would like to see in the town.[749] This portion of the study was to reveal that people who lived in Middlesbrough did not consider climate or health as a reason to either live there or move there.[750] Not entirely a surprising revelation, indeed it was cited instead as the main reason by those contemplating a move to the countryside. For those within the town, the fear of unemployment was the greatest consideration, it was named by 75% of working males, 53% of working females and 57% of housewives.[751] The next was housing with 35%, 45% and 36% respectively amongst the aforementioned groups.[752] When provided with a list of amenities they would like, health clinics were a popular choice amongst both sexes (72% men, 73% women). Housewives expressed the opinion that not only would they like more health clinics but that they would also like them located nearer to their homes. Although percentage figures remained high regardless of age, it was noticeably higher amongst those in the 13-34yrs and 35-44yrs age brackets.[753] In all likelihood, this was due to having young families that would increase their need and use of such clinics. This also tied in with their

[747] *Ibid.*, p. 62.
[748] *Ibid.*, pp. 51-73.
[749] Dennis Chapman (1945), *A Social Survey of Middlesbrough: Parts II and III*, London, HMSO.
[750] *Ibid.*, p. 4.
[751] *Ibid.*, p. 9.
[752] *Ibid.*
[753] *Ibid.*, pp. 23-5.

reasoning for wanting to move to a different area, with 31% giving their reason as being 'healthier, better air, better for children'. Therefore, whilst they considered a move to one of the new estates to be potentially healthier for their families, in the same survey they did not consider matters such as pollution or the impact of industry to be important. It is difficult to suggest what factors shaped their perceptions, but housing clearly appears to be the driving force. Although they do cite 'better air' alongside health, so on some level there must have been an acknowledgement that air quality was an issue. The survey does not break down the percentage figures for each ward on these matters, although the inference is that those in the poorer northern wards most desired relocation for gains in health. The figures also demonstrate the trend towards the younger part of the community pushing to move. The result being that the older, more run down areas of the town would be left to the old and poorer sections of the community. This in itself meant serious potential implications for the development of the town, with a divisive split between the different sectors. This had already begun to take place in Middlesbrough by 1945.

The final part included in the interviews reflected upon the ways in which neighbourhoods interacted, specifically neighbour-to-neighbour interactions.[754] When asked in what ways they helped their neighbours, 'helped in illness' was cited by 16% of both working sexes.[755] For housewives, the figure was twice as much, 34% mentioned helping a neighbour with illness, and 36% responded that they had received such assistance.[756] There were strong social bonds exhibited in the northern wards, even to the point of being the wards most likely to lend their neighbours money despite being amongst the poorest.[757] This section also looked at visits to maternity and child welfare clinics. It was calculated that 14% of Middlesbrough's housewives were involved, with 5% attending weekly and 9% only on occasion.[758] The proportion of those using clinics was highest in the northern wards when compared to the rest of the town. It was also discovered that the majority of those living in

[754] Dennis Chapman (1945), *A Social Survey of Middlesbrough: Parts IV-VIII*, HMSO, London
[755] *Ibid.*, pp. 12-3.
[756] *Ibid.*
[757] *Ibid.*
[758] *Ibid.*, p. 47.

these areas had to travel, on average, a quarter of a mile to visit a clinic. Those living in the newer housing estates and the more desirable areas had further to travel, anywhere up to a mile and over. The average time taken for such excursions within the town as a whole was 12 minutes (57%), the extreme was 23-40 minutes (13%).[759] It might well be argued that those from the newer estates were better placed to travel than those located in the north, at least financially. However, as the slum clearance in Middlesbrough had begun to take place in the 1930s many from the northern district had been moved south, their ability to travel was possibly more limited than initial analysis might suggest. The lack of amenities such as clinics in these newer areas was one that was highlighted in the Lock survey. It may not have appeared as important to the residents, perhaps overwhelmed by their new surroundings, but it certainly resonated with those collecting the data.

The social survey was also to highlight the inadequacies in certain areas of healthcare provision within the town, in particular, maternity and infant welfare services. The school medical service was also reviewed, and alternatives to existing strategies within Middlesbrough were proffered.

## Maternity and Infant Welfare Services

Historically, Middlesbrough had a poor infant and maternal mortality rate. This declined slightly during the Second World War, although this was more likely due to be to the fact that there were fewer births than previously. Ruth Glass, as part of the Lock survey of the town in 1944, looked at the services provided for women and infants. All of the information contained within the study was taken from a sample of births during the first four months of 1944. This resulted in a sample of 970 births, 887 of which survived past the first three months of life and were included in the figures.[760]

[759] *Ibid.*
[760] Glass, *Social Background to a Plan*, p. 58.

During the Second World War, extra rations and clothing coupons were made available for pregnant women.[761] Women only went to see a GP if they could afford to do so, the ones that did were from the higher income bracket and were examined at regular intervals midwives saw the rest, sporadically.[762] Additionally, there were fortnightly antenatal classes held in four welfare centres located in the north of the town. The chief site, however, was the Municipal Maternity Hospital; this opened four mornings a week and was staffed by a Medical Officer and the midwives that worked within the hospital.[763] The study uncovered that around 35% of mothers made use of the antenatal clinics and another 3% consulted their own family doctor. It is perhaps worthy of note that the clinics were better subscribed than the family GPs because they were provided free of charge.[764]

Half of the sampled mothers delivered at home with only a midwife in attendance there were 26 qualified midwives working within Middlesbrough at this time.[765] Subsequently, midwives attended for the first few days after the birth, at least twice a day, then once a day for a fortnight. In the case of a complication occurring during the birth, a midwife could either request the assistance of a doctor or for the woman to be admitted to the Municipal Maternity Hospital.[766] If the woman had puerperal fever, then the midwife could not attend. The mother had to be nursed in her own home by a district nurse or taken to an isolation hospital.[767] There was a charge for the use of a municipal midwife in Middlesbrough, and in 1944, this stood at £1.15*s*. If the family could not afford this sum, an affordable sum was agreed after being means tested.[768] Home helps were also available to assist families with general domestic duties during the mother's confinement, although there were only seven in total. They were not often requested, and when they were, it was from the prosperous wards

[761] *Ibid*.
[762] *Ibid*.
[763] *Ibid*., p. 59.
[764] *Ibid*.
[765] *Ibid*.
[766] *Ibid*.
[767] *Ibid*.
[768] *Ibid*., p. 60.

amongst families that could afford the fee.[769] Hospital accommodation was not extensive with only 58 beds available at any one time. The hospital was only originally intended to take in women with complications rather than simply any woman requesting it. Therefore, priority had to be a consideration, firstly emergencies, followed by those for whom it was their first confinement.[770] Emergency cases were admitted, without any agreement to pay, and the cost of all other admissions varied depending upon income.

There were ten health visitors in Middlesbrough, each of whom was assigned to one district in the town. This meant there were, on average, 1,200 children under five years of age per health visitor in 1944, each of whom had to undertake 30 home visits per day. [771] They also had to provide advice at welfare clinics and visit homes where illness or 'difficulties' had been reported. The main role of the health visitor was to encourage the mothers to attend the infant welfare centres for further advice.[772] These welfare centres were staffed by both health visitors and clerks, the centres sold food and vitamins, in addition to the provided classes. The centres were housed at existing premises, such as churches or public halls.[773] There were separate rooms if a mother or child needed to see a doctor privately. The environment was not ideally suited to infants; they were often cold and dark. The remaining centres in the town were former private homes, here the sanitary conditions were better, and they were not as cold, but they quickly became crowded and were somewhat impersonal.[774] The conclusion of the report was that few of the premises used were ideal or even suitable for their desired purpose.

There were not enough mothers in Middlesbrough using the antenatal clinics and infant welfare centres, and this was considered the case because of a number of crucial elements. There was a shortage of staff, space and beds reserved within the hospitals. Infant welfare centres were often overcrowded when they were attended, and this tended to

[769] *Ibid*. The service had only begun in 1943 and was not widely subscribed to.
[770] *Ibid*.
[771] *Ibid*., p. 61.
[772] *Ibid*.
[773] *Ibid*. There were four such centres located in Middlesbrough, and there were a further three, located in accommodation previously used as private homes.
[774] *Ibid*.

put mothers off returning, this was alongside the overall inadequacies of the existing premises.[775] Women from the poorer areas cited domestic ties as a reason for not attending the hospitals and clinics, many were financially unable to afford a hospital confinement or had no provision at home to look after the rest of the family should they choose to go to the hospital. Moreover, few GPs attended home confinements and even midwives had limited involvement.[776] The report concluded by making suggestions as to how the situation could be rectified in the future. Antenatal care needed to reach those who had their confinement in the home as well as the hospital, therefore, midwives needed to encourage its use further.[777] The accommodation in the Municipal Hospital needed to be increased and be utilised by the poorer section of the community. However, it was equally critical that the rest of the family was considered and taken care of; otherwise, the mothers would not go. This meant that the home help service needed to be extended and the charge for it kept as low as possible to further encourage its use.[778] The number of health visitors within the town also needed to be increased, and their role expanded. This meant the overhaul of welfare clinic provision, with new custom-made premises and an increase in their distribution throughout the town, especially to the north, so that they were accessible to all.[779]

The factors that influenced the use of maternity services within the town included details such as the experience of the mother; a first confinement received much more attention both pre- and post-natal than a woman did on her third, for example.[780] However, any mother who had given birth in an institution rather than at home, it was reported, tended to use the infant welfare services more frequently afterwards. Hospitals asked mothers to attend antenatal clinics, whereas midwives that attended within the home did not. It also appeared to follow that mothers that attended antenatal classes also went on to attend the

[775] *Ibid*., p. 65.
[776] *Ibid*.
[777] *Ibid*., p. 66.
[778] *Ibid*.
[779] *Ibid*.
[780] *Ibid*., p. 62.

infant welfare clinics.[781] The inference being that if mothers were well informed of the resources available then they would utilise them. Angela Davis has looked at the opinions of women who received maternal care in Oxfordshire from 1948 onwards.[782] As was the case with the Lock survey in Middlesbrough where result were produced as an overall analysis of maternity services, the opinions of the women involved were usually muted within official reports. Davis' study using oral history interviews found that the level of care experienced and offered to the women depended upon their locale, even within a given area.[783] Davis also found that in urban areas, the relationship between the women and their GPs was not as close as in rural areas, and midwives tended to fill the gap as confidante.[784]

Poorer mothers were unlikely to be influenced by the medical profession it was also rare for these women to involve them in their pregnancy in the first place. Additionally, midwives who worked in the poorer districts encountered difficulties persuading the mothers to attend antenatal clinics or welfare centres, as the mothers felt that they could not spare the time.[785] The greatest influence came from the educational value of the hospital, as already noted those in poorer areas who experienced a hospital confinement were likely to seek out further help afterwards.

A Joint Committee investigation into maternity provision in 1946 found that those who could afford care at this time received it. The middle classes received antenatal care earlier than their working class counterparts, they were also more aware of the need for medical supervision both during and after their pregnancy.[786] Importantly the committee found that better off families could afford to pay for domestic help after the birth, alleviating pressure from the mother to look after the house and any other children.[787]

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[781] *Ibid*., p. 64.
[782] Davis, 'A Revolution in Maternity Care?'
[783] *Ibid*., p. 404.
[784] *Ibid*., p. 403.
[785] Glass, *Social Background to a Plan*, p. 64.
[786] Harold L. Smith (1996), *Britain in the Second World War: A Social History*, Manchester University Press, Manchester, pp. 38-39. Consisting of the Royal College of Obstetricians and Gynaecologists, the Institute of Child Health, and the Population Investigation Committee, the report was published in 1948.
[787] *Ibid*., p. 39.

## Education and Child Welfare Services

When the School Medical Service was established in 1908, it highlighted the large number of children with health problems that impeded both their development and school life.[788] The School Medical Service within Middlesbrough largely detected minor ailments amongst the children as well as keeping a check on the school going population. The service provided within a school was diagnostic rather than therapeutic with the children being examined three times during their school life. The service had proved divisive amongst the medical profession. For example, in Leicester GPs were concerned about the encroachment into the previously GP based areas of school medical services, especially as children had always been ostensibly treated as fee-paying patients.[789] There does not seem to be an observable, open discourse on this topic with the GPs in Middlesbrough, at least not to the same extent that the GPs expressed their displeasure in Leicester.[790]

The 1944 Education Act demanded that local authorities provided free medical treatment for all pupils, so this removed the previously purely diagnostic nature the service provided and added a new therapeutic remit.[791] In Middlesbrough by 1944, there were three full-time assistant Medical Officers and six nurses. The MOH of the town was also the head of the School Medical Service.[792] During the Second World War, the service had reduced, although the workload had increased in some areas, for example, diphtheria immunisation. During this time, children were examined on entering and leaving school, rather than the previous three times. There were four school clinics, two of which were situated on the new housing estates, one centrally, and one in the northern sector, in Cannon Street. The Cannon Street clinic opened in early 1944 and proved extremely popular within the

[788] Harris, *Health of the Schoolchild*, p. 4.
[789] Welshman, *Municipal Medicine*, p. 175.
[790] *Ibid*., p. 280. Friction in Leicester on this matter was directly between the GPs and the MOH, this was a wider Midlands based issue.
[791] Glass, *Social Background to a Plan*, p. 101.
[792] *Ibid*.

community. This was probably because it was located in one of the more socially deprived areas of the town, access to medical services was poor here, especially for children.[793] The types of minor ailments treated by the service included skin diseases, ENT complaints, speech, orthopaedic and orthodontic issues.[794] Even nervous complaints were dealt with, although during the wartime staff shortages meant that its use was to a large extent limited it was known within the service as 'child guidance'.[795] The 1944 Education Act required an increase in the number of staff as well as improvements to the existing premises and opening of new, dedicated centres. These needed to be located in places where it was most convenient for the children to attend without the issue of travel being too much of an overriding consideration.[796] The question raised was whether the new style School Medical Service would be linked to the Health Centres expected to be developed throughout the town.[797]

Malnutrition amongst schoolchildren was still a matter for considerable debate during this period. In Leicester, Welshman found that 'parental inefficiency' was the leading theory as to the poor health amongst large numbers of the school age population.[798] However, in Leicester during the 1920s and 1930s few school meals were served, in this instance generally attributed to cuts to the service.[799] The situation was slightly different in Middlesbrough, here free school meals allocated prior to World War Two were often refused, perceived as charity and apt to be stigmatising for a family who accepted them.[800] This was because the free meals only applied to those who were in the lowest income groups. During the war, there was less reluctance to accept free or subsidised school meals, this was due to rationing and mothers working in industrial employment for the first time. Middlesbrough Education Authority had made the decision they would provide 75% of all schoolchildren with

[793] *Ibid*., p. 102.
[794] Harris, *Health of the Schoolchild*, p. 4.
[795] Glass, *Social Background to a Plan*, p. 102.
[796] *Ibid*.
[797] *Ibid*.
[798] Welshman, *Municipal Medicine*, pp. 182-183.
[799] *Ibid*., p. 181.
[800] Glass, *Social Background to a Plan*, p. 103.

meals, post-war.[801] Welshman does not discuss the stigma attributed to receiving free school meals. However, this might be due more to the nature of the survey in Middlesbrough highlighting this than there being any lack of similar discussions having taken place in Leicester.

Children had to be provided with institutional daytime care during the war as mothers frequently had to work. This led to temporary buildings being erected to accommodate this excess of children. It was considered that these temporary measures would give way to something permanent after the war as mothers would now continue to work. Additionally, the Education Act demanded the provision of nursery schools and more classes.[802] Lice infestations were found it was claimed, in the poorest districts of the north, such as Cannon and Newport.[803] However, families that were moved from the old slum areas to the new estates (such as Brambles Farm to the south of the town) still exhibited a high level of infestation. Therefore, there was an association not only with poverty but also with a lack of hygiene. The families may well have moved to superior houses, but the conditions within them were not much improved.[804] Allegedly, the school medical service staff had to dedicate the majority of time dealing with lice infestation that they could hardly deal with anything else. The whole household needed to be educated about the problem, clothes and bedding needed to be disposed or disinfected. This was a common theme across the country during the wartime highlighted by the evacuation of children, leading to accusations that School Medical Service had somehow been derelict in its duties or under-recording prior to the war.[805]

Illness also led to prolonged absences from school. Once more, the north seemed to be the area where this was most prevalent. It was not just a question of illness but 'avoidable absence' where children were kept off school for reasons other than ill health. Senior girls

[801] *Ibid*.
[802] *Ibid*., p. 104.
[803] *Ibid*., p. 116.
[804] *Ibid*.
[805] John Macnicol, 'The Effect of the Evacuation of Schoolchildren on Official Attitudes to State Intervention', in Harold L. Smith (1986), *War and Social Change: British Society in the Second World War*, Manchester University Press, Manchester, p. 21.

seemed to suffer most, helping with chores at home, to look after younger children, run errands and do housework.[806] Glass noted that the schools in the poorest areas (Cannon and Newport Wards) had the highest rate of absences.[807] Historically, girls had a higher rate of absenteeism than boys did, the former were often needed to help at home.[808] General housework was not considered as labour; therefore, it was not included in official child employment statistics during the 1920s and 30s. Instead, as Stephen Cunningham notes, it was considered as either 'helping or training' for the girls involved.[809] Additionally, girls were often responsible for younger siblings, even if they did attend school they were expected to assist their mother in the home once they returned.[810] This was all still occurring in the 1940s despite several high profile government investigations into school attendance and child labour in the 1930s.[811] In Middlesbrough, Glass felt that this indicated a need for greater provision of assistance for mothers such as day nurseries and home helps to alleviate the pressure placed on older girls in families.[812] There was also a need for advice on nutrition, hygiene and housing conditions, all of which could help in this matter.

Social and spatial distance between parents and teachers was also raised as a matter of concern.[813] By not living in the same area as their pupils teachers had little understanding of the conditions their pupils lived in. Teachers usually lived in the prosperous areas to the south. Parents rarely had any contact with either the school or the teachers, unless there was a dispute or a problem. It was felt that closer links needed to be

[806] Glass, *Social Background to a Plan*, pp. 117-8.
[807] *Ibid*. Attributable to avoidable reasons other than illness.
[808] Lionel Rose (1991), *The Erosion of Childhood: Child Oppression in Britain, 1860-1918*, Routledge, London, p. 192.
[809] Stephen Cunningham, 'The Problem that doesn't Exist? Child Labour in Britain 1918-1970' in Michael Lavalette (ed.) (1999), *A Thing of the Past? Child Labour in Britain in the Nineteenth and Twentieth Centuries*, Liverpool University Press, Liverpool, p. 151.
[810] Anna Davin (1982), 'Child Labour, the Working-Class Family and Domestic Ideology in 19th Century Britain', *Development and Change*, **13(4)**: p. 648.
[811] Cunningham, 'The Problem that doesn't Exist?', pp. 149-150.
[812] Glass, *Social background to a Plan*, p. 118. Even the lack of nearby shops on the new housing estates was cited as a reason for the absences.
[813] *Ibid*., p. 133. This was a similar situation to that observed between GPs and their patients, regarding social and spatial distance.

established between the parents and the school, perhaps through open days, concerts, sports days and so forth.[814]

These were all concerns that were to continue to be debated within Middlesbrough for the decades immediately after the publication of the report. The next section of this chapter shall explore some of the direct implications the NHS Act had upon the community. However, the central issue addressed shall be how the NHS changed the experience of medical professionals within Middlesbrough, in particular that of the GPs.

## The Introduction of the National Health Service

Ideas concerning free healthcare for all started in earnest towards the end of the Second World War. Labour had published *National Service for Health* in 1943; followed in 1944 by the coalition government's White Paper on health.[815] From this point, radical changes in the way health care was provided within Britain seemed almost inevitable; it was, however, a troubling time for GPs. As Charles Webster describes it, there was a fear that 'Labour was preparing to conscript general practitioners into becoming full-time salaried servants of a state medical service'.[816] Therefore, steered by the BMA, the profession made four key demands before it would give its consent and backing to such a service. These were payment by capitation fee rather than salary; allowance of the sale and goodwill purchases to continue; proposed controls over the distribution of GPs be scrapped, and finally that, in the case of potential termination of NHS contracts, the minister would not be the final point of appeal.[817] It was not until just before the NHS was due for introduction that any form of agreement was reached. A compensation package was developed as an alternative to the

[814] *Ibid*.
[815] Charles Webster (1998), *The National Health Service: A Political History*, Oxford University Press, Oxford, p. 12.
[816] *Ibid.*, p. 27.
[817] *Ibid.*, p. 28. The capitation fee was a defined sum paid to the GPs per person on their list.

abolished sale and purchase of goodwill agreement.[818] The tribunal system received only minor amendments. The greatest victory was over the pay structure for GPs; the idea of a salaried service was ruled out.[819]

Within the Stout collection, there are a number of interviews with GPs who were in practice during the transitional period of the arrival of the NHS. They provide an insight into the thoughts of GPs at this time, and how they fitted back into the profession at the end of the Second World War. Dr Hugh Doyle is a typical example of those Stout interviewed; he was a GP in Middlesbrough and had joined the practice of Dr Boohan as an assistant in 1938.[820] The practice consisted of two surgeries; one located on the Newport Road, the other in North Ormesby. As Doyle was a junior, he was given the club and panel patients, most of whom lived in the poorer Cannon Street area, to the north of the town. Indeed, Doyle himself remarks that, as a panel doctor, 'you became expert in making up your own favourite prescriptions with varying ingredients'.[821] Panel patients tended to be treated by junior members of a practice, whilst the senior partners saw to the surgeries' private, fee-paying clientele.[822] Assistants were taken on, often to expand an existing NHI practice; these patients could then be handed over to the new, junior assistant. As more patients could be added to the practice list, it brought in greater revenue than the expenditure of hiring a new member of staff. The most common type of practice in Britain post NHI was a mixed one, namely a combination of panel and private patients. Digby and Bosanquet state that this type of practice was most common in suburban and rural areas, with panel practices dominating in industrial towns.[823] However, Middlesbrough had a mixed practice strategy

[818] The sale and purchase of goodwill is based on the theory that the value of a business exceeds the physical assets. This could inflate the price of a practice based on the number of patients and their value. It also often made the buying into an existing practice prohibitively expensive for a newly qualified GP. Alysson M. Pollock (2004), *NHS Plc: The Privatisation of Our Health Care*, Verso, London, p. 136.
[819] Webster, *The National Health Service*, p. 28.
[820] TA/Accession 3720 Box 10.7 Envelope marked File D, Teesside Archives, Middlesbrough.
[821] *Ibid.*
[822] Digby, *The Evolution of British General Practice*, p. 312.
[823] Digby and Bosanquet, 'Doctors and Patients', pp. 80-81.

despite being predominately working class.[824] This might suggest that the middle classes in the town were stronger than previously considered. The consequences of such a strategy according to Digby and Bosanquet were complex. It often led to GPs minimising the amount of time they spent with their panel patients to be able to devote their energies to the more lucrative private patients.[825]

Doyle, like many younger GPs in the region and country as a whole, went into service in one of the various Medical Corps.[826] Doyle toured France, North Africa and Turkey, first as a Medical Officer, then eventually as a military attaché. After demob in 1946, Doyle was one of the few lucky enough to return and find his old post at Boohan's practice still open to him. As had been the case after the end of the First World War, there were problems to be addressed concerning medics returning from the war. This was in relation not only to their experiences out in the field but also the shortage of positions available upon their return. It was no different in this region than elsewhere in the country. Doyle speculated that this was possibly due to Boohan's own experiences from the First World War, and the difficulties he and many of his cohort had encountered.[827] Many of the vacancies during both wars had been filled by necessity, or older partners had either sold their practices or dissolved them upon retirement. Unlike the situation in the First World War, the profession had this time taken matters into their own hands and to some extent tried to protect the practices of those GPs who were away on army service.[828] To achieve this, doctors who were too old for active service, stood in and kept the practices running, a mammoth task at times for the aging GPs. However, the circumstances for those returning still varied depending upon their age and experience, despite all best efforts. Patient lists overall were smaller, as new patients had infrequently been registered and old ones had died or moved. The situation was infinitely more precarious for young, newly qualified doctors on their

[824] Ballard made referemce to this mixed economy of practice within Middlesbrough as early as 1888. *Supplement to Eighteenth Annual Report* 1889, p. 174.
[825] Digby and Bosanquet, 'Doctors and Patients', p. 82.
[826] TA/Accession 3720 Box 10.7 Envelope marked File D.
[827] *Ibid.*
[828] Digby, *The Evolution of British General Practice*, p. 89.

return, unless their position as an assistant had been kept open. Factors such as these once again fed into the transfer of practitioners from general practice to hospital work and even into public health roles.[829]

The early years of the post-war period were difficult ones for the profession as healthcare entered a time of tumultuous change. During this time, the precise mechanisms of the NHS were being thrashed out in the corridors of power and amongst the medical profession itself. The choice was a difficult one for returning GPs, whether to buy into an existing practice with the possibility that the NHS might forever change its worth, or alternatively, wait, and see what options might arise post-NHS, either within general practice or hospital consultancy.[830] The implication being that an opportunity might be missed no matter the decision. The NHS Act also planned to create the Regional Hospital Boards that took over the running of hospitals from the local authorities.[831] The overall power, however, in the case of public health matters was handed back to the local authorities. It was considered that this area of health was controlled in a much more satisfactory manner by local government than directed by central government agencies.[832] The act was to complicate health provision further, as to which group controlled each area and how much interaction there would be between the various departments. As shall be investigated in chapter IV, this was at times ineffective, and relationships between the various medical bodies and authorities were often strained.

Once the plans for the introduction of the NHS were entering its final phase, it became apparent that decisions would need to be made whether to continue a career in general practice or move over to full-time hospital consultancy. The choice could at times mean a drop in income, an example from within the region being Dr Gordon Fordyce.[833] He had been in general practice for over ten years in the Grangetown area of Middlesbrough. Alongside this, he had continued as an assistant surgeon at the NOH. When the NHS

[829] *Ibid.*
[830] *Ibid.*, pp. 88-89.
[831] House and Fullerton, *Teesside at Mid-Century*, p. 377.
[832] *Ibid.*, p. 384.
[833] TA/Accession 3720 Box 10.7 Envelope marked File E&F, Teesside Archives, Middlesbrough.

arrived in 1948, he was faced with the decision whether to become a full-time surgeon or revert to general practice entirely. Fordyce ultimately made the move into surgery, even though this meant a drop of £500 per annum, due to his initial SHMO (Senior Hospital Medical Officer) grading, compared to the income he had received as a GP.[834] However, sometimes these decisions to move to hospital work meant opportunities arose for those who previously might have struggled to find a practice of their own, namely female practitioners. Stout interviewed one such female GP, Dr Mary Forsyth; she had an assistant position, alongside two male doctors at a practice in Ormesby.[835] When the two male assistants left the practice to pursue careers as anaesthetists, she was offered the surgery. However, this offer was only made on the understanding that she took on a male partner. This demonstrates that although there were now opportunities opening up due to the re-structuring of the NHS, the male-dominated profession was not quite yet prepared to accept a woman alone at the helm.

The choices were not clear-cut even for those who had been in general practice for some time. Dr Doyle recalled that the period 1946-48 was a difficult time to enter general practice.[836] He reflected that he had a tough time deciding whether to buy a stake in the practice where he had a position as assistant, or wait until after the NHS and see what changes that might bring. Ultimately, Doyle decided to purchase a half share and continued in general practice.[837] Examples such as this show the state of flux within the profession, as it tried to regroup, firstly after the end of the Second World War and secondly as it waited, rather nervously, for the NHS to arrive. This may well be why hospital consultancy started to look so attractive, due to it being a less risky venture, at least financially; as rumour and hearsay about the terms of the NHS regarding GPs clouded judgements. The decisions that the medical profession faced in the immediate post-war years were to come to a head with the inevitable inception of the NHS in the summer of 1948.

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[834] *Ibid.* Fordyce does not state what either pay grade actually was.
[835] *Ibid.*
[836] TA/Accession 3720 Box 10.7 Envelope marked File D.
[837] *Ibid.*

In the HMSO publication, '*The National Health Service*' (1948), there is a section dedicated to the family doctor.[838] It outlines the impact that the arrival of the scheme would have on GPs and their patients. One of the key areas considered under the terms of the scheme was the issue of availability of GPs, especially in deprived or unpopular areas. These areas faced the greatest difficulties in attracting newly qualified doctors to practice there. To counteract this and potentially halt the flow of GPs to desirable, affluent regions of the country, oversubscribed areas now found themselves prevented from opening new surgeries or taking on GPs when vacancies arose.[839] GPs now received payment regardless of the circumstances of the city, town or suburb in which they worked. Additionally, the limitation of list sizes to no more than 4,000 per doctor, theoretically at least, prevented a GP from having more patients than they could reasonably serve.[840]

The NHS booklet, produced to coincide with the launch of the NHS stated that the class who had been most disadvantaged prior to the new initiative was the middle class.[841] They would not have necessarily been eligible for compulsory insurance schemes, meaning that illness would have been prohibitively expensive for them. One potential reason behind this conclusion by the publishers of the report was that the severely deprived had access to insurance schemes, charity and the poor law provision. Therefore, if the middle classes wanted access to free (or relatively inexpensive medical care) they could have it. Alternatively, the intention may have been to sell the concept to the already disenfranchised middle class, this group in particular feared a loss of social status by adopting the NHS. Additionally, as has been highlighted by a recent review of Mass Observation recordings by Nick Hayes, the middle class did not want the state to take control of health provision or

[838] Anon (1948), *The National Health Service*, HMSO, London. The section is entitled 'The Family Doctor and his Patients' pp. 24-31.
[839] *Ibid*., p. 25.
[840] *Ibid*., p. 28.
[841] Webster, *The National Health Service*, p. 3.

interfere with their choices.[842] This resonates with the attitudes of the largely middle class GPs.

The reaction to the plea for increased practice provision is observable through the reports of the Ministry of Health, which examined the percentages of patient lists sizes of GPs within the county boroughs. The report for July 1954 – July 1955 shows that Middlesbrough faired remarkably well in maintaining patient list sizes for GPs within the town below the national average.[843] The general trend highlighted within the survey for Middlesbrough was that of 1,000-2,500 patients per doctor. The other county boroughs in the region, namely Darlington and West Hartlepool, showed a slightly different pattern, with Darlington having lists slightly above the average, especially in the case of those that exceeded 3,000. West Hartlepool GPs predominately had list sizes of between 2,500-3,000, and an exceptionally low percentage of lists above 3,000. By 1961, the situation had improved further with even fewer lists over 3,000 occurring, despite an increase of over 15,000 registered patients.[844] It is unclear how representative of the entire population of the region this was, however, in Middlesbrough the residents, according to the national census stood at 157,308 in 1961 with apparently 162,021 patients registered with Middlesbrough based GPs.[845] The report does explain this anomaly to some extent as a doctors list could include patients from more than one area. In a place like Middlesbrough with a large number of outlying small towns and villages, in addition to a transient workforce, this variation in figures is not that surprising. *Table 25* shows the statistics for the 1954/55 period.

[842] Nick Hayes (2012), 'Did We Really Want a National Health Service? Hospitals, Patients and Public Opinions before 1948', *English Historical Review*, **526**: pp. 650-51.
[843] PP 1955-56, XX (Cmd. 9857), *Annual Report of the Ministry of Health, 1955*, pp. 206-7.
[844] PP 1961-62, XVII (Cmnd. 1754), *Annual Report of the Ministry of Health, 1961*.
[845] This figure can be found in the National Census returns for 1961.

*Table 25*

Registered Patient List Size in Middlesbrough, Darlington, and Hartlepool and the County Boroughs 1954/55

| | Number on lists | % on lists of 1-2,500 | % on lists of 2,501-3,000 | % on lists of over 3,000 |
|---|---|---|---|---|
| Middlesbrough | 147,921 | 44 | 24 | 32 |
| Darlington | 82,491 | 31 | 31 | 38 |
| West Hartlepool | 70,832 | 28 | 56 | 16 |
| County Boroughs | 12,313,119 | 39 | 28 | 33 |

Source: PP 1955-56, XX (Cmd. 9857), *Annual Report of the Ministry of Health, 1955*, pp. 206-7.

At the beginning of the 1950s, an article was due for publication in the *Lancet* that would unsettle the profession in a way never before witnessed. This was the notorious Joseph S. Collings article, entitled 'General Practice in England Today: a Reconnaissance'.[846] Collings described the bleak outlook for general practice, based, in the main, on observations of urban, industrial practices throughout the country.[847] Every area of general practice was highlighted for criticism, from the GPs themselves, to the conditions within their surgeries, through to their treatment and diagnosis. Few GPs' visited received any praise, and the overall quality of the profession was found to be extremely low.[848] Any survey after the Collings report used the study to investigate perceived inadequacies within general practice. This would include areas, for example, such as equipment, and how it was used to aid or complement diagnosis, if at all. On occasion, practices owned instruments but did not routinely use them as a diagnostic tool.[849] The next chapter looks in detail at the considerable changes to general practice after this period.

[846] Joseph S. Collings (1950), 'General Practice in England Today: a Reconnaissance', *The Lancet*, **255:** pp. 555-85. Collings was a New Zealand born doctor, who, when the article was published in the *Lancet* in 1950, was a research fellow at Harvard School of Public Health. Almont Lindsey (1962), *Socialized Medicine in England and Wales: the National Health Service, 1948-1961*, University of North Carolina Press, Chapel Hill, p. 79.
[847] Ibid. p. 563. Collings describes inner city and urban practices as 'unsatisfactory and at worst a public danger'
[848] Irvine Loudon and Mark Drury, 'Some Aspects of Clinical Care in General Practice' in Loudon *et al* '*General Practice'*, p. 93.
[849] Digby, *The Evolution of British General Practice*, p. 312.

## Conclusion

This chapter has aimed to examine the health of the area from the inter-war years through to the inception of the NHS and the reaction of the medical community. These years provide an opportunity to assess what GPs were doing within the region, not only from the viewpoint of their medical work but also regarding their public persona and commitments. Looking through the Medical Directory and obituaries helps identify those that worked as GPs in the town, and equally importantly, the other public roles they may have held within the town and district. It has also provided an insight into the location of surgeries and the correlation between this and the types of health care in the different wards. The issue of surgery location is one that persists throughout the period. Even by the time of the Lock survey in 1944 it was noticeable, as it had been in the 1920s and 1930s, that it was distinctly disproportionate throughout the town. The northern area of Middlesbrough that housed the poorest sections of the community were poorly attended regarding medical provision. The majority of those who lived in this area would have had to travel to visit their GP. It was also true that they were the people least likely to have the resources to hand to do so. From the GPs' perspective, they would have perhaps been reluctant to live in these wards, but it did not benefit the doctor-patient relationship and widened the perceived social and spatial distance between doctors and patients.

The late 1920s and 1930s were a time of economic depression, something that was keenly sensed in an area as reliant on industry as Middlesbrough. Ultimately, the knock-on effect was felt in all areas of daily life within the town, namely with unemployment, housing, diet, and ultimately health. Despite the optimistic musings of the MOH, things in Middlesbrough did not improve at the same rate as in the rest of the country. This suggested that the town had problems that were endemic, and these issues would persist unless addressed. This message must at some stage have resonated with the local authority, as a wide-scale survey of the town was commissioned, part of which investigated the health and health services within the town. The Lock survey highlighted a number of issues that the

authorities in Middlesbrough were already aware of, certainly by the 1940s. These included the distribution of GP surgeries and the inadequacies of child and maternity services, as well as those for the elderly and adolescents. However, many of these recommendations could only be achieved after the introduction of the NHS. This in itself caused concern amongst GPs in the town, faced with crucial decisions as to their future career paths in the new NHS environment. Healthcare for all would theoretically at least prove beneficial to the community, at least to those who had always been historically disadvantaged. GPs now struggled to assert themselves in a new medical era that seemed to favour hospitals over family practitioners.

The fourth chapter of the thesis will begin by assessing the impact of the Collings investigation and other reports during the 1950s, which caused substantial disagreements both within the field of general practice itself and within the wider medical community. It will also examine the oral testimonies of GPs who practised in the area from the 1950s onwards. In doing so, it will question the perceived wisdoms of what was relevant to GPs at this time and the way in which they dealt with health issues, and how they interacted with officials and the community.

## Chapter IV: 1950-1980: The Fall and Rise of General Practice

This chapter will consider further oral history interviews of practitioners from the region, the majority of who were in practice from the late 1950s until the early 1980s. It will assess this data in relation to evidence gathered so far from the secondary literature, as well as beginning to contextualise the information specific to the area in comparison to the established perspective.

Thus far, there have been few studies involving the interviewing of GPs about their experiences and careers, especially within a given community or locale. There has been one similar study undertaken, based in the Scottish town of Paisley. The details of this study were published in a variety of journals, including the *British Journal of General Practice*, from 2002-2007.[850] The town itself is much smaller than the area that this project covers and specifically reviews the career paths and motivations of both retired and current GPs in the town. Specifically, the Paisley project was split into eleven sub-topics. These were; motivations behind becoming a GP; partnerships; how practice evolved; gender and narratives; beyond the practice; outside interests; patients and populations; record keepers; diagnostics and therapeutics; teaching and training, and finally reflections and the history.[851] In terms of the Middlesbrough research, it is interesting to note that these topics are indeed

[850] The articles appeared in the *British Journal of General Practice* over twelve instalments under the title 'An Oral History of Everyday General Practice: Speaking for Change'. Graham Smith and M. Nicolson, et al (2002), 'An Oral History of Everyday General Practice: Speaking for a Change' *British Journal of General Practice* **479**: p. 516-517 and Graham Smith and M. Nicolson (2007), 'Re-expressing the Division of British Medicine Under the NHS: The Importance of Locality in General Practitioners' Oral Histories' *Social Science and Medicine* **64**: p. 938-948.

[851] Graham Smith (2002), 'An Oral History of General Practice, 2: Why do GPs Become GPs? : Family, Education and Vocation' *British Journal of General Practice* **480**: p. 604-605, Graham Smith (2002). 'An Oral History of General Practice, 3: Partnerships' *British Journal of General Practice* **481**: p. 692-693, Graham Smith (2002), 'An Oral History of Everyday General Practice, 5: Gender and Narratives of Profession' *British Journal of General Practice* **483**: p. 868-869, Graham Smith (2002), 'An Oral History of General Practice, 6: Beyond the Practice: the Changing Relationship with Secondary Care' *British Journal of General Practice* **484**: p. 956-957, Graham Smith (2002), 'An Oral History of General Practice, 7: Outside Interests' *British Journal of General Practice* **485**: p. 1038-1039. Graham Smith (2003), 'An Oral History of General Practice, 8: Patients and Populations' *British Journal of General Practice* **486**: p. 76-77, Graham Smith and M. Nicolson (2003), 'An Oral History of General Practice, 10: Diagnostics and Therapeutics' *British Journal of General Practice* **488**: p. 256-257, Graham Smith (2003), 'An Oral History of General Practice, 11: Teaching and Training' *British Journal of General Practice* **489**: p. 340-341, Graham Smith (2003), 'An Oral History of General Practice, 12: Reflections and the History of Disappointment' *British Journal of General Practice* **490**: p. 420-421.

amongst the common themes that the GPs interviewed during the thesis freely discussed, without too much guidance. For the purposes of this study, perhaps the most pertinent areas are the evolution of practice; patients and populations; record keepers; diagnostics and therapeutics, and teaching and training. It was reasonable to assume that there would be a certain amount of surplus data outside of the general remit of the investigation generated. This proved to be of interest during the later stages of the project, as it progressed further and developed.

The Paisley study focused heavily on the use of language and the inter-relationships of the doctors amongst themselves and with the community. For the purposes of the Middlesbrough study, due to the limited sample of interviewees that came forward, the decision was made to analyse what the GPs were saying in relation to existing perceptions and histories about both the location and the profession. As already suggested, the Paisley study proved invaluable when commencing a comprehensive evaluation of the completed interviews, especially in terms of key points to be reflected on and in particular on the appropriate methodology used during the analysis. It became apparent that, despite differing locales, there were common experiences amongst the two groups. Most pronounced when comparing the interviews of the retired GPs in the Paisley study rather than those still in practice.[852] As the Middlesbrough interviews progressed, it became possible to react to what the doctors were saying and make queries regarding their answers, during the course of the consultation. Whilst it is important not to guide or steer the interviews, at times, it was necessary to ask direct questions, sometimes to no avail. This was the case when trying to ascertain types of illness and disease encountered, often resulting in little or no depth of response. This often led to insightful discussion of over looked areas otherwise not considered. Certainly prior to commencing the interviews, there had been no consideration given to the level of interest or indeed frustration that the GPs had with administration, particularly during the late 1960s and into the 1970s.

[852] *Ibid*.

There were of course other developments during this time of relevance to the region, including the establishment of a link between smoking and lung cancer by Sir Richard Doll in the early 1950s.[853] The Middlesbrough area had always suffered severely from respiratory diseases conditions usually linked to pollution from industry. The smoking link with lung disease, however, provided an alternative possibility for a community with a high percentage of heavy smokers. In 1961, the contraceptive pill became available, initially only to married women, although, in 1967 this restriction relaxed.[854] This may well have been influential in lowering both of the rates of infant mortality and birth statistics within the area; however, often the prescribing of the pill was dependant on the opinions of the individual GP. Other advances worth attention that may well have been consequential to the community was the launch of several mass immunisation programmes in the 1950s. These included immunisation with the BCG (Bacillus Calmette-Guérin) vaccine for those under thirteen years of age against TB in 1953 and the polio and diphtheria vaccination programme for those under fifteen in 1958.[855] These were all issues that were to affect the GPs in the region directly, and cited as key events within the careers of those interviewed.

The 1970s and early 1980s were punctuated by successive strikes throughout numerous industries and services. This led to long-term unemployment with little chance for the revival of the traditional industries of the region, such as steel and iron manufacture and shipbuilding. The de-industrialisation of the region was almost complete by the beginning of the 1980s, and this led to a new set of health implications, not just physical manifestations of illness but also mental, with depression amongst those out of work increasing. Unlike the strikes and the subsequent depression of the 1920s and 1930s, this reduced income would not have the same effect upon the people's access to medical care. Patients no longer found themselves confronted with the situation of not having enough money to pay for healthcare,

[853] Richard Doll and Austin Bradford Hill (1956), 'Lung Cancer and Other Causes of Death in Relation to Smoking', *British Medical Journal*, **5001**: pp. 1071-1081.
[854] Hera Cook (2004), *The Long Sexual Revolution: English Women, Sex, and Contraception, 1800-1975*, Oxford, Oxford University Press.
[855] Geoffrey Rivett (1998), *From the Cradle to the Grave*: *Fifty Years of the NHS*, London, King's Fund Publishing, p. 389-390.

due primarily to the development of the NHS. However, during this period healthcare services became directly involved in industrial action, with a large proportion of medical personnel and ancillary staff going on strike to varying degrees.[856] The health of the region again found itself compromised as patients tried to gain access to care within a profession in crisis. This coincided with a number of technological innovations that improved diagnosis of non-communicable disease such as cancer, brain trauma, and other internal injury and disease. These developments included the introduction of computed tomography (CT) scans in 1972, followed by magnetic resonance imaging (MRI) in the early 1980s.[857] GPs could refer their patients to local hospitals with this advanced technology, however, with a period of prolonged industrial action within the health services the practical application of this new technology was jeopardised as waiting lists extended into years as opposed to months. Many GPs found their roles severely compromised by the limited nature of services at this time and the inability to provide patients with the treatment they required and the GPs desired.[858]

Whilst the legacy of heavy industry may well have taken its toll on the population in relation to their health, the 1950s to 1980s were an era of rapid industrial decline, years away from significant redevelopment. During this period, there began a slow drift away from predominately industrial employment, such as iron and steel, to work within secondary areas such as factories, retail and business parks and eventually call centres. The large-scale migration of workers to the area throughout the first half of the century now began to show signs of the strain it placed upon resources in the region as unemployment levels soared and the out-migration of the young and healthy began.

[856] For an analysis of the politics of the situation see Webster, *The National Health Service: A Political History*, and Charles Webster (1996), *The Health Services Since the War: Volume Two Government and Health Care: The British National Health Service 1958-1979*, London, HMSO, pp. 693-706.
[857] Rivett, *From the Cradle to the Grave*, p. 316.
[858] Accession 3076 Box 6 envelope 1, Teesside Archives, Middlesbrough

## The Voice of the General Practitioner

The concentration of the doctors interviewed were located around the edges of the Stockton area, and Middlesbrough, these GPs are all still in regular contact with one another having practised at a similar time within the town.[859] Dr Geoffrey Marsh was in practice, in Stockton, throughout the 1960s and 1970s and had an interest in obstetrics and practice management/administration.[860] Dr Marsh has also produced a large body of published material, including numerous journal articles and books on teamwork in general practice. Marsh remained as a senior partner in his practice until his retirement. Dr Colin Mackenzie was also a GP in central Stockton throughout the same period as Marsh.[861] Like Marsh, Mackenzie went on to be a senior partner in his practice, although he did not publish material in the way that Marsh did. Dr Aubrey Colling, likewise practised in Stockton at the same time as the previous two doctors, however, unlike them, Colling was a partner in a private fee-paying practice.[862] Dr Colling was also an enthusiastic researcher, producing published material much in the same way as Dr Marsh. Additionally, Colling was also instrumental in establishing a training program for GPs throughout the region, in conjunction with Newcastle University. Dr Ian Holtby practised as a GP throughout the 1970s in the Redcar area of Teesside, just outside Middlesbrough.[863] Holtby left general practice in the early 1980s to work within public health as a consultant for the control of infectious diseases in Teesside. The final GP who came forward to be interviewed was Dr Donald Morton, a GP in the 1960s through to the late 1980s in the Middlesbrough area.[864] Dr Morton was one of the original GPs who practised at the Cleveland Health Centre from its opening in 1973.

The career paths of GPs in Middlesbrough and Stockton were not excessively different from those of family doctors elsewhere in the country at this time. Most had been in

[859] All of the GPs interviewed during the course of the thesis gave their written permission for their names to be used without anonymity.
[860] GP Interview 1 G N Marsh 21/01/09.
[861] GP Interview 2 C Mackenzie 21/02/09.
[862] GP Interview 3 A Colling 26/02/09.
[863] GP Interview 4 I Holtby 02/04/09.
[864] GP Interview 5 D Morton 28/04/09.

the Medical Corps during the Second World War or had undertaken national service. They had then gone on to work within one or more of the hospitals located in the region, often specialising at some stage, frequently in obstetrics. Many GPs in the area had spent a considerable portion of their careers working within local hospitals, much of which was unpaid prior to the advent of the NHS. GPs in the region had become accustomed to enjoying access to hospitals to carry out their own surgery and research. For example, the Carter Bequest Hospital in Middlesbrough, opened in 1926, was a privately funded enterprise consisting of 52 beds, the majority reserved as GP beds.[865] These formed an essential basis from which family doctors could apply their surgical and research skills, as well as enhance their reputation and income. Many of the medical representatives on the hospital's committee consisted of senior members of the GP community.[866] In the 1930s, one out of three practitioners had access to hospital beds around half were GPs.[867]

The reasons that they cited for becoming a GP tend not to vary much between the interviewees. They opted for the field, often to start earning an income immediately, due in part to existing family commitments. Becoming a junior partner could provide GPs with living quarters, although this meant being available for 24-hour callout. Hospital based medicine could not offer this. Accommodation for the doctor may have been provided but not always for his wife and children. Drs Mackenzie, Marsh and Colling all cite this as a factor.[868] These issues are included in Michael Bevan's observations based on interviews with GPs taken as a part of the project 'The Oral History of General Practice in Britain, 1935-52'.[869] The doctors Bevan interviewed also cited similar concerns to those of the Middlesbrough GPs. The

[865] TA/H/TS/5/2 'Carter Bequest Hospital, Souvenir Commemorating the Occasion of it Opening 1926', Teesside Archives, Middlesbrough.
[866] TA/H/NOR/3/37 'Carter Bequest Hospital Annual Report and Balance Sheet of Management Committee 1946', Teesside Archives, Middlesbrough.
[867] Rosemary Stevens (1966), Medical Practice in Modern England: The Impact of Specialization and State Medicine, Yale University Press, New Haven, p. 56.
[868] GP Interviews 1, 2 & 3.
[869] Michael Bevan, 'Family and Vocation: Career Choice and the Life Histories of General Practitioners', in Joanna Bornat, Robert Perks, Paul Thompson and Jan Walmsley (eds.) (2000), *Oral History, Health and Welfare*, Routledge, London, pp. 38-42. These interviews, at least the majority of them are available at both the British Library Sound Archive and the Archives at the Wellcome Library, both in London.

doctors he interviewed would have practised at a similar time to the Middlesbrough and Stockton group.

The 1967 publication by Ann Cartwright, *Patients and Their Doctors: A Study of General Practice* can be used as a comparison when evaluating the information gathered from the Middlesbrough and Stockton GPs.[870] Some of the key areas observed within the interviews collected for this study were also areas that Cartwright picked up on during her 1960s survey. Cartwright's book was based on a study that took place in the early 1960s, prior to the formation of the Family Doctor's Charter (1965/6).[871] The study surveyed doctors and patients on a number of topics, such as consultations, preventive care, hospital services, medical education and practice organization. These topics shall be analysed and discussed identifying similarities, and perhaps importantly any differences.

## Medical Education

Chapter ten of Cartwright's study examined the variations between doctors concerning their year of qualification, further education, qualifications and membership of the CGP (now the Royal College of General Practitioners).[872] At the time of the survey, GPs working within the country had qualified from 1925 onwards. This meant that there was a variation in the styles, level and practice types the GPs offered. Cartwright found that the proportion of home visits by older GPs was much higher than those of newly qualified doctors.[873] This suggested a personal approach by the older GPs, but it was equally true that a larger percentage of their patient list was elderly. The elderly were a group of patients who required more frequent attention, as well as home care, primarily due to issues with mobility. Patients who had older GPs also stated that they had a 'friendly' relationship with their doctor. This was due in the

[870] Ann Cartwright (1967), *Patients and Their Doctors: A Study of General Practice*, Routledge and Kegan Paul, London. The study took place in twelve areas located throughout England and Wales including Newcastle-Upon-Tyne, Sheffield, Bristol, Luton and Cambridgeshire.
[871] *Ibid*.
[872] *Ibid*., p. 168.
[873] *Ibid*., pp. 168-9.

most part to having had the same family doctor for a prolonged period, in many cases this was in excess of twenty years. Those respondents with newly qualified GPs tended to cite a 'business-like' relationship, often these patients were from the mobile social classes, changing doctors frequently.[874]

An area that was different between the two groups of GPs was their attitude to research and education.[875] Those who had qualified prior to 1935 had been away from hospital-based medicine for some time and instead had become responsive only to the needs of their community. In the case of Middlesbrough, GPs had maintained strong links throughout the 1930s and 40s with the local hospitals. Nationally it was discovered that, newly qualified GPs tended to embrace the concept of specialism and further training far more than their established colleagues did. Obstetrics proved to be a popular speciality, for example, during the 1960s.[876] Older GPs were resistant, and the Cartwright study suggested this might have been due to the element of night work involved and associated with obstetrics.[877] This was a fact that the GPs interviewed during the course of research at Middlesbrough endorsed. At least three of those interviewed, cited and expressed an interest in this area during the 1960s.[878] Maternity duty was an integral part of the doctor's duties, up until the late 1970s.[879] In the early part of their careers, all of the doctors report delivering babies at home, or using the local maternity hospital to supervise the delivery. Marsh, in particular, was a specialist in GP obstetrics, and the rest all seem to have had a keen interest in the area.[880] Maternity provision became the domain of the hospitals; the decline in home births began soon after the NHS arrived. By 1968, 80 per cent of all births took place in the hospital.[881] The GPs' role effectively reduced to involvement before and after the birth. It became an increasingly diminishing skill for the average GP. This meant

[874] *Ibid*., p. 169.
[875] *Ibid*., pp. 174-9.
[876] *Ibid*., p. 171.
[877] Cartwright, *Doctor's and Their Patients*, p. 171.
[878] GP Interviews 1-5.
[879] Rivett *From the Cradle to the Grave*, p. 227.
[880] GP Interview 1.
[881] Rivett, *From the Cradle to the Grave*, p. 227.

that GPs, and indeed midwives that worked alongside them rather than in hospitals, were no longer confident about performing home deliveries. GPs found themselves pushed out of a process they used to have autonomy over, and the number of home births became negligible.[882]

At the beginning of the Teesside GPs' careers, there was little formal training for the role of being a GP. Dr Mackenzie recalls there being two or three lectures a year, run by the BMA. These usually consisted of a talk by a luminary of the medical profession, with no provision for questions or discussion. There was still the overriding feeling that general practice was for those doctors not capable of specialisation. Mackenzie cites areas such as minor ailments, stresses within families, anxiety and fears of patients as not being an area observed on the university curriculum, much to the detriment of the GP.[883] The primary way in which a GP learned and trained at this time was on the job, often through trial and error. There was also a lack of formal literature, explicitly designed for GPs. There was the *Practitioner*, although consultants often wrote articles with little relevance to the work of GPs. The *BMJ* also had few articles aimed at GPs. The College of General Practitioners founded in 1952 helped address this situation, but according to Mackenzie prior to its Royal Charter few GPs had any idea of its existence. Mackenzie cites the formation of the North Tees Medical Society in 1966 as an important step in the education of GPs locally.[884] It was not only beneficial in terms of education but also in drawing the GP community together, often GPs from different surgeries, even though in the same town, did not work together or share practical advice or information. They often socialised together but not on a professional basis. This society also drew in hospital staff and public health workers, all of whom widened the GPs' network and resource base.

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[882] *Ibid*.
[883] GP Interview 2.
[884] GP Interview 2. This society was actually the brainchild of Dr Colling who was instrumental in getting the doctor's together. They met and discussed issues pertinent to their own GP community but also had guest speakers from local hospitals and public health workers. These reports were then written up and kept by Colling and give an interesting insight into what the research the GPs were undertaking outside of their day-to-day work.

During the early part of the 1970s, there was to be the development of much more structured postgraduate training for GPs in the region. This was thanks in no small part to the work of Dr Colling. Colling became the lead trainer for the course, which became progressively larger, covering a wider range of topics as it developed, and as it gathered more support and credibility amongst the profession.[885] It was, however, to serve newly graduated GPs far better than it did for existing and established GPs. The latter group were much more likely to view the training with suspicion or believe that they needed no further training of this nature. Colling found there was reluctance amongst older GPs to participate, and if they did, it was in a far less open-minded manner than their less experienced counterparts.[886] The training course established in conjunction with Newcastle University, received the backing of the MOH for Teesside, Raymond Donaldson.

Education for GPs within the field of general practice had historically been poor. University medicine was based around the hospital, not on the work of the family doctor. This frustrated the GPs, especially those who qualified after 1945. There was little in the way of a career structure for GPs, they quickly reached a plateau with no real opportunity for advancement.[887] To buy into a practice was expensive, and for a junior partner it inevitably meant more work, taking them away from their young families. Even for GPs who had practised for many years, there was a sense of disillusionment at the lack of training and advancement.

As part of the issue of further education during service, Cartwright tried to determine how doctors received up-to-date information.[888] In the case of group practice, informal meetings amongst the partners seemed to be a popular source. This was certainly the case amongst the doctors interviewed in the Middlesbrough area. However, here GPs also cited the formation of the Teesside Medical Society as an important way of learning about new methods and techniques. Additionally, it provided an insight into the research of their peers

[885] GP Interview 3.
[886] *Ibid*.
[887] *Ibid*., pp. 172-3.
[888] Cartwright, *Doctor's and Their Patients*, p. 175.

as well as keeping them in touch with their hospital-based colleagues.[889] During the mid-1960s, there were pilot vocational training schemes for GPs, which were to pave the way for the implementation of further schemes in the 1970s. The Todd Report was a landmark publication that established that GPs needed training in their chosen field to the same level offered to other 'specialities'.[890] This was one of the first reports to acknowledge openly general practice as a medical speciality. As far as training went this was not to happen until the mid-1970s and was based on the NHS Vocational Training Act of 1976.[891] One GP who took part in the Cartwright study commented on the lack of direction and open communication within general practice. When they had trained as a junior doctor their every move had been questioned, but this was not the case when they became a GP.[892] They felt isolated and did not always have to reflect upon their decisions or learn further. In the 1960s, newly qualified GPs were those most likely to attend any training courses or those enthusiastic about their work. As Cartwright stated: 'The impact of further education programmes appears to be somewhat haphazard and there is a real danger that they fail to reach those in most need of education.'[893] Cartwright also called for more structure and greater variety in the types of courses that were to be made available to the GPs.[894]

## Views on Preventive Care

During the 1960s, there were on-going issues concerning general practitioners taking on extra duties such as immunization and routine tests. These tests would have fallen under the auspices of the local authority in the shape of the Medical Officer of Health. One such issue was the question of cervical smear tests for middle-aged women.[895] The prevailing attitude of MOHs was that this test needed to be extended, so that it routinely included this age group,

[889] GP Interviews 1-5.
[890] Charles Webster, 'The Politics of General Practice', in Loudon *et al*, '*General Practice'*, p. 31.
[891] *Ibid*.
[892] Cartwright, *Doctor's and Their Patients*, p. 144.
[893] *Ibid*., p. 184.
[894] *Ibid*., p. 185.
[895] Ibid., p. 93.

and be performed by GPs. The GPs, however, were not overly enthusiastic at this prospect, some felt that it opened unlimited possibilities and would overburden an already stretched system.[896] The GPs even contested the issue of collection of samples and responsibility for the subsequent cytological examinations. GPs worried about the message such a scheme would send to their patients.[897] Time was a precious commodity to GPs, and they already felt overworked and adding preventive roles to their existing schedule would be unworkable in their opinion. Many of those interviewed by Cartwright cited remuneration for their services as the only incentive to carrying out the work at all.[898]

In Middlesbrough and Stockton, the doctors do not seem to have had a high opinion of public health or its work. At least they do not seem to feel that they had any real involvement with it. They were more involved in dealing with their patients and their health problems than what they saw as 'town hall politics'. They occasionally had dealings with public health officials when notifying an outbreak of a disease or food poisoning, but other than that very little.[899] MOH Donaldson does seem to have left a positive impression on them, working tirelessly to bring all strands of the profession together. The overriding impression the GPs give is that they were aware of public health issues but not entirely, directly involved.

There was also concern that GPs would end up seeking out patients on their list who were not sick, just to fulfil their mandate. There were also territorial issues over services, such as well-baby clinics and the school medical service. GPs felt that they, rather than local authorities, should run such facilities. They felt existing provision was not as effective as it could have been, and GPs had to pick up the pieces when things went awry. One such GP commented in Cartwright's study, '...advice is given without consultation with the GP, but any harmful results of such advice falls on the GP to sort out – usually in the early hours of the

[896] *Ibid*.
[897] *Ibid*.
[898] *Ibid*., p.94.
[899] GP Interview 3

morning.'[900] Another felt that local authorities should '[o]pt out of clinical medicine.'[901] Doctors considered that the concept of such a system was set up when people needed treatment or advice they could not afford.

In the case of health visitors, GPs thought they should have had at least basic nursing training, and they, along with district nurses, should be under the control of the GPs rather than the MOH. The suggestion was made that perhaps GPs now wanted curative and preventive care joined together, rather than separated as the two branches had been historically. Cartwright's study also attempted to outline what the two different approaches within preventive care were.[902] Firstly, to discover conditions that could be cured or alleviated by preventive screening via mass x-rays or surveys of the community. Secondly, to examine groups such as children via the school medical system with the expectation that health and well-being would be promoted amongst the pupils as well as their parents.[903] The problem with this approach was that only the vulnerable sections of society would be targeted, therefore, widespread health promotion would not take place. The elderly were central to Cartwright's survey, especially when it came to local authorities organizing check-ups.[904] The elderly were much more likely to go and see their own GP rather than a stranger appointed by the MOH. The implication was that GPs might be best placed to encourage the elderly to attend for a routine health examination.[905] Once again, GPs were in general agreement about this, but they felt they needed both time and financial incentives to become involved. A solution to the question of workload and resources was the suggestion that female doctors might be recruited to take up such posts and deliver these preventive services.[906] Additionally, GPs felt that local-authority run clinics were a waste of valuable resources and that most of their work could easily be done by the GPs instead. This was especially so as the doctors considered there was a high percentage of work overlap between the two health

[900] Cartwright, *Doctor's and Their Patients*, p.95.
[901] *Ibid*.
[902] *Ibid*., p.96.
[903] *Ibid*.
[904] *Ibid*., p. 97.
[905] *Ibid*.
[906] *Ibid*., p. 98.

providers.[907] The one sticking point to arise from all this discussion concerned the child welfare clinics. Mothers worried that they might lose a useful resource, without any replacement, if the changes the GPs desired were to come about.[908]

In 1975, a parliamentary subcommittee assembled to look into the matter of health expenditure.[909] It concluded that too much money was currently spent on curative medicine rather than preventative medicine. The following year the government produced the publication *Prevention and Health: Everybody's Business*. Unfavourable behaviour and habits were blamed for many of the biggest killers such as coronary heart disease, lung cancer and bronchitis. Smoking, alcohol consumption, drug use and obesity had become an intrinsic part of modern, urban, industrial living it seemed.[910] Richard Doll remarked in the early 1980s that the primary requirement to make the nation healthier was to identify the requisites needed to prevent disease, implement measures to do so and then monitor their success. Many diseases such as lung cancer and heart disease were preventable, especially if the correct controls and measures were in place.

Many GPs were researching ways to achieve this goal; an example is the screening of patients for conditions such as high blood pressure; a development of the highly innovative GP, Julian Tudor-Hart, during his time in practice.[911] There was a real emphasis placed on identifying the potential for disease to occur before it became a reality. Tudor-Hart advocated the adoption of such systems in areas such as diabetes, smoking, alcohol abuse and monitoring cholesterol levels.[912] An example of such a study from within the Middlesbrough and Stockton cohorts is that of Dr Colling.

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[907] *Ibid*.
[908] *Ibid*., p. 99.
[909] Rivett, *From the Cradle to the Grave*, p. 210.
[910] *Ibid*. Interestingly cigarettes and alcohol at this time were made cheaper with each successive budget rather than more expensive. Rivett states that a reversal of this strategy would have perhaps done more than any other policy to improve health.
[911] *Ibid*. p. 211. Tudor-Hart was interested throughout his career in this particular area of research, publishing numerous books and journal articles on the subject of hypertension, dating from the 1970s onwards.
[912] *Ibid*. p. 238.

Dr Colling was heavily involved in the Teesside coronary survey, the results of which appeared in 1976.[913] Again, Raymond Donaldson was an integral component of the study, demonstrating once more the close relationship he had with the work of GPs in the region and the commitment he had to the role of MOH. The survey was a twelve-month study carried out from 1972-73 in Teesside, assessing attacks of acute myocardial infarction.[914] It examined the incidence and mortality in both sexes. Through this study, it was found that a third of the patients received treatment at home and that they had a lower fatality rate than those treated in hospital. Age, sex or the severity of the attack appeared not to affect the results or the outcome of this. The primary aim of the survey was to assess the potential of developing a mobile coronary care unit. Some GPs, according to the results, had a tendency to send almost all patients with suspected myocardial infarction to hospital. The majority, however, adopted a mixed policy depending upon the situation. The conclusion of the survey was that the best plan would be to form an active unit that would begin treatment in the patient's home rather than risk moving them to hospital, which was often dangerous. The survey further suggested that the appropriate approach should be a cooperative one, involving hospitals, GPs and unspecified 'other helpers'.[915]

Aside from this survey, Colling also published articles on other GP-related issues. These included the benefits of family interviews to GPs and the composition of social groups in private practice.[916] The former article, co-authored by another Stockton GP, Dr. Angus Bird investigated the impact of family problems on illness and the importance of family doctors being aware of such issues. The study's influence and inspiration was largely attributable to Colling's time at the Peckham Health Centre. Initially 100 families received invitations to attend; nineteen of which did so, and the rest had a questionnaire sent to their homes if they did not respond. After being divided into social groups, there were various

[913] Aubrey Colling, Alexander W Dellipiani, Raymond J Donaldson and Peter MacCormack (1976), 'Teesside Coronary Survey: An Epidemiological Study of Acute Attacks of Myocardial Infarction', *British Medical Journal*, **6045**: pp. 1169-72.
[914] *Ibid*.
[915] *Ibid*. p. 1172.
[916] Angus Bird and Aubrey Colling (1968), 'Family Interviews in General Practice', *Journal of the Royal College of General Practitioners*, **15**: pp. 123-27.

questions about family composition, work and schooling, in the case of children.[917] The interviews highlighted gaps in immunization, and the occurrence of inadequate follow-ups in the case of chronic medical conditions.[918] Colling and Bird concluded it was beneficial to conduct these interviews if a GP suspected a family might be experiencing difficulties that could affect their health.

Sometimes government policy appears to have been counter-productive to the GPs' aims to improve health. An example of such is the reintroduction of prescription charges in 1968. GPs now had a wider array of drugs at their disposal, but it did not always follow that they were able to prescribe these drugs as required. The introduction of the charge led to a decline in the number of prescriptions issued.[919] Patients became reluctant to pay for their medicine, preferring instead to buy cheaper over-the-counter remedies. GPs aided patients too by prescribing larger quantities of drugs at any one time than they did previously. Additionally, exemption groups were created, patients within these groups did not have to contribute at all, and these included the elderly, children and those with chronic long-term conditions. It was the exemptions that dominated the total number of prescriptions made, this effectively negated the main reason behind the introduction of charges, namely to supplement Exchequer funds diminished after the devaluation of the pound.[920] In an area such as Middlesbrough with high unemployment and widespread poverty, it is likely that this situation was a common feature of practice life, as GPs struggled with the needs of their patients versus the reality of what the patients could afford.

[917] The social classes were based on occupation and were as follows: Class I – Professional; Class II – Intermediate; Class III – Skilled; Class IV – Partly skilled; Class V – Unskilled; Unclassified – widows, HM forces and unemployed. In his practice, Colling predominately saw patients from Class III. However, despite the fee paying status there was still a healthy representation amongst each class. Aubrey Colling (1963), 'The Social Class of Private Patients in General Practice', *Lancet*, **7273**: pp. 155-6.
[918] *Ibid*. p. 127.
[919] Webster, *The National Health Service*, p. 129.
[920] *Ibid*. pp. 46-7.

## GP–Hospital Relationship

Cartwright's study explored the relationship between GPs and local hospitals. It highlighted the problems, particularly regarding delays and appointments/referrals.[921] Once more, the elderly were singled out as causing the greatest concern when trying to secure a quick referral. This was put down to the fact that many of the issues with geriatric patients were not solely clinical but also social. The GPs tended to blame the hospital for the situation, including administrators, GPs felt they exerted pressure on the hospital consultants, particularly regarding referrals. GPs felt that there was a lack of communication within the hospital itself, and often consultants had to work under unsatisfactory conditions with aging equipment and poor staffing.[922] However, some GPs considered that the consultants exploited the situation to secure private patients. It was accepted that long delays between referral and appointment did sometimes lead patients into paying privately. The knock-on effect of all this for the GPs was that they had to deal with dissatisfied patients. Even after their patients had been seen at the hospital the GPs were not necessarily informed as to the course of action taken. The GPs complained that they were kept out of the loop, not even being told what medication their patient had been discharged with.[923] Unfortunately, during the 1960s the reputation of GPs within hospital medicine was not at a premium. There was a perceived distance between the two groups. This was especially so in the case of junior hospital doctors, who did not always show GPs the level of respect the latter felt they should have.[924] There was a feeling that GPs should have worked towards a positive reputation within their local hospital, increasing their chances of being treated with courtesy. Cartwright suggested that the way the GPs could have achieved this, was to have used the same hospital and consultants rather than to have changed to the one with the shortest waiting list.[925] Ultimately, therefore, it became a question of whom the GP wanted to keep happy, his

[921] Cartwright, *Doctor's and Their Patients*, p. 141.
[922] *Ibid*., p. 142.
[923] *Ibid*., p. 143.
[924] *Ibid*., p. 144.
[925] *Ibid*., p. 143.

patients or the consultants. The GPs needed to have established links to hospitals; some even took ad hoc positions within one. However, general practice found closer links to other medical specialities outside of hospital medicine such as community medicine or social welfare. For this reason, it was perhaps understandable that there was a division between GPs and their hospital colleagues. Cartwright did stress the need for collaboration and parity in treatment.[926]

In Middlesbrough and Stockton, the case was somewhat different amongst the GPs interviewed. On this point, the doctors all seem to report a respectful working relationship with the local hospitals, observable through the North Tees Medical Society, which brought together both local GPs and hospital consultants. They did feel understandably protective of their career choice and felt disappointment that there was the perception during the 1960s that they were somehow an inferior branch of the medical profession. Even Dr Colling, who worked in private practice, reported no problems existing between the GPs and the hospitals. He managed to refer patients who paid him privately to local hospitals for NHS treatment.[927]

This was not always the case within the region. Strikes were an issue that punctuated British history at this time, specifically the 1970s; both within industry and unusually within the healthcare service itself. Prior to 1971 less than 3,000 staff had been involved in industrial action, this dated back to 1948. This was to change in 1972, however, when ancillary staff at hospitals voted to strike. The trend continued over the next few years with ambulance staff striking in 1978. This ended with crews being temporarily replaced with military ambulances.[928] The effect upon the GPs was noticeable in a number of ways; it influenced their interaction with patients as waiting lists from referrals by the GPs to consultants reached crisis level.[929]

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[926] *Ibid*., p. 145.
[927] Even Colling could not explain this anomaly as anything more than an administrative oversight. He concluded that there was no possibility that the same situation would be allowed to exist today.
[928] Rivett, *From the Cradle to the Grave*, p. 348.
[929] Loudon and Drury, 'Some Aspects of Clinical Care' in Loudon *et* al *'General Practice'*, pp. 103-8.

In a letter, sent from Dr Stout's practice, dated June 8, 1976, to the local medical committee issue is made over the extended waiting times that patients had to endure to see an ENT consultant at the North Riding Infirmary.[930] Patients whom the GPs referred in 1976 received appointments to meet with a consultant no earlier than late 1978. This was a direct result of the problems the hospital services were experiencing, combined with a shortage of consultants in most departments. Indeed, many of the departments had even withdrawn the facility of informing GPs directly as to what they had found, thereby keeping the GP restricted as to what they could tell their patients or what help they could offer.[931] Disruption within the ancillary services provided by nurses and ambulance crews, led to problems with emergency calls, outpatients and admissions to residential care. Indeed, in the Teesside area, industrial action by social workers meant no new work was undertaken. No escorting of patients and no new sections could take place, usually carried out under the Mental Health Act of 1959 and handled by social workers.[932] The north east was particularly compromised during the industrial strikes that occurred within the wider workforce, be it the miners' strikes of the 1980s or the three-day-week imposed in the early 1970s.[933]

## Partnerships and Practice Administration

During the 1960s, the appointment system that we use today was not widespread; rather it was new and innovative. Cartwright's study looked at the impact of appointments at a time when it had still not been universally implemented.[934] Preliminary findings suggested that waiting times for patients were less with appointments rather than the old system whereby

[930] Accession 3076 Box 6 envelope 1, Teesside Archives, Middlesbrough.
[931] *Ibid*. In this case, a letter was sent from the paediatric department of Middlesbrough General Hospital to GPs in the region informing them of this decision through a lack of administrative personnel. Although this cannot be described as unusual in the 1970s where further follow up hospital appointments were not routinely brought to the GPs attention, it does highlight the lack of cooperation between hospitals and GPs that had developed over the preceding years, even in Middlesbrough.
[932] Accession 3076 Box 6 envelope 1, Teesside Archives, Middlesbrough. Memo sent to all the practices in the region dated November 2nd 1978.
[933] Peter Hain, (1986), *Political Strikes: The State and Trade Unionism in Britain*, Harmondsworth: Penguin.
[934] Cartwright, *Doctor's and Their Patients*, p. 155.

patients simply turned up and waited. Many of the GPs surveyed, however, were not sure whether their patients liked or trusted an appointment system.[935] The group of patients who favoured it the most were the middle-class, perhaps already accustomed to a different level of service from their family doctor than their working class counterparts.[936] Additionally, the flexibility it offered might well have appealed to their personal routine. It was perceived that patients and doctors were more relaxed and free to discuss problems fully. However, it did not lead to a reduction in the overall workload of the GP. Cartwright proffered that it might have offered the doctor the opportunity to influence when their patients attended.[937] Indeed, it seemed that patients were less inclined to visit the doctor for a trivial matter, perhaps because their visit had to be pre-arranged rather than simply turning up on the day. Accident and Emergency at Middlesbrough General Hospital was a department frequently used by the population of Middlesbrough, perhaps in lieu of a visit to the GP. Barry Doyle suggests that this might be due to the historic reliance of the population on the casualty department in times of contributory schemes when access to A&E was free.[938] Practices that had already considered setting up an appointment system appeared to be group practices with a large percentage of newly qualified GPs. They also had up-to-date, well equipped surgeries in which to work.[939]

In the case of the GPs interviewed in the course of the Middlesbrough study, all seemed relieved when the volume of call outs they received began to reduce. In the early years of their respective careers, this appears to have been a significant issue. The key factors in reducing this part of their duties included things such as increased access to transport for the patients (namely, increased car ownership), medical education and importantly the utilisation of auxiliary staff in the form of nurses and midwives.[940] Nurses now

[935] Digby, *The Evolution of British General Practice,* p. 149. Prior to 1948, appointments were seldom used other than for private, fee paying middle class patients.
[936] Cartwright, *Doctor's and Their Patients*, p. 156.
[937] *Ibid*., p. 158.
[938] Doyle, *A History of Hospitals in Middlesbrough*, p. 73.
[939] Cartwright, *Doctor's and Their Patients*, p. 159.
[940] Geoffrey Marsh (1968), 'General Practice Observed: Visiting-Falling Workload in General Practice', *British Medical Journal*, **5592**: pp. 633-35.

took on some of the workload of GPs this meant involvement in immunisation, clinics (often maternal and infant) and even some house visits, mainly for routine check-ups of chronic cases. GPs now had greater control over the nurses they employed than they ever did with the district nurses previously attached to practices but not paid by the GPs directly. The GPs developed an increasingly close working relationship with the nursing profession following the 1966 Charter.[941] The employment of nurses to assist GPs within their practices became prominent in the case of single-handed surgeries or those run by a small number of doctors but with a large patient list size.

Administration was of high importance for the GPs interviewed, more so than anticipated. This may be the case because it was often a time consuming task, particularly prior to the computerisation of patient records. The doctors seem to view it as problematic and often recall that it was left to them to both treat patients and organise the running of their practice. As this was prior to the widespread introduction of receptionists, and certainly before the advent of practice managers, the doctors' wives often performed these duties, frequently fielding calls for night visits. In some practices, the nurse often doubled up as a receptionist and filing clerk. In the early 1960s, up until the Family Doctor's Charter in 1966, there was no regimented appointment system, patients simply turned up and waited for a consultation. At Dr Mackenzie's practice, for example, patients received a disc numbered 1-120, and were seen in order.[942] His recollection was that the average number seen per day was around 40-50 although 90 was not extraordinary.[943] The records kept for each patient were not always used during a consultation, only when necessary and were not routinely updated after each visit. Mackenzie also recalled that the most consultations he ever had in one day was a staggering 177 (68 in the morning in Stockton, 32 at the lunchtime surgery at Billingham, 55 back in Stockton in the evening and 32 home visits).[944] As mentioned in 1966, the adoption of an appointment system slowly began. At Mackenzie's Stockton practice,

[941] 'New Contract for General Practitioners: A Charter for the Family Doctor Service', (1965), *British Medical Journal Supplement*, **3138**: pp. 89-91.
[942] GP Interview 2.
[943] *Ibid*.
[944] *Ibid*.

repeat prescriptions no longer took place face to face, and patient records began to be utilized during consultation.

Records also needed to be restructured; practices at this point still used the old Lloyd George folders, first introduced in 1912.[945] These reports were often incomplete, messy and rarely used efficiently to record information. Marsh, Colling and Mackenzie all seem particularly proud of their respective involvements in developing A4 record systems and of grouping the records by familial links.[946] It was felt at Mackenzie's practice that A4 folders would be a preferable system. The doctors managed to persuade visiting pharmaceutical and medical reps to donate A4 folders to the practice until enough were collected for the entire patient list that stood at around 13,000.[947] They then enlisted two local schoolchildren to write the name, address and date of birth of each patient on the outside of the folders. This seemingly small act revitalised the way the practice used patient records and was an example followed by many others in the area, and indeed the country. Raymond Donaldson was so impressed with the A4 system that he subsequently installed it in all of his new health centres.[948]

## Disease and General Practice

The GPs interviewed for this thesis seemed to be recalcitrant when it came to discussing health in terms of disease, even when asked directly to discuss the kinds of illness they encountered during the course of their career. They appeared to have a standard, patented response of, 'Nothing out of the ordinary', 'Just the usual really', 'what you would expect'.[949] It is difficult to ascertain whether the diseases the GPs encountered were ordinary or whether, over time, those interviewed came to see them such. Perhaps, for those who spent

[945] David Morell, 'Introduction and Overview', in Loudon *et al*, *General Practice*, p. 10.
[946] GP Interview 1, 2 & 3.
[947] GP Interview 2.
[948] GP Interview 1 & 2.
[949] GP Interviews 1, 2, 3 & 4. All the doctor's express the same sentiments when asked this question directly.

their entire career in the region, their entrenchment in the minutiae of the health of the region skews their perception of 'usual and ordinary'. That is to say, they no longer have an objective view of what was common to this region but perhaps exceptional elsewhere.[950] They do point out cardio-vascular disease as a recurrent feature, but for the same reason are quick to emphasise that it was more usually colds and minor ailments that they dealt with on a daily basis.[951]

Rather surprisingly, given the industrial nature of the majority of Teesside, they do not make any significant mention of respiratory disease. Once again, it was, in their opinion, only to the level of any other large town or built up area. It is worth considering how at odds this is with the first half of the twentieth century at least. It is also a different viewpoint from that which we are still led to believe about the area, via various articles and publications on the topic.[952] However, consideration is required of two key factors. Firstly, during the 1960s there was the passing of numerous clean air acts that vastly improved the quality of air in the region by reducing emissions and closely monitoring the atmosphere.[953] Secondly, there were no mines in the area, unlike further north in Durham; therefore, the workforce was not susceptible to the kinds of respiratory problems associated with mining.[954] Historically, pneumonia had been problematic in the area, but this was prior to close monitoring of pollution levels and emissions. Additionally, it is perhaps the case that industry was not linked quite as directly as assumed to the causation of pneumonia. In fact, it points to industry being a secondary factor in terms of health, particularly pneumonia. It was more probable, translating the opinions of the GPs, that the social conditions of the community,

[950] This is a similar situation to the MOH reports in the 1920s within Middlesbrough, where Dingle stated that the health of the town had improved considerably, when the official records did little to support this notion. It was possible both then and during the time that the interviewed GPs practiced that their judgement on unusual rates of disease (specifically respiratory disease) was coloured by their own expectations.

[951] GP Interview 3 & 4. These two interviews in particular make mention of this, in the case of Colling this is probably due to his close involvement in the Teesside Coronary Survey. Mackenzie also makes mention of this study but really in deference to Colling's work.

[952] Judith Bush, Suzanne Moffatt and Christine Dunn (2001), ``Even the Birds Round Here Cough': Stigma, Air Pollution and Health in Teesside.' *Health & Place* **7**: p. 47-56.

[953] *Ibid*. Dr. Holtby also mentioned this fact during his interview that the area had improved vastly in terms of pollution since the 1960s.

[954] GP Interview 4.

driven by industry, were the key agents. The area had poor housing clustered around the plants and works, overcrowding, and inadequate sanitation in the first half of the century, followed by widespread de-industrialisation. This was exacerbated by increased mechanisation of processes in those industries that survived and led to a rise in unemployment and the subsequent lowering of living and social conditions throughout the region.[955] In addition, there was now at least some form of therapeutics available for the treatment of pneumonia, in the form of the sulphonamides, and antibiotics. Furthermore, pulmonary tuberculosis was treated much more efficaciously than it had been during the previous decades. These would also have been contributing factors leading to the perceived decrease, at least in the opinion of the GPs, of respiratory conditions.

The GPs involved themselves in a range of health related issues, an example being the proposed diversion of the A19 at Billingham (near Middlesbrough) in 1976. Dr Marsh was anxious that the placement of a main road next to a residential area would further burden an already compromised community. The lung cancer rate in this area was already high, due to its proximity to the ICI plant the subsequent increased flow of traffic would only have added to the pollution, in the form of carbon dioxide and sulphurs.[956]

The GPs did have opinions on the social implications of some of the developments that occurred during their career. Dr Mackenzie cites the development of the contraceptive pill as perhaps the most powerful pharmaceutical development during his career.[957] Not least because of its implications socially, now women could take control not only of the number of children, they had, but also importantly when they had children. This event could be delayed until new, young married couples could afford to support a family and had a home and at least a modicum of security behind them. Mackenzie also stressed the contraceptive pills integral role in reducing unwanted pregnancies, especially amongst young, unmarried women. He described, with an element of sadness and regret, the situation in his formative

[955] Nicholas, *The Social Effects of Unemployment*, p. 84.
[956] Accession 3720 Box 10.3 envelope 3c, Teesside Archives, Middlesbrough. This information comes from a newspaper article printed in the *Evening Gazette* dated 2.12.1976 entitled 'Doctor's Warning'.
[957] GP Interview 2.

years as a GP. When a young woman at around 35-36 weeks was sent to Gateshead to give birth and the baby was taken away within the first 48 hours and never seen again by the mother. The options were limited at this time for unmarried, pregnant women. Abortion was illegal, and unless they could marry, the option to have the baby adopted was often the only one left to them.[958]

There appears to be a consensus amongst the doctors that the incidence of mental illness increased throughout the course of their careers. They seemed a little non-committal as to the reasons behind it, although they do cite unemployment, poverty and social conditions as possible explanations. Dr Marsh went so far as to suggest that at one point, during the 1970s, he even considered depression to be a 'normal' state of affairs; that people were not clinically depressed but rather anxious and worried about their situation.[959] Dr Marsh felt he was unable to counsel his patients effectively on such matters. Therefore, he arranged for a counsellor to visit the practice to meet with such patients and give them the time and expertise he felt they deserved. The gender composition of those requiring such treatment tended to be predominantly female. Dr Marsh felt that there was no way that the allotted consultation time of around ten minutes was sufficient to deal with people exhibiting such problems. It made sense to him to tackle the situation in this manner. A survey of practice workload carried out in 1972, at the Norton practice, recorded depression as the second most common condition, with 7% of consultations, anxiety was fifth.[960] It was sometimes a problematic area in terms of securing treatment, especially when a patient required sectioning to an asylum or secure ward. It was a labour intense process, taking numerous hours to resolve, especially if it occurred during the night. This was a scenario outlined in particular by Dr Mackenzie, but subsequently echoed by Dr Colling.[961]

It is intriguing to note that when asked to describe the key issues they faced in their working lives, it is factors such as this that they recall rather than, in general, treatment or

[958] *Ibid*.
[959] GP Interview 1.
[960] Geoffrey Marsh and Peter Kaim (1976), *Team Care in General Practice*, Croomhelm, London, p. 53.
[961] GP Interviews 2 & 3.

the arrival of new equipment. The GPs seemed to be preoccupied with matters such as working conditions and administration. The long hours they worked seem to have constantly taken them away from their families, much to their disappointment. However, the doctors interviewed do not appear to have regretted their career choice and feel it was a worthwhile occupation. Most of them did take on extra roles and duties, supplementary to that of being a GP. Only one, Dr Holtby, left the field and became a consultant, effectively working within public health from the early 1980s onwards.[962] These themes are echoed throughout Cartwright's study in the 1960s, and judging from the recollections of the Middlesbrough and Stockton GPs, they are ideas that they carried with them for the rest of their long careers.

As has been briefly touched upon in this section the development of health centres became a central aim of local health authorities during the 1960s and early 1970s. Health centres were seen as the future of primary care and the most effective way to present community based healthcare to the public. The centres were to become an increasingly attractive package to health authorities, and Middlesbrough and the surrounding area was no different. In the following section, the issue of how successful these enterprises were, and the background to their development will be explored, using the Cleveland Health Centre in Middlesbrough as a case study.

## Health Centres in the Region

The background to the concept of health centres predates the arrival of the Cleveland Health Centre in 1973, by over forty years. The Dawson Report (1920) first introduced the term 'health centre'; Webster has defined the characteristics of a health centre as:

> 'Collaboration and division of labour among a range of personnel working under one roof, exploitation of modern diagnostic and therapeutic techniques, and

[962] GP Interview 4.

finally the diffuse implication that health centres would pay more positive regard to maintenance of health, rather than merely react by treating disease.'[963]

This report suggested that 'primary health centres' be built to house GPs and their ancillary staff, whilst the proposed 'secondary health centres' would house specialist services. Such 'secondary' centres would then work closely with the GPs, relying on referrals from the 'primary' centres. This, however, proved to be more problematic than initially anticipated as little agreement could be reached as to responsibility for paying the doctors involved.[964]

Health Centres had strong links with the Labour Party and the Socialist Medical Association. In the case of the latter, health centres were increasingly prominent in their documents from the mid-1930s onwards.[965] Even *The Times* newspaper advocated the idea of Health Centres around this time.[966] The question of health centres arose just prior to the planning of the NHS in 1942.[967] The recommendations were similar to those of the Dawson Report, extended this time to include radiological, pathological and even minor surgical facilities.

Local authorities at this time were discouraged from trying to convert an existing institution or dispensary. At the inception of the NHS, there were twenty-five recognised health centres, with only nine providing a GP service.[968] A strategy was implemented to develop health centres in 'new towns' and new estates (namely those with more than 2,500 houses). This was never successfully executed, and the arrival of the NHS did not help the initiative's cause, as capital for building projects was virtually eliminated.[969] For example, in Birmingham such projects proved problematic, as GPs were not allowed to see their private patients at the new health centre premises. The GPs, therefore, refused to participate in the scheme, which led to the plans for the centre being dropped by the Birmingham

[963] Charles Webster (1988), *The Health Services Since the War: Volume One, Problems of Health Care: The National Health Service Before 1957*, HMSO, London, p. 380.
[964] Jane Lewis and Barbara Brookes (1983), 'The Peckham Health Centre, "PEP", and the Concept of General Practice During the 1930s and 1940s', *Medical History*, **27**: pp. 161-61.
[965] Webster, *The Health Services Since the War: Volume One*, p. 380.
[966] *Ibid*., p. 382.
[967] Donaldson, *Health Centres in Teesside*, p. 2.
[968] Webster, *The Health Services Since the War: Volume One*, p. 382.
[969] *Ibid*., p. 383.

authorities.[970] In Sheffield GPs withdrew from the proposed project as the doctor's became suspicious and doubtful as to whether the centre could be successful.[971] The Ministry of Health saw this as tantamount to 'blackmail' on the part of the local doctors. In addition, it highlighted the fact that neighbouring practices could be problematic and actively attempted to sabotage plans to develop a nearby health centre.[972] The Ministry of Health then decided to advise local health authorities to prioritise conventional GP surgeries within the new housing estates rather than health centres.[973]

The idea of trying to establish a health centre in or close to Middlesbrough was not a new one. There were new housing estates at Eston, near Middlesbrough, and there was local support for the development of a health centre. However, the Ministry of Health, despite persuasive arguments from the local supporters, turned down the proposal in 1949. The petition put forward to the Ministry had advised that local GP surgeries were oversubscribed, and the proposed health centre had the support of both local MPs and the community.[974] In January 1950, the Executive Council in Eston complained about patients having to wait outside in the cold during an influenza epidemic.[975] This was due to the inadequacy of existing premises to cope with such demand. The campaign for a health centre within Eston continued for over a decade but ultimately was rejected. The Ministry of Health advised that improvements were instead to be carried out in existing practices.[976]

Health centre GPs often had little enthusiasm for the concept behind them. As Webster points out, '[h]ealth [c]entre doctors collaborated neither with one another, nor with other users.'[977] This meant that relations between GPs and the Local Health Authority (hereafter, LHA) staff were at best distant and that patients received no extra treatment or benefits, often complaining about the practices. The failure of health centres, therefore, was

[970] *Ibid*.
[971] *Ibid*., p. 384.
[972] *Ibid*.
[973] *Ibid*.
[974] *Ibid*., p. 386.
[975] *Ibid*.
[976] *Ibid*.
[977] *Ibid*., p. 387.

often due to the attitudes of the GPs, there was no cohesion in making the health centre a group effort and centres were still like distinct, individual practices.[978] Practices that had managed to develop strong relationships with the LHA and hospital consultants, as well as integrating midwives and social workers to the full were upheld as examples as to how effective, modern primary care units should be run under the newly formed NHS. This was despite the majority of these practices owing little in their modelling or success to the NHS.[979] By the 1950s, there were too many elderly GPs and too few female practitioners.[980] There were also large patient list sizes in the North of England, especially when compared to the South of the country (an average of 2,700 per practice in the north versus an average of 2,200 per practice in the south).[981] This, it was hoped, could be rectified by the development of large-scale primary care practices, with all available services under one roof. The desired outcome being reduced waiting times for patients and concomitantly a reduced workload for the doctor.

The situation for GPs had not improved dramatically by the late 1950s and early 1960s. The speciality of general practice was still suffering from a post NHS 'hangover' that had seen the GPs' role and numbers diminished. The prestige of the profession reduced when compared to that of the ever-expanding numbers of new recruits to hospital consultancy. The profession was also smarting from a number of highly critical reports from the 1950s. The most notorious of which was the Collings article, in 1950.[982] Collings described the bleak outlook for general practice, based, in the main, on his observations of urban, industrial practices throughout the country.[983] This disparaging report unsettled both practitioners and the BMA alike, so much so that by the mid-1960s, there was a great deal of

[978] *Ibid*. Health centres were not successful in Leicester either, which is not entirely surprising as this tended to be the national trend from the 1950s onwards. Welshman, *Municipal Medicine*, pp. 282-83.
[979] Webster, *The Health Services Since the War: Volume One*, p. 388.
[980] Webster, *The Health Services Since the War: Volume Two*, p. 12.
[981] *Ibid*.
[982] Collings, '*General Practice in England Today'*, pp. 555-85.
[983] Ibid. p. 563. Collings describes inner city and urban practices as 'unsatisfactory and at worst a public danger'

disenchantment both privately and publicly amongst the profession.[984] Many were threatening to resign; others were emigrating to practice abroad and the flow of doctors from general to hospital-based medicine continued. Therefore, in 1965, the BMA produced a list of requirements, and to a certain extent demands, to improve the situation and make the role of the family doctor more attractive to those newly qualifying rather than losing them to what, at that time, was considered more attractive, not to mention lucrative, option of hospital specialism.[985] These demands included the right to practice in well equipped, adequately staffed premises, subsidised by grants, but at the same time free from state intervention, and retaining their status as independent practitioners. The GPs and the BMA wanted a guaranteed minimum income, with levels of pay related to workload and responsibilities rather than list size. The income of a GP, they argued, should also be comparable to that of other similar professions. The BMA also wanted reimbursement of the costs, or at least a percentage of them, of employing ancillary staff to work within the practice, such as nurses and receptionists. Finally, they wanted assurance that, upon retirement, the doctor and his family would be financially secure.[986]

This extensive list was to form the backbone of the *Family Doctors Charter*.[987] After much negotiating between the doctors, BMA and the various government departments involved, a workable charter took formation. The first phase of the plan, introduced in October 1965, saw the GP eligible for a reimbursement of 70 per cent of the wages of his ancillary staff. Other concessions soon followed; there came a decrease in the percentage of their income directly linked to their patient list size. There were extra allowances made to encourage group practices to form, as well as vocational training payments for young and newly qualified doctors about to enter into general practice.[988] There was also to be direct reimbursement of the costs of rents and rates of practice premises this stipend is particularly

[984] Peter Bartrip (1996), *Themselves Writ Large: The British Medical Association 1832-1966*, British Medical Journal, London, p. 325.
[985] Webster, *The Health Services Since the War: Volume Two*, pp. 271-3.
[986] *Ibid*.
[987] Anon (1965), 'New Contract for General Practitioners: A Charter for the Family Doctor Service', *British Medical Journal Supplement*, **3138**: pp. 89-91.
[988] Bosanquet and Salisbury, 'The Practice', p. 51.

interesting in reference to its development within Middlesbrough. The development of group practice within Leicester was similar to Middlesbrough. For example, in 1898 only one practice is a joint one in Middlesbrough (Drs Steel and Scanlan), within Leicester by 1920 there were three, rising to nineteen by 1947.[989] Two or three doctors, with usually at least one senior partner, ran the majority of practices by the 1960s. They shared responsibility for a patient list size that could be as extensive as 12,000.[990] Premises were often inadequate, with few changes since the First World War to many. In some instances, GPs still saw their patients in converted town houses. The idea, therefore, of purpose built centres had a certain appeal, especially when compared to the working conditions of some. It took until 1965 and the arrival of the Family Doctor's Charter for health centres as envisioned by the previous plans, to become a reality. From the arrival of the NHS in 1948 until just after the Doctor's Charter in 1967, a mere twenty-eight health centres had been built. In the following ten years, a staggering 700 health centres were developed.[991] The charter meant that rents on such centres could be subsided by Exchequer funds, reducing the question of cost and risk for the doctors involved, although not entirely, as shall now be discussed. This had the result that these LHA run centres became increasingly attractive, as private accommodation became not only inadequate in places but also at times prohibitively expensive.

The following section of the chapter will review how the concepts of the plan were adapted locally and the contrasting reactions of GPs concerned, focusing in particular on the development of the Cleveland Health Centre in Middlesbrough.

## The Cleveland Health Centre

MOH Donaldson was the driving force behind initiatives to build health centres. In his capacity as MOH for the region, he was a vocal exponent of preventive medicine, his involvement in developing these centres is, therefore, not surprising. Donaldson stated that

[989] Welshman, *Municipal Medicine*, pp. 277-8.
[990] GP Interview 2 C Mackenzie 21/02/09.
[991] Bosanquet and Salisbury, 'The Practice', p. 51.

existing surgeries were often situated on premium land, in terms of market value or rental. By selling these premises, the GPs could gain financially when moving into purpose built health centres with heavily subsidised rates and rent.[992] MOHs at this time to some extent had joined forces with GPs; they now felt the threat of an ever-expanding hospital service and their own role reducing.[993] The 1960s altered the role of the MOH dramatically, the revival of general practice took back much of the ground it had lost to the MOH from the 1920s onwards.[994] In effect, the role of the MOH had become a weakened one, their professional status considerably lower than that of the GP.[995] Many of the key roles of the MOH in the 1970s would be taken over by the new style GPs whose work was centred increasingly on prevention, not just treatment and cure.[996]

In his report, written in 1970, Donaldson outlined the benefits of the centres, especially with regard to Teesside. He correctly stated that, by this time, much of the population had moved from the overcrowded centres of towns such as Middlesbrough and Stockton to outlying areas. A fact further exacerbated by the proposed slum clearance still to take place in some areas.[997] Health centres in the region, therefore, had to be central, with strong and frequent transport links from all of the nearby areas so that existing patients could still visit their GP.[998] This led to criticism at times from doctors and practices that were in opposition to the scheme, noting that patients would be required to travel greater distances than previously to see their GP or attend clinics.[999] It is interesting to reflect that these same issues had been highlighted in the Lock survey almost thirty years earlier, and remain a topic of debate even today. The main difference being that the 1944 survey did seem to suggest

[992] Raymond J. Donaldson (2000), *Off the Cuff: Reminiscences of My Half Century Career in Public Health*, Murray Print, Richmond, p. 178.
[993] Susan McLaurin and David F. Smith (2002), 'Professional Strategies of Medical Officers of Health in the Post-War Period – 2: 'Progressive Realism': the Case of Dr. R. J. Donaldson, MOH for Teesside, 1968-1974', *Journal of Public Health Medicine*, **24**: pp. 130-35.
[994] Welshman, 'The Medical Officer of Health in England and Wales', p. 447.
[995] *Ibid*., p. 448.
[996] McLaurin and Smith, 'Professional Strategies of Medical Officers of Health', pp. 130-35.
[997] Donaldson, *Health Centres in Teesside,* p. 1.
[998] *Ibid*.
[999] This is a claim similar to the ones levelled at GPs in Middlesbrough during the 1940s where many chose to locate practices far away from the deprived areas of the town. Indeed, it was also an effect of the slum clearances of the 1930s and 40s where families found themselves relocated to areas far away from their existing GP. Glass, *Social Background to a Plan*.

also that it would have been preferable to locate smaller health centres within the community, rather than having just one central location.[1000]

Donaldson's report, entitled *Health Centres in Teesside*, appeared when plans were all but finalised for a large-scale health centre to be built in the centre of Middlesbrough. Preliminary meetings to discuss the viability of a health centre in the middle of the town had taken place in 1968.[1001] Over fifty meetings followed during which key factors such as location, size, facilities and cost came under discussion. Eventually, 21 doctors decided to opt-in to the scheme and in doing so, according to Donaldson, created the largest health centre in the country at that time.[1002] The sheer number of doctors and individual practices involved proved to be problematic. There was an inherent difficulty in trying to accommodate the wants and needs of so many people. Compromises were required; amongst the first obstacles faced was reluctance for anyone to commit to the scheme. When there was, inevitably, an enormous financial risk for those involved it was hard to persuade the interested parties to sign on first.[1003] It fell, consequently, to the local health authority to take the initial step to commit itself to the centre financially, after this bold move the rest followed suit. Although, as Donaldson pointed out at the time, these negotiations did hamper the project's progress somewhat.[1004] Indeed, he stated that the management of the entire process consisted of 'a series of "gentlemen's agreements"'. The doctors were to pay £14,000 per annum for their allotted area, and a further £5,000 per annum was the agreed share of the cost of water, heating, lighting, internal repairs, decoration and cleaning.[1005] Nonetheless, all this negotiating and planning was not to be wasted. Not only did the Middlesbrough Health Centre open as projected, and still exists today, but it was decided

[1000] Glass, *Social Background to a Plan*, p. 82.
[1001] Donaldson, *Health Centres in Teesside,* p. 8.
[1002] *Ibid*. p. 11. It consisted of one, five-man practice, four, three-man practices and two, two-man ones.
[1003] *Ibid*. p. 4.
[1004] Initial talks took place in 1968, yet the centre was not open and operational until 1973.
[1005] TA/Accession 3076 Box 4 Envelope 14, Teesside Archives, Middlesbrough. This information is taken from a copy of the agreement/contract that was sent to the practitioners involved; the agreement being between the GPs and the Teesside Executive Council.

that the Middlesbrough project should effectively become a blueprint for all other proposed health centres in the region.[1006]

The interesting question to arise from this document and other correspondence relating to it is what were the factors that provoked GPs to 'opt-in' or to 'opt-out'. Did those who opted in decide that the arguments of the executive council, Family Doctors Charter, and the regional MOH, that health centres were the future of primary care too persuasive to ignore? Did those who opted not to take part feel it was interference from outside agencies, trying to control their practice and alter their roles? Correspondence from the time seems to highlight worries over the lack of control when employing ancillary staff such as receptionists, the threat of an impersonalised service and the possible breakdown of the doctor-patient relationship. Commenting on the development of the Centre, Dr J. Whewell, one of the doctors involved, stressed the need to run the practices as separate entities to avoid the centre becoming impersonal.[1007] In spite of these concerns, the overall impression seems to be one of optimism, even pre-dating the plans for a health centre in the town. Writing in a letter dated 9th August 1966 to Dr J.R. Rowell from Dr H. Kay regarding 'Health Centres in Middlesbrough' the latter stressed the importance of the creation of such a centre in the area, particularly after the charter and the fact many doctors wanted new premises due to changes in circumstances. He seemed to be the one pushing for such a development. He concluded

> 'I know what I have in mind would amount to a complete change in General Practitioner service in the town but I feel that this is perhaps the right time to think on these lines as the whole face of General Practice is altering and if the present opportunity is missed, we may well regret this in the future'.[1008]

The GPs interviewed during the course of this research, in general, do not appear at all enamoured by the health centres built over the course of the early 1970s. It has been a

[1006] Planners in Middlesbrough had used existing centres as their blueprint when designing this one. Indeed, in Donaldson's report there are numerous copies of existing, successful plans from up and down the country.
[1007] TA/Accession 3076 Box 4 Envelope 14, Teesside Archives, Middlesbrough.
[1008] *Ibid*.

mixed reception and mixed emotions concerning their development. The practice that Dr Marsh worked in remained in the hands of the GPs who worked there, whilst still under the auspices of the NHS.[1009] Marsh and his colleagues resisted the offer of a purpose built health centre, made to them by Donaldson in the late 1960s. The doctors in this practice felt that many of the initiatives and supposed benefits of a health centre were already in place at their surgery. Marsh did procure assistance from Donaldson in implementing further plans, largely concerning administration and record keeping as well as ancillary and nursing staff.[1010] Marsh thought that surgeries that remained in the hands of the GP developed at an accelerated rate without the constraints imposed on the health centres due to local authority intervention. This was a sentiment echoed by Dr Mackenzie, although Mackenzie at least spoke from having, at least temporarily, worked in a health centre. Mackenzie found the situation to be wholly unsatisfactory, he felt that it did not work in the best interests of the doctors involved and could see no real benefit to it.[1011] Practices initially involved withdrew and went back to their own units. Mackenzie was of the opinion that initially the health centres were superior to the privately run practices as the centres received an injection of money and equipment from the local authority, and money was also influential in terms of the building of the site and the reimbursement of rent.[1012] After this initial period, Mackenzie contested, local authority health centres were quickly overtaken by the doctor-run practices. The latter, he felt, invested more and stayed apace with the new techniques and technologies. They were, in other words, free from any limitations on both their financial spending and subsequent investments.

As previously mentioned, Dr Colling was a partner in a private, fee-paying practice that would suggest a lack of involvement in health centres at first assessment. However, Colling was involved in trying to develop a health centre in central Stockton, based loosely

[1009] GP Interview 1
[1010] *Ibid*.
[1011] GP Interview 2. Mackenzie worked on a part-time basis in the centre as a satellite surgery to the existing practice. His practice were left with no alternative but to become involved in the enterprise as to have declined would have led to a drastic reduction in their patient list size and therefore potential income.
[1012] *Ibid*.

on the Peckham Health Centre.[1013] This was to include a fully comprehensive system of healthcare, including a doctor's surgery, leisure centre and various clinics. Its premise was to tend to the needs of a deprived community by promoting preventative health measures as well as supplying curative ones. Colling had worked in the Peckham Health Centre prior to its closure in the 1950s. Impressed by its holistic method of healthcare provision, Colling had pushed forward the idea to the MOH and local authority. They received his ideas with enthusiasm; however, it met with more than a little resistance from the local doctors.[1014] Many felt that this was not part of their role and it would diminish their status and threaten their positions as well as their existing surgeries. Indeed, in his biography of his time within public health, Raymond Donaldson reports that the doctor who spoke on behalf of the other GPs in Thornaby, told the committee that supporting such a proposal was tantamount to a vote of no confidence in the local authority run centre.[1015] Therefore, after five years of planning, the MOH and authorities, so as not to destabilise the doctors' community within Stockton, dropped the idea.

Dr Holtby was the exception to these reports in so much that he spent almost the entirety of his time in general practice based within a health centre.[1016] Soon after his appointment within his Redcar practice they moved to a new, purpose built health centre located centrally. His overriding recollection was that a major difference after the move was an increase in the number of call-outs as now they were further away from many of their patients, a lot of whom were elderly and found attending the surgery difficult. The health centre in Redcar still exists today, although some of the initial practices did move back out.[1017]

[1013] Lewis and Brookes 'The Peckham Health Centre', pp. 151-61.
[1014] GP Interview 3 and Aubrey Colling (1971), 'Personal View', *British Medical Journal*, **5742**: p. 227.
[1015] Donaldson, *Off the Cuff*, p. 179. Prior to this meeting construction of a health centre, in Thornaby consisting of two existing practices had begun under the remit of the North Riding Council.
[1016] GP Interview 4.
[1017] *Ibid*.

Dr Morton had practiced in Middlesbrough for the entirety of his career as a GP; moving from North Ormesby to a more central location in the town.[1018] He and his two practice partners had purchased their surgery six years prior to the Cleveland Health Centre opening. A vacancy had arisen after a three-man practice pulled out of the venture; after having discussed the plans with a fellow GP who had already opted in, he and his partners decided to follow this lead. Morton cites the reasons behind their decision as three-fold. It provided them with an opportunity to sell their practice and recoup their initial investment.[1019] It was also considerably more spacious than their existing premises. The consulting rooms were larger, provision being made for a nurse and a midwife, and they could take their own existing staff with them. Additionally, the GPs no longer had to worry about issues such as lighting or heating.

The third positive as Morton saw it was the issue of travel, as the centre was positioned above the transportation hub of buses to and from the town; therefore, patients were able to access the GPs easily. He also felt it was beneficial to be around other GPs. At the centre, other doctors were there who could be called upon for advice. This took the form of both medical guidance and medical politics. This was a welcome change for the GPs who often felt isolated in their surgeries from their fellow professionals.

The disadvantages as Dr Morton saw them was that GPs no longer owned their own premises and, therefore, had to get permission for everything and all changes they wished to make.[1020] In addition, funding was not always as available as the doctors may have perhaps wished. Travel was the other factor he cites as problematic; whilst this was perhaps sold to the GPs as a positive, it did not always appear to be the case. Dr Morton acknowledged that many of their patients now had to get up to two buses to get to the centre, something not always practical for the elderly or those with children. People could now no longer walk to their surgery. Despite this, patients were reluctant to change their GP to one closer. The

[1018] GP Interview 5 D Morton 28/04/09.
[1019] *Ibid*. At this time GPs had to buy their way into a practice and could usually only remove this investment upon retirement and only then if they could find a new doctor to sell it to.
[1020] *Ibid*.

overall effect perhaps being they did not visit as frequently as previously, or at least not in the case of minor complaints.

The biggest issue that Dr Morton felt existed with the centre was the principle of all facilities being under one roof. Whilst housing GPs, family planning, chiropody and a mental health nurse in one place seemed like a perfect solution, it was not quite as ideal in practice.[1021] When patients were referred to one of these clinics within the centre by their GP, they could not get to see them on the same day. They had to make an appointment and return another day. This raised questions of the efficiency of the system, requiring increased travelling on the part of the patient. Dr Morton felt that if the patients had to make separate appointments and journeys anyway, then there was no real advantage in having all these facilities under one roof. In basic terms, the centre might as well have been located anywhere in the town. On the whole Dr Morton stated that his practice was 'pretty happy' with the centre, and the premises were well looked after and serviced.[1022]

To address the situation specifically in Middlesbrough, despite having seemingly strong transport links, doctors involved in the Cleveland Health Centre appear to have felt sufficiently isolated from their patients that they eventually chose to move back out. Holtby backs this hypothesis, as based on dealings with his colleagues in Middlesbrough the main reason practices moved out was to be back amongst their patients rather than be isolated in some central location.[1023] In fact, the Lock survey in 1944 had suggested that it would be preferable to locate smaller health centres within the community, rather than having just one central location.[1024] However, those who pressed for the building of the centre already felt this separation had begun. The majority of GP surgeries at this time were centrally located, whilst patients had drifted southwards and eastwards from the area. Patients, in general, liked having their surgery close to where they lived and often chose

[1021] The services provided were extensive and included audiology, chiropody, developmental screening, diet, family planning, mental health, mothercraft and relaxation, obesity, ophthalmic, screening for hearing and vasectomy. TA/Accession 3076, Box 4, Envelope 10, Cleveland Area Health Authority: Health Centres and Clinics, c1965-1975, Teesside Archives, Middlesbrough.
[1022] *Ibid*.
[1023] *Ibid*.
[1024] Lock, *County Borough of Middlesbrough: Survey and Plan*.

their GP based on this fact.[1025] Middlesbrough was different in so much that existing surgeries were not always clustered around the population, hence why the development of a central health centre appealed to some. The perceived benefit was the transport hub, which was to be located within the £5 million shopping and office complex in which the health centre was to be housed. In addition, there was also to be car-parking facilities available, this came at a time when car ownership was on the rise.[1026]

Ultimately, the changes and adoption of health centres as the main means of primary care provision was not driven by patient needs, but rather by those of the GPs. Ann Cartwright contested that these changes would be motivated by the GP, and the public would have to adapt. She stated that patients would '[a]djust their picture of the ideal doctor and come to see him as one who practices at a health centre'.[1027] The inference was that patients could be moulded, quickly, into a new way of thinking, despite, perhaps, their initial reactions or reservations. It is a question of what is better for the GP involved rather than his patients. GPs may well have cited location, impersonal nature of services and travel as reasons to delay the development of such centres, but often they had their own interests at heart. The doctors in Teesside seemed preoccupied with the threat of losing their independence and surrendering their practices to local authority control.

The key issues as to the division over health centres in the areas appear to be complex, and perhaps surprisingly not due to patient-centric concerns. GPs disliked the idea of losing control over their practice, they embraced the concept of being independent practitioners, free from the constraints that may be placed upon them by health authorities and those in charge of the centres. There is also the recurrent feature of the level of service offered to patients. GPs were divided as to whether their relationships with patients would be compromised, with patients no longer being able to see the doctor they wished, and in certain cases having to travel long distances to see a GP at all. Travel became an issue; not only for the patients but the doctors too, house calls were still an integral part of the GPs'

[1025] Cartwright, *Patients and Their Doctors*, p. 106.
[1026] TA/Accession 3076 Box 4 Envelope 14, Teesside Archives, Middlesbrough
[1027] Cartwright, *Patients and Their Doctors*, p. 166.

daily routine at this time. Moving into a health centre could mean the GPs were removed from the nucleus of their patient list, and had increased travelling times when required to make a home visit. This was felt most keenly in the case of night calls. It was not until the 1980s that systems were developed for shared night duties between practices, to alleviate some of this pressure. It was, therefore, for practical reasons that GPs decided against the move to a health centre. On reflection, these practices felt that the negatives outweighed the positives. In the case of the practices in Teesside, this may well have been a common perception. Those practices that remained in the control of the GPs appear to have flourished whilst those that went into the health centres perhaps did, to some degree, falter.

Those involved in the development of their own practices tended to be almost evangelical about their achievements, extolling the virtues of what they did and the way they did it. There seems to be a slightly apologetic tone amongst those who went into a health centre practice; as though it was not the best decision but had seemed like the appropriate course of action at the time. Those GPs who worked in such centres seem to have a hazier recollection as to the reasons why their practice chose to join. Ultimately, it would appear that the motivation was financial; a secondary influencing factor was an existing inadequacy in their private premises. Not an insurmountable obstacle, at least not for those who chose to remain in their own surgeries.

## Conclusion

This chapter has included an overview of the interviews conducted with retired GPs in both Middlesbrough and in neighbouring Stockton. They help to give an indication of the key issues for GPs in the region during the 1960s and 1970s in particular. The GPs interviewed appear to have experienced events in a similar way to other areas of the country, especially in regards to problems with administration and working conditions. There was a hierarchy in terms of what the GPs felt had been of critical importance to their daily work. This was not

the treatment of illness, but administration and the efficient running of their surgery. The retired doctors were reluctant to discuss the types of illness they dealt with, not for fear of any breach of confidentiality, but rather because they did not think it interesting or unusual. To them that was just the routine part of their work, one for which they were equipped and trained. Administration was the area that they cited as the most problematic and time consuming, the GPs felt they struggled to contend with it. They did not feel that they received enough support. In other words, they considered this side of their occupation distracted them from carrying out their work as a doctor.

The doctors were also clear on the nature of their role as a curative one. They did not feel that public health was part of their remit and tended to become involved only when requested to do so.[1028] All of the GPs interviewed had been extremely active, within both their profession and the community. They also seemed to defend the population they lived and worked amongst, and tended not to make exceptional judgements regarding poverty and deprivation, or, at least, not about the responsibility of the individual. This situation contrasts with much of the first half of the century. Nonetheless, the GP had about the same level of exposure in the first half of the century in relation to this, as during the time that the interviewed doctors practised.

The second section of this chapter looked specifically into the development of health centres in the region. There appears to have been reluctance on the part of the GPs to become involved with such ventures. This again feeds into the idea that the doctors were opposed to what they saw as interference from outside agencies, even if it might have ultimately proved beneficial to them. The GPs were fiercely protective of their status and resistant to any changes that might be brought about by the LHA. It would appear that even when the doctors did attempt to join forces, as was the case with the Cleveland Health Centre, the results in the long-term were eventually the same. In this instance, many of the doctors and practices that initially signed up to participate in the scheme withdrew after a few

[1028] Dr Holtby admitted that GPs generally only got involved with public health initiatives if there was some form of reimbursement for their time, for example vaccination or testing programs. GP Interview 4.

years and returned to privately owned and managed surgeries. The question that needs to be addressed is why this was the case. What were the motivations for GPs to opt-in to the plan, only to withdraw by the early 1980s? As discussed, many of the reasons cited ostensibly appeared to be altruistic on the part of the GPs. Namely, concern for their patients, a feeling that the centre was impersonal, and the inability for patients to gain access to multiple services on the same day. Whilst these reasons do hold true, the crux of the matter tended to lie with the GPs themselves. The GPs felt restricted by the LHA, they could not expand or run their own clinics or initiatives, even the process of appointments had become centralized. In short, the GPs wanted control back in their hands they wanted to be able to make their own decisions and not be set up in direct competition with one another for patients.

These reasons are similar to the ones Dr Marsh provided as to why his practice turned down the offer of a comparable health centre in Stockton. Marsh felt that the decision was a sound one, both financially and for the development of the practice. The failure of health centres in the region, at least on any large scale, was not in any way an indictment of those involved. MOH Donaldson worked tirelessly to make the project work. He, like the GPs, had his hands tied by the financial constraints imposed by the LHA. To his credit, Donaldson made no distinction between those practices that chose to opt-in and those that chose to opt-out. He ensured that equal support was given to both groups, especially in the further development of GPs, in terms of training and of the practices in which they worked.

This chapter has assessed the voice of the GP within the region and how they viewed their role and how this in turn came to change over the decades that their careers spanned. On occasion, this turned out not to be what was anticipated before the interviews commenced.

## General Conclusions

In this thesis, a number of different issues have been discussed relating to health and medical practice in Teesside, specifically Middlesbrough. The conclusions that can be drawn from the research can be divided into sections, mirroring the aims of the study as set out in the introduction. These are, how did health change in the region over the course of the hundred years reviewed? Why was health so bad in the first place? How did the main stakeholders interact with one another and how much power did each group exert in relation to the decisions made? Most importantly, what was the role of GPs within the context of all these matters?

The health of the community in Middlesbrough, as would be expected, altered dramatically over the course of the twentieth century. It could be argued that it did so in a similar pattern to all other industrial towns within Britain. Namely, it emerged from the shadow of infectious disease in the formative years of the twentieth century to find these maladies replaced instead by chronic illness. There were reduced mortality figures, especially amongst those children under five and the birth rate eventually stabilized. All of these observations appear to, at least superficially, hold true. It is only on closer inspection that it becomes apparent that the health of the population of Middlesbrough did not enjoy the same level of improvements. Indeed, the figures for the town, even today, are far from impressive, or close to the national average. The IMR did not drop until the 1950s, way behind comparable towns. However, the problematic nature of infant deaths and ill health within the town was established in the first few years of the twentieth century. Likewise, the birth rate for Middlesbrough remained high right up until the end of the century reviewed. Rather similar to the situation outlined for the late nineteenth century, there were a high number of young, inexperienced mothers in the town, causing both infant death and birth rates to remain discouragingly high. Nor did epidemic disease dissipate as quickly as

anticipated, with outbreaks of epidemic pneumonia continuing to plague the town even during the interwar years and beyond.[1029]

The question that results from these statistics is, why. Why did health not improve and whose responsibility was it? Why was the health record still so poor in a Borough that had an excellent hospital structure, way ahead of most other industrial towns by the early twentieth century?[1030] The answer to this final question quickly becomes self-evident once reviewed. The town may well have had an exceptional hospital system, but this was reserved for a precise section of the community, particularly in the late nineteenth and early twentieth centuries. This group was the male workers who had been members of the works' sick clubs or friendly societies. Hospitals were created in Middlesbrough for the treatment of the inevitable industrial accidents that occurred from time to time. Major accidents were not entirely commonplace, but smaller ones, equally devastating for those involved, occurred almost daily. Therefore, it would appear that it was not secondary healthcare provision that was found wanting, but that of primary care, namely the GPs within Middlesbrough. That is not to suggest that the GPs of the town were neglectful or incompetent, but a variety of reasons led to their services not being used to their full potential.

The community was reluctant to see a doctor. This was due to financial constraints, a lack of interaction between the two groups due to social differences (as well as spatial distances), and finally a fear that a visit to the doctor would lead to a prolonged absence from work. This was not a perception that was quick to be dispelled. Indeed, not until the years immediately following the arrival of the NHS in 1948 did patients feel they had the 'right' to approach their doctor, especially with complaints they might have dismissed themselves as minor or trivial.

The blame, if blame needs to be apportioned, cannot be solely laid at the door of the GPs, especially as the century progressed. The community required education as to the types of services that were available to them. This would strictly fall into the remit of the

[1029] Respiratory illnesses of all categories still dogged the population into the 1970s.
[1030] Doyle, *A History of Hospitals in Middlesbrough*, pp. 8-10.

MOH, as for the majority of the period examined they were accountable for all aspects of preventive medicine and its implementation. It was beneficial if they could work harmoniously with the medical practitioners of the town, but this was not always possible, as GPs took their historical role of curers not preventers extremely seriously. The MOH possibly had one of the most difficult jobs within the town, the responsibility of bringing all the disparate groups (industry, local authorities, and medics) together ultimately being placed upon the medical officer. This was a thankless task; the relationship between these groups was fractious and complicated at the best of times. All had their own individual agendas, and the chances of getting them to agree on any given issue were negligible. Therefore, it is not surprising that the ultimate result was one of inaction. Decisions were often left to the local authorities, with the other interested parties working as mere advisors. This was an issue in Middlesbrough, as little could be achieved when the stakeholders all acted as autonomous factions.

Welshman's study of Leicester reveals a similar situation concerning the relationship between the MOH and GPs as in Middlesbrough. It was one of 'mutual respect rather than disdain.'[1031] It would appear that, as with Middlesbrough, the interactions between MOHs and GPs were not necessarily as fractious as has previously been considered. Rather, the geniality of the relationship was dependent upon who the MOH was and their motivations rather than relations being automatically hostile. However, even Welshman's study seems to suggest that GPs would engage as a group when they felt it beneficial or advantageous to them, but withdraw immediately if they felt their services were threatened or marginalised.[1032] For example, Welshman makes the case of GPs willingly accepting a 1s fee for all diphtheria immunisations in the late 1930s whilst at the same time remaining critical of public health initiatives.[1033]

The structure of power relations between the groups changed within the town in the course of the century discussed. Industry tended to hold the most power in the late

[1031] Welshman, *Municipal Medicine*, p. 282.
[1032] *Ibid*., p. 279.
[1033] *Ibid*., p. 280.

nineteenth century and early decades of the twentieth century. The town, and its people, relied upon industry for every aspect of their lives; work, finance and health. Without industry, the town would not have been able to support itself during these years. However, the price that was paid was the health of the community. Industry was seldom held accountable, as all parties involved knew that the town was in a precarious position, and it would have been a dangerous strategy to bite the metaphorical hand. When industry began to decline in the 1930s, power, at least in terms of health, shifted to the local authorities. Industry could no longer sufficiently support the town, and now the MOH did not fear the repercussions of blaming the town's troubles on it. It is at this junction that the 'legacy' of industry related to health issues began to be acknowledged. The MOH had unrealistic hopes that health would improve as a direct consequence of the decline of industry, despite the high level of poverty and destitution that now pervaded the town. The local authorities were free to make all the crucial decisions regarding public health, reinforced by the increased powers they received upon the arrival of the NHS. Outside of industry and the community, GPs were the group to suffer the most at this time. Their period of influence and power was to arrive late, not until towards the end of the 1960s did the authority of the GPs exert itself on the way health was experienced take place. Even so, in the case of Middlesbrough, it was often limited with the authorities trying to force the GPs into becoming part of their health centre schemes.

The issue of whether mistakes were made within the town is a difficult one to evaluate. The length of time that it seemed to take decisions to be made would indicate errors of judgement on behalf of the authorities. This is especially visible in the case of epidemic pneumonia, and reaction to 'lesser' epidemics such as measles. By the time the various committees (predominantly the Sanitary Committee) had met and discussed the current situation, delayed making any definitive decisions, then reconvened, the epidemic had passed and nothing further was attempted until the disease inevitably returned. Conversely, in the case of smallpox, the medical profession, MOH and authorities did attempt to ensure the protection of the town, even if their actions were, at times,

misguided.[1034] From this, it would appear that if the town's officials were guided sufficiently by the LGB they could act decisively. It was only in the event of an epidemic outbreak, where they did not receive any assistance that they faltered.

Pneumonia, as discussed in chapter I of the thesis, can be used as a case in point of the way in which GPs tried to be involved in matters of public health. The period from 1888-1901 seems to suggest that the GPs were willing to assist the MOH. Even on the issue of payment for notifying the disease, the doctors were happy to agree to waive the fee.[1035] The problem here seemed to be the local authority (Sanitary Committee) who had initially been resistant to making pneumonia notifiable due to the cost of paying the GPs fee. However, the GPs had offered to notify the disease, temporarily, at no cost, so what was the reason behind the delay subsequently? The Sanitary Committee members now changed their stance and considered that they were unable, legally, to make pneumonia a notifiable disease, due to the wording of the Notification of the Infectious Diseases Act. So was this still an issue of money? It is most likely to be the case, as further measures would have been required such as isolation of individuals with the disease. However, the situation was not, it would appear, due to any lack of commitment or cooperation on the part of the town's GPs. The blame, if any can genuinely be apportioned, has to lie with the members of the Sanitary Committee and the town's councillors. Ironically, a number of the members of the town's council were drawn from the medical community. The involvement of the town's authorities in matters of health permeates every era examined within the thesis.

Town officials also tried, towards the end of the Second World War, to set the wheels in motion for an overhaul of the town. Here, for perhaps the first time, they seemed to acknowledge that there were systemic problems within the town that needed to be addressed. The Lock survey was Middlesbrough's attempt to identify the key issues within

[1034] The same could be said for cholera, as every precaution that could be employed was. Possibly to alleviate the chance of the town being blamed for a national outbreak, as was the case with Sunderland in 1832.

[1035] This seems to contradict the opinions of those interviewed who practiced in the 1950s-1980s in the area. Dr Holtby stated that GPs only got involved when there was financial incentive to do so. GP Interview 4.

the town and, it has to be assumed, be given the opportunity to change them. The survey was a success in terms of its production, involvement of the community and subsequent dissemination; it was certainly an innovative approach by the town council to scrutinize the Borough so thoroughly. However, once again, little activity took place after the publication of the report; the plans were all but effectively ignored. It would seem that the intentions of the town's officials were overall honourable, but constraints, be they financial or practical, always seemed to hold them back from wholly committing to any form of substantial change.

The thesis has explored the health of the County Borough of Middlesbrough and the subsequent interactions and conflicting attitudes of the active key groups within the town. The population of the town has endured a long history of ill health, dating back almost to the date of its development in the mid-nineteenth century. The goodwill of the community and plans of successive MOHs and medical professionals were wilfully ignored, on occasion, in favour of politically or industrially motivated directives. These factors and those discussed within the rest of the thesis have shown how detrimental these incompatible positions could be and how they proved to be obstructive. This was due, in the most part, to the expressed lack of cooperation between the groups who held most power and influence within the town. There is the potential for further research in this area to be undertaken, to compare the situation within the Iron and Steel industry with that of the Coal industry. This is especially so in the North East of England as the comparatively young Iron industry of Teesside came to rely on its older industrial neighbour in South Durham. Coal was a requisite for the Iron and Steel mills to function, and was deeply affected by strikes and shortages in supply of the material in the 1890s. Coal had also been the initial reason that Middlesbrough developed as a community beyond its existing agricultural background in the first place, to act as a port for the South Durham coalfield. The interdependence of the two regions would therefore make an interesting and potentially valuable study in its comparison of medical provision within the two industries.

# Appendices

## Consent Form

**TITLE OF PROJECT:** Public Health Challenges for General Practitioners in the Tees Valley during the 20th Century.

*Please cross out as necessary*

Have you had a chance to read the Participant Information Sheet? YES/NO

Have you had an opportunity to ask questions and discuss the study with Victoria Brown? YES/NO

Have you received satisfactory answers to all of your questions from Victoria Brown? YES/NO

Have you received enough information about the study? YES/NO

Do you consent to participate in the study? YES/NO

Do you understand that you are free to withdraw from the study:

- at any time and
- without having to give a reason for withdrawing and
- without any adverse result of any kind? YES/NO

Do you understand that interviews will be audio-recorded YES/NO

Do you agree to the use of quotes and information given in publications with reference to your name? YES/NO

If NO do you agree to the use of anonymised quotes? YES/NO

Do you agree to the storage and future use of your interview data as a reference source for *bona fide* researchers at the British Library sound archive ? YES/NO

**Signed** ..... **Date** .....

(NAME IN BLOCK LETTERS) .....

## Participant Information Sheet

**Title:** Public Health Challenges for General Practitioners in the Tees Valley during the 20th Century.

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please read the following information carefully, discuss it with others if you wish and take time to decide whether or not you wish to take part. If you would like more information or have any questions please contact the researcher, Ms Victoria Brown.

**Researcher:** Ms Victoria Brown M.A.

**Supervisors:** Professor A-H Maehle and Dr LDH Sauerteig, Centre for the History of Medicine and Disease, Wolfson Research Institute, Durham University, Queen's Campus, University Boulevard, Thornaby, Stockton on Tees, TS17 6BH

**Sponsors:** Durham University

**Purpose/Objectives:** My PhD project looks at the relationship between the health issues that have arisen historically in the Tees Valley over the course of the 20th century, and the General Practitioners who dealt with these varying and multifarious concerns. These include, although not exclusively, themes as diverse as occupational and environmental health; unemployment, poverty and its effects; nutrition and sexuality. The study aims, through the collection of oral interviews from general practitioners, to assess this particular groups' experience of public health within the region, their personal perceptions of what health issues were of the highest importance and relevance in their working lives as GPs. It will aim to evaluate from this whether these support or challenge the perceived wisdom of what affected the region over the course of the 20th century.

**Benefits:** The rationale behind the project is the potential to not only add to the existing body of research on the history of modern public health, but also provide us with insight into the administration of health care in the region over the previous hundred years. Additionally, in evaluating how GPs coped with problems in the past, information beneficial to those planning future health policies and strategies in Teesside may arise. Participation in the study provides a voice for a professional group not previously engaged at this level, in this type of research within the region.

**What you will be asked to do in the Research**: You will be asked during the course of a recorded oral interview with the researcher to describe your experience of general practice in the Tees Valley area and the issues surrounding public health that you encountered.

**Length of research:** The research is to be carried out over an estimated eight-month period, beginning no later than January 2009. Each interview shall be approximately one-two hours, with further follow up interviews if required, or requested by the interviewee.

**What will happen to the results of the research:** The information recorded during the interviews will form a substantial part of the PhD project 'Public Health Challenges for General Practitioners in the Tees Valley during the 20th century', supplementing existing information and archival records. The data may also at some time stage, either prior to or after completion of the thesis, form part of oral presentations and published articles (e.g. newspapers, journals and book chapters).

**Voluntary Participation**: Your participation in the study is voluntary and you may choose to stop participating at any time. Your decision not to volunteer will not influence the nature of your relationship with Durham University either now, or in the future.

**Withdrawal from the Study**: You can stop participating in the study at any time without giving reasons, if you so decide. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with Durham University.

**Confidentiality**: Your name will appear in any report or publication of the research in relation to the information provided, unless you specifically request otherwise. In that instance, anonymisation of the transcripts of the interviews will take place. Your data will be available to any research staff involved, namely, myself, the supervisory team, and other bona fida researchers via the British Library sound archive, only with your complete consent. Otherwise, your data will be safely stored in a locked facility and only myself and my supervisors will have access to this information. Confidentiality will be provided to the fullest extent possible by law; however, research data given in confidence may not enjoy full legal privilege, and may be liable to sub poena by a court.

**Contact Information:** If you have questions about the research in general or about your role in the study, please feel free to contact Ms Victoria Brown M.A. at the Centre for the History of Medicine and Disease, Wolfson Research Institute, Durham University, Queen's Campus, University Boulevard, Thornaby, Stockton on Tees, TS17 6BH telephone: 0191-33-40367 or by e-mail v.a.brown@durham.ac.uk

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GP Interview 1 G N Marsh, Date of Recording 21/01/09

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