The medical response to epidemic disease during the long eighteenth century

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In the years between 1700 and 1830, London was singularly free from major epidemics of the infectious diseases of man. Of the great invaders, plague had receded from England with the seventeenth century, and the scourge of cholera waited upon the extension of British military and trading interests in India in the second decade of the nineteenth century. The endemic infections, like smallpox and the fevers, were rife in London and continued to fluctuate in prevalence and severity, but at levels which made no exceptional imprint on popular memory or on the Bills of Mortality. The mortality patterns of these epidemic diseases as recorded in the Bills, and the meaning of the categorizations used in the Bills, have as yet received little attention from historians.¹ The story of how the city's doctors reacted to these diseases, and analysis of the ways in which disease patterns relate to their activities, remains unexplored. Medical responses to infectious disease are essentially uncharted territory. This paper accordingly presents, by way of introduction, a synthesis of relevant literature which more detailed studies may both illuminate and modify.

Scholars approaching the history of epidemic disease in the eighteenth century should be informed by Roy Porter's warning that eighteenth-century medical responses to infectious disease should not be judged by the standards of the Victorian public health movement.² Although eighteenth-century London was a far from healthy place, it was in many ways still a pre-industrial city: it was not


until the nineteenth century that its population began to spiral out of control, driving the city limits ever further outward, and imposing an ever-more complex sanitary discipline upon inhabitants and local authorities alike. There was no established framework of administrative concern with matters of public health and disease. The eighteenth century suffered from political inertia in this respect: 'Parliament left London's salubrity to the city; and the City passed the buck to the parishes, which were mesmerised by the Poor Law philosophy of individual personal entitlements to relief.'

Individualism seems to be the key to the eighteenth-century response to epidemic diseases. The theory and practice of eighteenth-century medicine was very different from that even of the early nineteenth century, when the clinical revolution of the Paris medical schools had begun to extend its influence through the hospitals and medical schools of Europe. Medical treatment, and the medical response to illness, centred on the individual patient, and did not extend from the individual to the implications for society at large. In England too, the intellectual climate differed from that of some continental states: the concept of medical police, put forward by Johann Peter Frank in the 1780s, was absent from the writings of English doctors on the subject of sickness and its prevention in the later eighteenth century, although it was influential in Prussia and France. It is a measure of eighteenth-century England's individualistic homocentricity, of its detachment from the wider implications of epidemic disease in other species, that when cattle plague (rinderpest) appeared as a major agricultural problem in 1714 it was ruthlessly dealt with, but that no analogy to human epidemics was made. Some hundred and fifty years later, in 1868, Sir James Young Simpson picked up the example of responses to cattle plague to evolve the stamping out policy for smallpox.

Nonetheless, despite this broad indifference, eighteenth-century physicians were interested in epidemic diseases, and studied them accordingly. Although evidence for their involvement at a 'hands on', preventive level, remains obscure, doctors responded to the endemic epidemic diseases on three levels: the observational, the practical, and the institutional.

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3 Ibid., p. 63
6 Porter, 'Great Wen', p. 64.
The observation of epidemic disease - eighteenth-century epidemiology - derived from the writings of Thomas Sydenham, John Locke and William Petty. It was directed, as James Riley has argued, towards the better understanding of the causes of disease. In the years after 1650, English physicians developed new tools and methodologies for studying disease, based on the environmentalist, Hippocratic notions of airs, waters and places. Many eighteenth-century physicians kept their own records of epidemics, of causes and cures, and processed data from hospitals, dispensaries and the Bills of Mortality, with the object of establishing medical topographies. They investigated specific diseases, among which the fevers became prime targets of research, and they concluded from experience that there was indeed a connexion between these diseases and insanitary conditions.

These investigations became the basis of what Riley has called the eighteenth-century campaign to avoid disease. There was a shift in emphasis, which moved the physicians' gaze onwards, to encompass the individual's environment as well as the individual. As a result, physicians set out, in practice, to improve the health of individuals through public health and education. Londoners were showered with advice on domestic and personal hygiene through the agency of hospitals, dispensaries and the ubiquitous eighteenth-century pamphlet. Further, Riley argues, the physicians also promoted ideas about making the environment healthier, and urged improvements on governments and public-spirited individuals.

The doctors' most visible response to the problem of infectious diseases was, however, institutional. This approach took two forms: the establishment of dispensaries, and of special hospitals for infectious fevers.

Eighteenth-century physicians depended on private practice for a living, and the focus of their professional gaze was thus on the lives of the upper and middle classes, who bought their services. However, physicians too shared the great philanthropic ethos of the eighteenth-century, and it was their frequent custom to serve, free of charge, in the city's voluntary hospitals. Here they saw a much poorer class of patient than their normal clientele. Admission to the voluntary hospitals was by subscriber's ticket. Among various restrictions on entry, these hospitals did not accept infectious disease cases.

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Between 1720 and 1745, London's medical philanthropy manifested itself in a spate of hospital building. Five new general hospitals were built in these years: the Westminster, Guy's, St George's, the London and the Middlesex. The admissions requirements with which these hospitals were founded made them an inflexible provision: they did not evolve and adapt to meet changing perceptions of the city's social and medical needs. As concern with smallpox and other infectious fevers mounted after 1745, so new methods of tackling the problem were developed.

The first such development represented a variation on the established theme but one which, nonetheless, marked a departure and set an important precedent. The London Smallpox Hospital was founded in 1746, in a house with 13 beds in Windmill Street off the Tottenham Court Road. It claimed to be the first specialist smallpox hospital in Europe. Although it was to play an important part in London's medical scene for over a hundred years, the details of its history are largely obscure. Its first physician-in-charge was one Robert Poole, who is likely to have played a part in its foundation. The express objects of the hospital were two-fold: to remove infected individuals, specifically servants, from their place of residence, 'for the securing of private families'; secondly, to promote the practice of inoculation which, 'has a tendency to preserve our species from the ravages of this infectious malady'. Opening a window on a common eighteenth-century hazard, the hospital's governors noted, in their report for 1760, that smallpox was,

so frightful, even in its first appearance, and at the same time so contagious and almost inevitable, families of all degrees are thrown into the utmost confusion when it invades any person amongst them, let his or her station be what it will.

Smallpox was generally accepted as a directly contagious disease in the eighteenth century. Contemporary disease theory offered various explanations for the existence of other fevers, often based on their environmental associations, but by the end of the century these too had come to be identified as contagious in the sense that, like smallpox and cattle-plague, one case alone could be shown to result in others. Indeed, whatever the theoretical beliefs of the individual physician, there existed a general consensus on the practical measures to be followed with all diseases other than plague: removal of the

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19 A history of the hospital was written by Herbert Goude (1846-1894), but I have been unable to trace a copy. Annual reports lodged in the British Library have been lost.
20 Cited in Green, 'Eighteenth-century small-pox hospital', p. 1246.
patient from the site of contagion, or his medication at home, and the instruction of friends and relatives in habits of hygiene.\textsuperscript{21}

It was this consensus, together with the failure of the general hospitals to approach the problems of fever and poverty, that led to the development, in the 1770s, of the provincial fever hospital movement, and of the dispensary movement. Both these developments were inaugurated by doctors. William Haygarth of Chester (1740-1827) was the first to set aside wards for fever patients in 1783 (it had been his ambition since 1774), and this practice was taken up in other provincial hospitals.\textsuperscript{22} The dispensary movement, however, originated in London, where its most active proponent was John Coakley Lettsom (1744-1815), a man of great charm and decided social conscience.\textsuperscript{23}

Beginning with the General Dispensary in Aldersgate Street in 1770, there were sixteen general dispensaries in London by 1800, handling an estimated 50,000 cases a year. Not all of these were of fever, of course, but it was the dispensary experience that introduced a significant group of London physicians to the problems of poverty and disease among the city's ordinary people. Unlike hospital or private practice, dispensary service actually took the doctors into the homes of the poor, and they were shocked by what they saw.\textsuperscript{24}

It was this experience that made dispensary doctors into pioneers of fever hospitals and of public health.\textsuperscript{25} In London, it was two physicians from the Public Dispensary at Temple Bar (serving the area which lay between Smithfield and St Paul's in the east to St Martin's Lane and Tottenham Court Road in the west) who were instrumental in founding the London Fever Hospital in 1801. Like the Smallpox Hospital, this was specifically intended to remove foci of infection from the community. It also took on a more broadly environmental role, becoming involved in disinfecting and fumigating the homes of the infected poor. Significantly too, admission to the Fever Hospital depended not on lay patronage, but on the recommendation of a doctor.\textsuperscript{26}

It was from the London Fever Hospital that the move away from the individualistic eighteenth-century approach to infectious disease was made, in the opening decades of the nineteenth century. In 1824, Thomas Southwood Smith (1788-1861) and Alexander Tweedie (1794-1884) were appointed physicians to the Hospital. Between them they were to serve it for seventy years.\textsuperscript{27} They were influenced by the new French medical science, and by the

\textsuperscript{21} Porter, 'Great Wen', pp. 71-2; Pickstone, 'Dearth', pp. 130-1.

\textsuperscript{22} M.C. Buer, \textit{Health, wealth, and population in the early days of the Industrial Revolution} (1926), p. 199.

\textsuperscript{23} Loudon, 'Dispensary movement', p. 323.

\textsuperscript{24} Ibid., pp. 331-3.

\textsuperscript{25} Ibid., p. 333.

\textsuperscript{26} W.F. Bynum, 'Hospital, disease and community: the London Fever Hospital, 1801-1850' in Charles E. Rosenberg (ed.), \textit{Healing and history} (1979), pp. 100, 104.

\textsuperscript{27} Ibid., p. 108.
1830s were practising the new style hospital medicine, performing autopsies on fatal cases and correlating symptoms and lesions, in the best style of pathologically-based clinical medicine. In their hospital practice, therefore, they had moved away from the individualism of the eighteenth century.28

Southwood Smith was also becoming increasingly critical of the traditional doctrine of the contagiousness of fevers. He, too, was a dispensary physician (at the Eastern Dispensary). Drawing on his experience of fever among the poor, and influenced, no doubt, by the recent revolution in the theory of clinical medicine, Southwood Smith moved towards anti-contagionism - towards a miasmatic explanation for epidemic fevers.29 Smith was also a Unitarian, and personal physician to Jeremy Bentham, and he absorbed both Bentham's utilitarian philosophy and his reforming zeal.30 In 1830, he published his *Treatise on Fever*, a work recognized by contemporaries as a classic, in which he argued that the poor were impoverished by fever, and that fever was preventable.31 This book at once set the agenda for Edwin Chadwick's later career with the New Poor Law Board, and moved the whole ethos of public health away from the voluntary, philanthropic, individualistic eighteenth-century approach, and into the imperative, community-oriented Victorian mode.32

In sum, the medical response to epidemic disease in the eighteenth century was determined not simply by observation of the social context and behaviour of infections, or by the existence of a philanthropic ethos and absence of a political drive for social medicine. Medical responses to infections were shaped by the physician's concern for the individual patient, and by the view that the patient's symptoms, his physical and mental condition, and his physical environment were all contributory factors to his disease process. This patient-centred medicine inhibited any collective medical response to epidemic outbreaks. By contrast, the increasing reduction of the patient to a mere clinical object combined with the flowering of the greatest happiness principle in the years after 1830 to generate a growing co-operation among medical men in meeting the challenge of epidemic disease.

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28 Ibid., p. 110.
29 Margaret Pelling, *Cholera, fever and English medicine 1825-1865* (1979); Pickstone, 'Dearth', pp. 143-6 gives a recent assessment of Smith and his ideas.
30 Bynum, 'Hospital', p. 109.
32 Bynum, 'Hospital', pp. 109-110. For the relations between Smith and Chadwick, see Pelling, *Cholera*, chapter 1.