‘Where is the Fault?’: The Starvation of Edward Cooper at the Isle of Wight Workhouse in 1877

Kim Price*

Summary. Edward Cooper was a disabled pauper who died of starvation in a workhouse ‘idiot’ ward. His neglect was the result of systemic problems, exacerbated by policy, and the poor law’s free market approach to employing doctors in this period. In the 1870s community care came under assault from a policy that is known to historians as the ‘crusade against outdoor relief’. Though it sought to target ‘idlers’ and ‘undeserving’ cases, the withdrawal of vital payments for familial carers drove up the number of institutionalised and vulnerable patients. In turn, workhouse medical officers and nurses were unprepared for disabled patients, such as Edward, and charges of negligence increased. This article will provide a rare and detailed comparison between Victorian workhouse care and care in the community, drawn from extant contemporary affidavits.

Keywords: negligence; patient; disability; poor law; doctor

On 26 February 1877, Edward Cooper, a severely disabled (but otherwise ‘healthy’) twenty-three year old man, was admitted to the Isle of Wight Union workhouse as an ‘idiot’.1 One month later, he was dead. A letter was sent to his mother, Mary, informing her of the death. Her son-in-law, Francis Munns, came to the workhouse to fetch Edward’s corpse. Munns said to the staff that ‘it wasn’t fit to be seen’: the body was contorted and naked, the jaw hung slack and the eyes had not been closed—Edward was emaciated and there were visible injuries.2 Munns paid for a calico shirt and to have the jaw bound up and the eyes covered. He placed the body in a coffin—made and sent by Edward’s uncle—and brought the body home. Mary insisted on seeing Edward one last time and was devastated by his condition. She contacted her eldest son, Henry, a corporal in the telegraph department of the Royal Engineers. He came from

* School of Historical Studies, University of Leicester, UK. E-mail: kp178@le.ac.uk

Kim Price is an Honorary Visiting Fellow at the University of Leicester. He recently completed a Wellcome Trust Postdoctoral Fellowship at Leicester, which examined the ‘voice’ of paupers in official inquiries into poor law neglect and English medical law in the nineteenth century. He has also published in The Lancet and is completing a monograph for Continuum about medical negligence in the Victorian period.

1This article draws from the inquiries of the Coroner and Local Government Board, following the death of Edward Cooper: National Archives Ministry of Health Records Local Government Board and predecessors, correspondence with Isle of Wight Poor Law Union, 1877–78 MH12/11106–7 (henceforth: TNA IWU).

2TNA IWU Affidavit of Francis Henry Munns at the official inquiry, 8–11.

© The Author 2012. Published by Oxford University Press on behalf of the Society for the Social History of Medicine. This is an Open Access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (http://creativecommons.org/licenses/by-nc/2.5), which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited. doi:10.1093/shm/hks057

Advance Access published 24 July 2012
London immediately. Henry’s description of the corpse was almost identical to that provided by the subsequent coroner’s inquest:

My brother was laying in a front room of our home. I took a light & removed the lid of the coffin. The body was very emaciated. Mouth was open—chin dropping very much. Eyes open but very much sunken. The cheek bones seemed to be almost protruding through the skin, just covered. I then noticed his mouth. The bottom lip had marks as if the teeth had been tightly compressed upon it. I forced his upper lip up & saw that his teeth were gone—looked as if they had been broken off & the stumps turned inwardly as if forced off by some hard substance. I noticed the right knee was drawn up & the right knee joint swollen. I noticed then a very large sore on his right hip, it had a very black appearance. I then noticed his mouth. The bottom lip had marks as if the teeth had been tightly compressed upon it. I forced his upper lip up & saw that his teeth were gone—looked as if they had been broken off & the stumps turned inwardly as if forced off by some hard substance. I noticed the right knee was drawn up & the right knee joint swollen. I noticed then a very large sore on his right hip, it had a very black appearance. I then noticed his mouth. The bottom lip had marks as if the teeth had been tightly compressed upon it. I forced his upper lip up & saw that his teeth were gone—looked as if they had been broken off & the stumps turned inwardly as if forced off by some hard substance. I noticed the right knee was drawn up & the right knee joint swollen. I noticed then a very large sore on his right hip, it had a very black appearance. I then noticed his mouth. The bottom lip had marks as if the teeth had been tightly compressed upon it. I forced his upper lip up & saw that his teeth were gone—looked as if they had been broken off & the stumps turned inwardly as if forced off by some hard substance.

After Henry had viewed the body, he went to Colonel Atherly, a local dignitary who had previously helped the family. He referred Henry to a local medical practitioner, Dr Barrow, who assisted in their complaint against the union. Barrow examined Edward’s body, made out a certificate for Henry to take to the police and arranged a coroner’s inquest. Henry then hired ‘legal advisers’. Local and national press followed the case. The guardians, unable to reach a decision, panicked and requested an official inquiry from the Local Government Board (LGB). Two inspectors, Baldwyn Fleming and Dr Mouat arrived on the island and held an inquiry on the 8th and 9th of May. Subsequently, the workhouse medical officer, his deputy, a nurse and a ward attendant were all dismissed or forced to resign.

Cases of neglect, such as this can prise open and lift the lid on pauper experiences of poor law medicine. They can provide the ‘carefully contextualised analyses’ that some historians have argued is missing from the history of the patient’s view. The Coopers were the ‘deserving’ poor and should have received the cream of charity and voluntary aid. Instead, they slipped through the gaping holes of a welfare net stretched wide by a recession and the withdrawal of outdoor relief (non-institutional benefits paid to the poor in their own homes). They were typical of the labouring classes, weathering economic downturn and hardship by negotiating a ‘mixed economy of care’ and residual paternalism. This family knew their rights and the duties of officials, and their desire to do ‘battle’

---

3TNA IWU: Affidavit of Henry Cooper at the official inquiry, 51–3.
4Ibid., 54.
5F. Condrau, ‘The Patient’s View Meets the Clinical Gaze’, Social History of Medicine, 2007, 20, 525–40, 536.
6D. Fraser, The Evolution of the British Welfare State: a History of Social Policy since the Industrial Revolution (2nd edn, Basingstoke: Macmillan, 1984), 144.
7A. Borsay, Disability and Social Policy in Britain since 1750: A History of Exclusion (London: Palgrave Macmillan, 2005), 31–6.
8L. Hollen Lees, ‘The Survival of the Unfit: Welfare Politics and Family Maintenance in London’, in P. Mandler (ed.), The Uses of Charity: the Poor on Relief in the Nineteenth-Century Metropolis (Philadelphia: University of Pennsylvania Press, 1990), 68–91, 72; J. Melling, B. Forsythe and R. Adair, ‘Families, Communities and the Legal Regulation of Lunacy in
with the guardians feeds into recent poor law history. Surprisingly, it also meets with and pre-dates today’s patient-centred medical complaints’ systems. Although there was no mechanism for compensation payments under the poor law, they sought retribution for Edward. Henry’s search for knowledge and truth resonates with the primary motivations of health care complainants in the twenty-first century.

Perhaps it is an indication of a visceral and historical motivation—an atavistic reaction to human tragedy. The fight to rehabilitate Edward from a dehumanised pauper ‘idiot’ to a patient—with rights—pitted the Coopers against the medical profession and poor law authorities, leaving a rare and rich account of disability and care in the community—from a lay perspective. Vague definitions of idiocy sometimes led to diagnoses that drew heavily from the testimonials of family, community and lay officials. In general, the permanence of idiocy—a congenital condition—was contrasted with lunacy, which was characterised by sudden onset (from previous sanity) or chronic lunacy with moments of lucidity. Cases, like Edward—who received relief payments for disease of the spine, not idiocy—were not so easily categorised. His alleged ‘memory’, ‘understanding’ and ‘recognition’, should have legally prevented him from being classed as an ‘idiot’. His physical condition, though, made him appear the ‘perfect idiot’ to many, including the Isle of Wight poor law doctor. In an era that pre-dates medical supremacy, Edward’s case is an extraordinary example of a pauperised family successfully fighting for a disabled patient’s rights.

Contrary to the historical stereotype of poor people shunning, abandoning or stigmatising disability, Edward is a prime example of those who were accepted and cared for, in surprising numbers, by family and local community. Despite this, in 1877, after 23 years of a dependant but rich and nurtured life, Edward was incarcerated. This was not an isolated incident and his death in the workhouse is intimately linked with contemporary policy, medical practice and notions of disability.

Edward’s case is exemplary of a

Victorian England: Assessments of Crime, Violence and Welfare in Admissions to the Devon Asylum, 1845–1914, in P. Bartlett and D. Wright (eds), Outside the Walls of the Asylum: the History of Care in the Community 1750–2000 (London: The Athlone Press, 1999), 153–80, 153.

9 S. King, “Stop this Overwhelming Torment of Destiny”: Negotiating Financial Aid at Times of Sickness under the English Old Poor Law, 1800–1840, Bulletin of the History of Medicine, 2005, 79, 228–60, 234.

10 A. Merry and A. McCall Smith, Errors, Medicine and the Law (Cambridge: Cambridge University Press, 2001), 33–5.

11 The search for cause and culpability in medical errors can be traced back to Ancient Greece: Stephen Miles, The Hippocratic Oath and the Ethics of Medicine (Oxford: Oxford University Press, 2005), 113–17.

12 Historians, such as Wright, have lamented the lack of such resources. D. Wright, Mental Disability in Victorian England: the Earlswood Asylum, 1847–1901 (Oxford: Clarendon Press, 2001), 47.

13 P. Rushton, ‘Idiocy, the Family and the Community in Early Modern North-East England’, in D. Wright and A. Digby (eds), From Idiocy to Mental Deficiency: Historical Perspectives on People with Learning Disabilities (London: Routledge, 1996), 47–9.

14 Ibid., 58; M. Thomson, The Problem of Mental Deficiency: Eugenics, Democracy, and Social Policy in Britain c. 1870–1959 (Oxford: Clarendon Press, 1998), 7; Wright, Mental Disability, 10, 15.

15 Wright, Mental Disability, 16; A. Digby, ‘Contexts and Perspectives’, in Wright and Digby, From Idiocy, 1.

16 For medicine and disability, see D. Turner, ‘Introduction: Approaching Anomalous Bodies’, in D. Turner and K. Stagg (eds), Social Histories of Disability and Deformity (London: Routledge, 2006), 1–16.

17 Although David Wright has said that such care has been ‘exaggerated by historians’, Anne Borsay has said that the decline of familial care is a ‘myth’. Borsay, Disability, 175–87; Wright, Mental Disability, 66.

18 D. Wright, ‘“Childlike in His Innocence”: Lay Attitudes to “Idiots” and “Imbeciles” in Victorian England’, in Wright and Digby, From Idiocy, 118–133, 19–27.
growing number of cases revealed by research into medical neglect in the late nineteenth century.\(^\text{19}\) His incarceration stemmed from the altered landscape of welfare between the 1870s and 1890s. It was a time when civil servants and local health and welfare administrators encouraged a ‘crusading’ mentality against what they and their contemporaries considered to be wasteful and undeserving welfare recipients.\(^\text{20}\) Historians, such as Elizabeth Hurren, now view the 1870s and 1880s as a critical episode in the history of welfare. It was a period which embraced a cynicism towards welfare recipients, shrank access to vital benefits, and scrutinised claims for medical welfare: ‘The crusading experiment drove those in deepest poverty to enter a system in which they were shuffled about to save costs.’\(^\text{21}\)

This article will therefore contextualise Edward’s case within the poor law, using his experience as an example of the interplay between policy and neglect in this period. It begins with a discussion of welfare provision for the sick and disabled poor in the 1870s, arguing that the ‘crusade against outdoor relief’ lay behind Edward’s incarceration in the workhouse. The inquiry into his subsequent death drew from a diverse social range and, as Steve King has said of such narratives, these voices are ‘not just important in their own right, but also for what they tell us about the sentiment of communities towards the poor and the experiences of paupers in those communities.’\(^\text{22}\) The second section therefore provides a rare appraisal of home care in this period—drawing on affidavits taken at the official inquiry. The final section will compare this to the circumstances of Edward’s death in the workhouse and argue that the standard of care, there, was not equal to that of his home. However, this article will contend that the economics of welfare in this period and the contractual arrangements of medical officers combined with the ‘crusade against outdoor relief’ to create a widely negligent system that was ultimately responsible for Edward’s death.

**The social cost of the ‘crusade against outdoor relief’**

Although there is an extensive body of research into the new poor law, it has tended to brush over the end of the nineteenth century when policy reforms altered conventional approaches to the sick and poor.\(^\text{23}\) The expense of pauperism was evened out across a union after the Union Chargeability Act (1865), which removed the liability from parishes

---

\(^{19}\)Charges against medical officers rose exorbitantly in the 1870s and 1880s. In some regions, at least a quarter of workhouse medical officers were forced to resign or (less commonly) dismissed during this period. Rising numbers of vulnerable patient categories (such as ‘idiots’) led to latent safety failures in the system and underpinned a considerable proportion of charges. K. Price, ‘The Crusade against Out-Relief: a Nudge from History’, *The Lancet*, 2011, 377, 19 March, 988–9; K. Price, *Medical Negligence in Victorian England* (forthcoming: Continuum, 2013). For rising numbers of disabled, see: Borsay, *Disability*, 32–6.

\(^{20}\)K. Williams, *From Pauperism to Poverty* (London: Routledge & Kegan Paul, 1981), 96–129.

\(^{21}\)E. Hurren, *Protesting about Pauperism: Poverty, Politics and Poor Relief in Late-Victorian England, 1870–1900* (Woodbridge: Boydell, 2007), 56.

\(^{22}\)S. King, ‘Regional Patterns in the Experiences and Treatment of the Sick Poor, 1800–40: Rights, Obligations and Duties in the Rhetoric of Paupers’, *Family and Community History*, 2007, 10, 61–75, 63.

\(^{23}\)For examples of otherwise comprehensive works, see: A. Kidd, *State, Society and the Poor in Nineteenth-Century England* (Basingstoke: Macmillan, 1999), passim; L. Hollen Lees, *The Solidarities of Strangers: the English Poor Laws and the People, 1700–1948* (Cambridge: Cambridge University Press, 1998), passim; B. Harris, *The Origins of the Welfare State: Society, State and Social Welfare in England and Wales, 1800–1945* (Basingstoke: Palgrave Macmillan, 2004), passim.
with large numbers of paupers and spread the cost to those with relatively few.\(^{24}\) Although this created an opportunity to invest in workhouse care and improve institutional provision, liberal reforms in medicine, welfare and public health were effective but costly (such as those brought about by the Metropolitan Poor Act of 1867 and Sanitary Act of 1866).\(^{25}\) Therefore, Mary MacKinnon noted: ‘The potential to increase expenditure was indeed created by union rateability, but there is considerable reason to believe that its introduction in fact encouraged restrictive changes in poor law policy.’\(^{26}\) Instead of widening access, after the 1860s, the operation of the poor law became more cynical towards all applicants for relief and continued this way for at least two decades.\(^{27}\)

George Goschen, the last president of the Poor Law Board, claimed the poor had abused the system. He expressed the ‘reforms’ that set the ‘crusade’ in motion in an 1869 circular, since known as the Goschen Minute.\(^{28}\) He called for strict delineation between the deserving and undeserving poor: ‘... an attempt should be made to bring the authorities administering the poor laws and those who administer charitable funds to as clear an understanding as possible, so as to avoid the double distribution of relief to the same persons.’\(^{29}\) Goschen’s ideas took hold and inspired the aims of many administrators, including Henry Longley, who became ‘legal Inspector of the Board to hold Official Inquiries’ in 1870.\(^{30}\)

Four years after beginning this onerous role—a period when official inquiries into medical negligence had consistently shifted blame onto medical staff—he published the Longley Report, which set out and expanded Goschen’s aims in no uncertain terms.\(^{31}\) Longley went further, seeking complete withdrawal of outdoor relief and more stringent controls on medical relief. This rather personal brand of welfare attrition was never ‘officially’ implemented across the nation, but Longley’s report (and his authority over other inspectors) had a profound influence on poor law practice in the 1870s and 1880s—becoming the ‘Longley Strategy’. The economic historian, Michael Rose, described its radicalism: ‘Even the aged and sick, the Board advised, should have their applications for relief carefully scrutinised.’\(^{32}\) The policy intentionally took a heavy, broad-brush stroke to all areas of outdoor relief—including medical relief. In contrast, the original creators of the new poor law had not intended it to be applied towards the sick poor.

While the Longley Strategy was being backed by a strong majority, the vulnerable and sick

\(^{24}\)K. Waddington, ‘Paying for the Poor: Financing Medicine under the Victorian Poor Law—the Case of the Whitechapel Union, 1850–1900’, in M. Gorsky and S. Sheard (eds), Financing Medicine: the British Experience since 1750 (London: Routledge, 2006), 95–111, 95–7.

\(^{25}\)Ibid.

\(^{26}\)M. MacKinnon, ‘English Poor Law Policy and the Crusade against Out Relief’, The Journal of Economic History, 1987, 47, 603–25, 614.

\(^{27}\)E. Hurren, ‘Welfare to Work Schemes and a Crusade against Outdoor Relief in the Brixworth Union, Northamptonshire, in the 1880s’, Family and Community History, 2001, 4, 19–30, 19–30; Hurren, Protest, 242; MacKinnon, ‘English Poor Law Policy’, 603–8.

\(^{28}\)For further details on Goschen, see: S. H. Jeyes, The Life and Times of the Right Honourable the Marquis of Salisbury K.G. A History of the Conservative Party during the Last Fifty Years, Volume 1 (London: Virtue and Company, c.1900), 79–92.

\(^{29}\)‘Relief to the Poor in the Metropolis—Minute of the Poor Law Board’, in M. E. Rose, The English Poor Law 1780–1930 (Newton Abbot: David & Charles, 1971), 226–8. For a discussion of mid-Victorian Charity, see K. Waddington, Charity and the London Hospitals 1850–1898 (Woodbridge: RHS Boydell Press, 2000), 22–132.

\(^{30}\)TNA Inspector’s Correspondence MH32/9, memorandum of R. B. Cane: 13 December 1870.

\(^{31}\)Williams, From Pauperism, 96.

\(^{32}\)Rose, English Poor Law, 228.
poor (including those with disabilities, mental health problems or learning disorders) saw their options dwindle and many were faced with institutional care or nothing. ‘Crusaders’ had therefore unintentionally ‘replaced the lenient system of outdoor relief with the more expensive one of institutional care.’

Contrary to traditional history, ‘crusading’ was not confined to a handful of ‘model’ unions. Hurren described how the process of the ‘crusade’ worked from central to local government in the early 1870s: ‘Central government used the Brixworth union to raise its profile in the Midlands where it lacked real authority. This enabled civil servants to publicise the cost-saving benefits of adopting the Longley Strategy to pursue cost-saving goals, making radical cuts in poor law expenditure.’ Nationally, inspectors were at the hub of ‘crusade’ policy dissemination and they organised conferences throughout the 1870s to spread the success of model unions, such as Brixworth. For example, there were eighteen unions represented at a Midland conference in 1872, with delegates from every county in Inspector Henley’s district (and some from beyond). The Midland delegates discussed the cessation of outdoor relief and the ‘strict regulation and curtailing’ of medical extras. Henley encouraged guardians to monitor their medical officers and pushed for ‘closer testing and checks on the widespread faking of sickness and abuse of the system’ by the sick poor.

Workshops, meetings and conferences were thus an important spoke in the ‘crusade’ wheel—a place to insist both on policies being put into practice and to propagate ‘crusade’ ideals. Unions all over the country were thus influenced by the energetic work of LGB inspectors. By the mid-1870s, there was an almost universal belief that welfare was a loophole for over-generous and indiscriminate relief. The ‘crusade’ had fed into the nation’s wider concerns about welfare expenditure, and inspectors ‘encouraged guardians of the poor to think of themselves as medical experts, using “sound business sense” in both welfare and public health administration.” Thus The Lancet was quick to defend the Isle of Wight workhouse medical officer and blame the LGB:

Guardians are permitted to practise a paltry economy at the expense of the poor, and when an accident occurs inspectors hold an inquiry, censure what they previously sanctioned, supersede certain of their approved agents, and, in this pleasant way, appease the clamour of public opinion. … We are strongly of opinion that the case which has just occurred at Ryde is not only a typical but a publicly important instance of systematic mismanagement and neglect.

The contradictory programme of workhouses—built to deter the feckless but evolving into hospitals for the poor—had indeed resulted in frequent neglect that reached its

33Waddington, ‘Paying for the Poor’, 107; C. Smith, ‘Family, Community and the Victorian Asylum: a Case Study of the Northampton General Lunatic Asylum and its Pauper Lunatics’, Family and Community History, 2006, 9, 109–24, 115.
34Hurren, Protesting, 254.
35Medway Archives G/ST/AM 14 North Aylesford Union Board of Guardians Minutes 1871–4: ‘Interesting Poor Law Conference’, 3 October 1872.
36Ibid.
37E. Hurren, ‘Poor Law Versus Public Health: Diphtheria, Sanitary Reform, and the “Crusade” against Outdoor Relief 1870–1900’, Social History of Medicine, 2005, 18, 399–418, 403, paraphrasing Williams, From Pauperism, 99.
38The “Starvation Case,” Isle of Wight’, The Lancet 16 June 1877, p. 889. Edward’s parish of residence was Brading in the Ryde district.
apotheosis in the 1870s. ‘Crusaders’ argued that workhouses and their newly-built infirmaries were (after reforms, such as the Chargeable Act) fully capable and rejuvenated institutes, equipped with ‘modern’ medicaments and provisions and staffed with well-trained doctors who were assisted by able nurses. The reality on the ground was often quite different. In general, poor law infirmary development was almost half a century behind equivalent services in voluntary hospitals. There had been no investment in staff and the majority of those who actually carried out the care (and medical) work were untrained and unqualified. Looking back, from the perspective of the early 1900s, the Webbs observed that ‘the two fold policy thus emanating from the Local Government Board has been reflected in the medical administration of the boards of guardians up and down the country, in an irregular manner and to a varying degree.’ The ‘crusade’ had cleaved a schism of negligence through poor law medicine, hemmed in by welfare attrition on the one side and low standards of institutional care on the other. It was a crushing blow to delicate micro-economies outside of the workhouse and contributed to an ‘exodus’ of vulnerable cases, such as Edward, into workhouses during this period. The Coopers’ experience is thus historically important and Edward’s fate contrasts the ‘crusade’ rhetoric with the pathos of its enactment.

The Coopers first applied for poor relief in 1874 when Edward’s father was sick and temporarily hospitalised. In addition, his sister had married and was pregnant and could therefore no longer share the greater burden of care with their mother. The loss was keenly felt in the Cooper household and lowered their earning potential while both parents were not working. The guardians did not consider this a case for outdoor relief. Mary was able-bodied and could work. Edward was thus a prime candidate for the workhouse ‘idiot’ ward. Mary described his experience in 1874:

My husband was off work for the day & I asked him to stop & see the boy. He came home & began to crying ready to break his heart. He said the poor boy was fell away to nothing & had sores all round the lower part of his body—the dry skin was hanging off his back & he had like boils round him. We then made up our minds to take him out. …. His mouth was dry & turned up hard—& his body had got very thin—all round the lower part was in these large wounds, more especially one on the hip. …. His other parts were all but dropping from him. He had been then in the W.H. 10 clear days …

On this occasion, the family did not complain. Instead Colonel Atherly helped the family to bring the case before the guardians. A grant was arranged of one shilling a week, which

---

39 For example, there were between five and ten times the regular annual incidence of charges of neglect against workhouse medical officers in the 1870s. Price, Medical Negligence.
40 Williams, From Pauperism, 128; F. Driver, ‘The Historical Geography of the Workhouse System in England and Wales, 1834–1883’, Journal of Historical Geography, 1989, 15, 269–86, 276–284.
41 S. Webb and B. Webb (eds), The Minority Report of the Poor Law Commission (Clifton: Augustus Kelley, [1909] 1974), 214.
42 Although Wright does not say the ‘crusade’ played a part in this, Borsay does attribute rising numbers to widespread ‘crusading’: D. Wright, ‘Learning Disability and the New Poor Law in England, 1834–1867’, Disability and Society, 2000, 15, 731–45, 740; Borsay, Disability, 31–3.
43 TNA IWU: Affidavit of Mary Cooper at the official inquiry (henceforth: affidavit of Mary), 1–26.
continued until Edward’s incarceration in 1877. Possibly, this was hush money to appease the family and prevent them bringing unwelcome public attention or a latter-day paternalistic gesture. Atherly was a respected island dignitary, guardian and chairman of the workhouse visiting committee.

Corroborative statements in the inquiry indicated the family had received other types of aid from various local people—helping with Edward’s care and transport or by paying for important goods. Such support would have formed a critical element of a fragile economy of makeshifts, but, after 1870, ‘few could maintain their independence outside the workhouse’. Edward’s was not an isolated case. In 1870, there were 843,000 claimants of outdoor relief; six years later, the number had dropped to 567,000. Moreover, between 1850 and 1890 the proportion of ‘insane’ on outdoor relief fell from approximately 25 to 6 per cent. Mary’s decision to place Edward in the workhouse was a traumatic but commonplace one, ‘predicated less on an acceptance of a medical approach to idiocy than on practical issues of household economy and life-cycle poverty’. When Edward’s father died at the height of the ‘crusade’ in 1877, it was made clear to Mary that poor law relief for Edward meant the workhouse. Widows were one of the prime targets of the ‘crusade’ and within weeks Edward was incarcerated while Mary went to work.

Historians have tended to highlight the shortcomings of community care and rightly focus on the numerous cases of familial abuse and neglect reported by the Lunacy Commissioners. However, Edward was clearly not better ‘in’ than ‘out’—he was not shunned by the community, abused by his family nor hidden away. Edward was remarkably well accepted and cared for by his family and the local community. An extensive ‘kinship network’ had helped the family to keep Edward in relative comfort. His life experience goes against the familiar image of disability and domiciliary care in the nineteenth century and weakens the ‘myth’ of declining familial care in the face of industrialisation.

Edward had survived in the Coopers’ home for 23 years and this begs the question: how? ‘He was not an idiot’: disability and care in the community

In short, the Coopers were the inventive and creative poor—those that utilised all means of survival at their disposal. Moreover, Edward was accepted as a regular family member

44TNA IWU: ‘Report of the Inspectors’, May 1877, 1–2. 45Hurren, Protestings, 256; M. Hanly, ‘The economy of makeshifts and the poor law: a game of chance?’ in S. King and A. Tomkins (eds), The Poor in England 1700–1850: an Economy of Makeshifts (Manchester: Manchester University Press, 2003), 76–99; King and Tomkins, The Poor in England, 272–9. 46Borsay, Disability, 152. 47Ibid. 48Wright, ““Childlike””, 131. 49Atherley arranged for Edward’s place in the workhouse, by-passing the relieving officer. He reassured Mary that Edward would be well cared for by the master, who had met with Atherley. This irregular committal was censored by the LGB inspectors. 50Waddington, ‘Paying for the Poor’, 98; E. Ross, ‘Hungry Children: Housewives and London Charity, 1870–1918’ in Mandler, The Uses of Charity, 161–96, 163. 51A study of lay attitudes to idiocy ‘cuts against the grain’, Wright, ““Childlike””, 118. 52Borsay, Disability, 175–82; P. Bartlett, The Poor Law of Lunacy: the Administration of Pauper Lunatics in Mid-Nineteenth-Century England (London: Leicester University Press, 1999), 176–89. 53Borsay, Disability, 169–96; D. Englander, ‘From the Abyss: Pauper Petitions and Correspondence in Victorian London’, London Journal, 2000, 25, 71–83, 71–81; King and Tomkins, The Poor in England, 274–5; T. Sokoll, Essex Pauper Letters, 1721–1837 (Oxford: Oxford University Press, 2001), 15;
and they fought hard to keep him alive. It is difficult to say how common this type of
domestic care of the disabled was, because it has received far less attention from histor-
ians than institutional provision. As Wright has argued: ‘for individuals kept with relatives,
there are no documents with which to judge the care, diet, treatment’ and that there is no
‘fair’ way for historians to compare institutional with community care. Notwithstanding
Wright’s assertion that a dependence on government documentation has led historians to
fixate on the experience of the institutionalised mad, inquiries into medical neglect under
the poor law can provide an unusual comparison between workhouse and home care.

An acceptable standard of care was a slippery concept under the new poor law—a
system built on less eligibility and deterrence. Yet, a low level of care at home may miti-
gate subsequent neglect in a workhouse and shift attention elsewhere. Inspectors
working in an official inquiry therefore tended to establish standards and expectations
on a case-by-case basis and sometimes this entailed an assessment of both institution
and community. In such circumstances, inspectors subpoenaed witnesses from a wide
social range and asked questions pertaining to standards of care in the home and work-
house. Many official inquiries can therefore provide a vast untapped resource for social
and medical historians seeking to make comparisons. Moreover, the extensive affidavits
of an inquiry—drawn from diverse social groups—can restore voice to what Peter
Mandler has described as the ‘comparatively dumb’ poor of history.

Though Edward could not speak for himself, the statements of the relieving officer,
local officials, neighbours and family compose an impressive record of domestic care. Almost all of those interviewed at this official inquiry—including the deputy workhouse medical officer—argued that Edward would have survived at home if funds had been pro-
vided for Mary. The Isle of Wight Chronicle agreed and blamed the guardians’ adher-
ence to the ‘crusade’ ideals: ‘Had an amount of out-door relief proportionate to the
peculiar requirements of the case been afforded, there is no doubt, judging from the
almost heroic affection displayed by the widowed mother [that] she would have much
preferred to have kept him beneath her own roof.”\(^5^8\) This would have been no mean
feat for any family, let alone one struggling with poverty.

Edward’s severe disability occupied a space within nineteenth-century ‘lunacy’ aetiol-
ogy that was neither strictly idiocy nor imbecility but was open to interpretation. With
shrunken feet and hands and little control over his limbs, he was almost completely
dependent on other people. According to Mary, Edward’s head had been injured
during the birth process ‘and he was never able to speak, but he had very quick
hearing. He knew what was said to him and I never considered him an idiot.’\(^5^9\) Emma
Macmahon was a neighbour who had seen Edward almost every day for four years.
She described his ‘wholesome’ appearance—‘like a lad of 16 or 17’—and his disability:

---

\(^5^4\)Wright, \textit{Mental Disability}, 47.
\(^5^5\)Mandler (ed.), \textit{The Uses of Charity}, 1.
\(^5^6\)For further context in domestic care, see: Wright, \textit{Learning Disability}, 738; B. Forsythe, J. Melling and
R. Adair, ‘The New Poor Law and the County Pauper Lunatic Asylum—the Devon Experience
1834–1884’, \textit{Social History of Medicine}, 1996, 9, 335–55, 350.
\(^5^7\)TNA IWU: Daniel Beckingsale under cross-
examination by Dr Mouat, LGB Inspector.
\(^5^8\)TNA IWU: \textit{Isle of Wight Chronicle}, 7 June 1877
(cutting: original unavailable).
\(^5^9\)TNA IWU: Mary Cooper’s statement at the Coroner’s
inquest, 1.
'he used to make a funny kind of noise like a person who can’t talk—I don’t think he was deaf. I know he was very quick at hearing—he would turn his head if you called to him.'

This was also corroborated by another friend of the family, James Walker, who said that Edward was mute but not deaf.

Despite the medical diagnoses of idiocy—documented by poor law doctors in 1874 and 1877—the Coopers refused to accept or describe Edward in those terms. In addition to his mother, Edward’s sister, brother, aunt, uncle and neighbours all testified that he was not an ‘idiot’. The facts that he could cry and respond if his name was called from out of sight—that he warmed to or recoiled from people—were all touted as evidence. Non-medical protagonists, such as the coroner’s jury and LGB inspectorate, were also interested in Edward’s emotional and cognitive range and had sought the opinions of family and community. For example, questions were asked, ranging from his ability to feel emotional pain and joy to whether or not he could recall people, establish relationships and recognise his surroundings. Wight has said of this push–pull method between medical professionals, lay and family, ‘one senses a process of negotiating the meaning of disability in which, if anything, the family had the stronger say’.

Moreover, their combined affidavits do indicate that Edward may not have been mentally impaired. He was well aware of his surroundings. It is possible that his starvation in the workhouse could have been purposeful self-harm or suicide. Mary’s description of Edward indicates limited physical abilities, but mental awareness and processing:

He did not make much noise during the day, unless a stranger came in—then he would throw his arms about in an excited sort of way—or perhaps smile—take it in different manner—some strangers he was pleased to see—some he didn’t like to see. … He was very pleased at seeing his father come up the garden. He would jump up & make a pleased noise whenever he saw him coming in sight. … He could not speak at all, but he could make anyone used to him understand what he wanted. … He would have allowed a stranger to feed him. He would have allowed you to feed him if he liked your appearance. He would make a little pleased hallo out, if he was glad to see you. If there was anything peculiar in appearance he would seem timid like.

Edward had the ability to recognise and form emotional bonds. Therefore he was not an ‘idiot’ to the Coopers, who seem to have interpreted idiocy as a condition with no emotional or cognitive interaction.

His inability to work or perform any household duties meant Edward was a full-time prospect in an impoverished family. Nonetheless, he was loved and endearingly referred to as ‘Teddy’ by his primary carers—his mother and sister. In addition to them, a father, uncle, brother and male friend of the family also contributed. They were (historically) unusually caring, describing Edward in openly empathetic and compassionate terms.
Mary described the help Edward had received from others and detailed Edward’s daily care regime to the inquiry. He had specially-made flannel shirts of which ‘the sleeves were sewn up to keep his hands from the cold’ and made with double flannel on the arms, chest and back. During the day he remained in a bespoke chair made by a relative, which reclined and performed as a commode. At night he was carried upstairs to a bed with a comfortably adapted mattress. According to Mary, ‘He was generally very quiet at night’ and ‘never cried’. Critically, someone was always with him and Edward never slept in a room alone. Moreover, Edward could not eat without assistance. It took between fifteen and twenty minutes to feed him:

He always had his meals when we had ours. We generally breakfasted between 8 & 9 he had nothing before that—he used to take bread & butter dipped in tea. He could not feed himself at all—he was powerless. I used to feed him, or my daughter. He used to move his mouth as if he masticated, but I always fancied dry food seemed to hang in his throat as if he could not swallow it. … Generally he took his food well … 67

Crucially, for an inquiry into starvation, it was confirmed that he had a healthy appetite. The inspectors concluded that Edward had a reasonable to high standard of care at home and that he was capable of eating, though he could not masticate well and needed assistance to eat.

Almost from the moment Mary became a widow, she was physically and financially unable to continue caring for him: ‘He was very heavy for me to lift—hurt my back very much. I had to bring him down stairs in morning and my husband took him up at night … After my husband’s death I found I couldn’t manage him. I had no means of supporting him besides the 2/- a week.’ 68 She had battled for years to keep the family’s finances afloat, only to have chance and tragedy defeat her best laid plans. 69 The Coopers joined with an unknown number of working class families whose experience of bereavement during the ‘crusade’ was to set their disabled or mentally-deficient children ‘on the road to the asylum’ or workhouse—literally and figuratively. 70 Mary borrowed a wagon from Colonel Atherly and, together with her daughter and a neighbour, she took Edward to the workhouse.

‘He was a perfect idiot’: disability and the workhouse system

The workhouse was supposed to be, in essence, a safe house for the chronic ‘imbecile’ or ‘idiot’—the physically disabled, such as Edward, or those with mental disability or learning disorders. 71 However, historians of disability, such as David Wright and Anne Borsay, have argued that by the 1860s many county asylums were overcrowded and the chronically

67 Affidavit of Mary, 9–12.
68 Ibid., 9.
69 For a discussion of single-parenthood, see: K. D. M. Snell and J. Millar, ‘Lone-Parent families and the Welfare State: Past and Present’, Continuity and Change, 1987, 3, 387–422, 389–404; Ross ‘Hungry Children’, 161.
70 Melling, Forsythe and Adair, ‘Families’, 178.
71 Ibid., 377; Bartlett, Poor Law of Lunacy, 37; Smith L.D., ‘Cure, Comfort and Safe Custody: Public Lunatic Asylums in Early-Nineteenth Century England’ (London: Leicester University Press, 1999), 284; R. Ellis, ‘The Asylum, the Poor Law, and a Reassessment of the Four-Shilling Grant: Admissions to the County Asylums of Yorkshire in the Nineteenth Century’, Social History of Medicine, 2006, 19, 55–71, 55; E. Murphy, ‘Workhouse Care of the
mentally-ill poor were, in over-stretched counties, returned to the workhouse.72 As a result of this, and the ‘crusade’, there were inflated numbers of institutionalised poor-law patients in this period under various contemporary mental-health categories.73 Nationally, the workhouse system was understaffed, ill-equipped and totally unsuited to cater for mentally-ill or disabled patients. The commissioners of lunacy did inspect amenities but their powers were limited.74 The BMJ said the ‘inspection of the insane in workhouses by the Commissioners in Lunacy was a mere farce [and] there is one subject which, somewhat to our surprise, the commissioners pass over in silence, and that is, the obvious insufficiency of the medical staffs ...’75 Despite some workhouses employing nurses and wardsmen there tended to be a very low standard of care.

Epileptics and the disabled were left alone for long periods of time with patients with learning disorders or serious mental-health problems—housed in wards for ‘lunatics’, ‘imbeciles’ or ‘idiots’. In general, nursing staff were drawn from the pauper inmates—a mix of long-term paupers, the aged, chronically sick or those with learning disorders.76 Even if a workhouse did employ a trained nurse, she was likely to be overstretched and heavily reliant on a handful of untrained wardsmen and pauper nurses.77 Day-to-day care work, such as assistance with eating, bodily excretions and ablutions, were therefore regularly carried out by fellow inmates. Fatal accidents were not uncommon. The injury or death of an ‘imbecile’ or ‘idiot’ (including preventable deaths of epileptics) is a recurrent theme in records of workhouse neglect.78

Edward’s mother and sister visited the Isle of Wight workhouse once or twice a week—and were accompanied by family friends on two occasions. They observed his physical and mental condition rapidly deteriorate. Despite bringing him food and bribing the nurses with extra food and money, Edward starved to death. Whether or not he was having difficulty eating due to depression and trauma from the loss of his family and home environment, it was obvious that Edward needed assistance to eat. The overstretched and uninterested workhouse staff were unable or unwilling to invest their time in managing Edward’s meals.

His starvation was made more appalling to Edward’s family because during his short stay in the workhouse his body became covered in ‘wounds’ and ‘sores’ and he lost several teeth.79 He had spent much of this time tied to a bed by sheets or slumped in his chair, causing deep bedsores. These were exacerbated by Edward soiling his linen

72Wright, Learning Disability, 740; Borsay, Disability, 31–6.
73Bartlett, Poor Law of Lunacy, 44; Hurren, Protesting, 45; Smith, ‘Cure, Comfort and Safe Custody’, 286.
74Murphy, ‘Workhouse Care’, 495–524.
75‘The insane in workhouses’, BMJ, 31 December 1881, 1065.
76‘Pauper Nurses’, BMJ, 28 June 1890, 1518; ‘Nursing in Country Workhouses’, BMJ, 11 November 1893, 1063. For further context: P. Ardern, When Matron Ruled (London: Robert Hale, 2002), 28; R. White, Social Change and the Nursing Profession: a Study of the Poor Law Nursing Service, 1848–1948 (London: Henry Kimpton, 1979), 56–9.
77Forsythe, Melling and Adair, ‘The New Poor Law’, 353.
78For examples, see: Oldham Local Studies and Archives: PUO 1/15 Oldham Union Board of Guardians’ Minutes 1872–73, 62. Shropshire Archives: Atcham Union Guardians’ Minute Book PL1/2/2/11, 9.
79Several accusations were made about the lost teeth (including violent force-feeding), but, from the statements, a fall from his chair seemed the most probable cause.
and lying or sitting in urine for long periods of time. This situation was worsened by the exchange of Edward’s regular nightgown for workhouse attire: a shirt and heavyweight woollen trousers which were wholly unsuited to his sensitive skin and physical condition. Mary had taken Edward’s own chair to the workhouse, which had been used part of the time, but he had been left in it for long periods of time.

The medical officer, Dr John Beckingsale, was present at the Coroner’s post-mortem and attempted to subvert the final judgment of starvation and neglect by making claims that there were other causal factors. Although Beckingsale remained silent throughout the autopsy, he subsequently claimed it was flawed and constructed several alternative ‘medical’ reasons for Edward’s death: ‘pining’ for his mother, ‘mal-assimilation of food’, ‘ulceration of the stomach’ and ‘disease of the liver’. Yet, he had originally certified Edward’s death from ‘debility and imbecility of the mind’. In his defence, Beckingsale stated: ‘I thought from the time I first saw him that he was wasting, & he continued to get weaker till he died—I think his life was shortened by separation from his mother, & I consider that he died from debility—he was a perfect idiot …’ In direct contrast to Edward’s family and friends, guardians and other lay witnesses at the inquiry, the doctors did not use Edward’s name and only referred to him by his condition: idiocy. Beckingsale was backed by his son (a medical student) and Dr Charles Meeres, the poor law medical officer for the Coopers’ district. They tried to destabilise the Coopers’ statements by insinuating Edward was starved before entering the workhouse and that Mary was somehow culpable. The medical officers argued vehemently that Edward was an ‘idiot’ and therefore his death was timely and expected and that ‘he could die from pining because he wasn’t normal’. Whereas family and friends had described a disabled but communicative patient, the doctors focused on his visual deformities and portrayed a degenerate creature that made incoherent ‘animal noises’.

When asked about Edward’s bedsores, Beckingsale said that he did not think of using water beds,—the common nineteenth-century remedy,—and claimed, ‘besides they were broken’. He was unperturbed of his lack of attendance—it was, after all, the way that he had practised poor law medicine for three decades. When asked how he decided which patients to see, Beckingsale said that he asked the nurse: ‘If there was anything she wished me to see? & if she says not I rely upon the nurse—Having confidence in the nurse I have always thought that sufficient.’ Thus a complete reliance upon an absent medical officer led to Edward’s starvation: ‘It never struck me that it was desirable that I should myself see him fed—notwithstanding the representations of his mother & his failing state—I understood he took all the food ordered.’ Edward had starved because despite being severely disabled he had been left to fend for himself.

At the official inquiry into Edward’s death, Inspector Baldwin Flemming noted: ‘No record of state of body at death. … No other record of the treatment of lunatics and idiots. As a matter of fact there is no record where Cooper was visited by himself or

80TNA IWU: LGB inspector’s observations on the case, 11–12.
81TNA IWU: Dr John Beckingsale’s statement at the coroner’s inquest, 30.
82TNA IWU: Affadavit of Dr John Beckingsale at the official inquiry, 3.
83TNA IWU: Dr Charles Meeres’ statement at the coroner’s inquest.
84TNA IWU: Affadavit of Dr John Beckingsale at the official inquiry, 3.
85Ibid., 10.
deputy whilst in the workhouse. In common with other LGB inquiries into neglect at this time, the inspectors pointed the finger of blame at the medical officer’s (lack of) attendance:

Neither the Medical officer nor his substitute took trouble to see that the instructions they say they gave as to pillowing for the relief of the sores were carried out and in fact instructions were never acted on. The medical officer never saw Cooper fed or examined his evacuations though he believed the rapid wasting and death to be due to mal-assimilation of food.

Flemming found that Beckingsale left the workhouse duties to his son, Daniel, who had worked as his assistant. In turn, Daniel had barely attended the workhouse himself and had not properly examined Edward. He had missed all of the salient points of the case: ‘the Board cannot avoid the conclusion that both those gentlemen gravely failed in their duty.’ The medical officer was subsequently forced to resign, while Daniel, who was not actually employed by the poor law, was initially banned from holding future poor law appointments. Later, this was overturned on appeal by his father and the guardians. The Lancet responded on behalf of the medical men, arguing that the LGB were quick to attribute blame but slow to take responsibility themselves: ‘… an inspector is the officer responsible to the Central Board for the arrangements he may be called to condemn. … The result must necessarily be a grotesque absurdity, and it is almost inevitable there should be injustice inflicted somewhere when the whitewashing process begins.’ Indeed, throughout most of the 1870s the public were hoodwinked into blaming doctors for systemic faults. For example, Sick Paupers and their Medical Attendants was a pamphlet written by an unknown author who was moved by Edward’s death to condemn poor law doctors who used assistants. The author joined with the LGB in blaming the medical officer and emotively argued against the widespread use of assistants:

The practice of Poor-Law Surgeons leaving the attendance on the Sick to Unqualified Assistants is not only a breach of contract, for which they are liable to dismissal, but is a fraud both on the Patient and Ratepayer. … In many cases the Sick Pauper is visited once at the commencement of his illness by the Medical Officer, and if his Assistant is sufficiently intelligent to detect symptoms of approaching death, a second visit is made; certificates of the cause of death are, however, in many instances, given by the Medical Officer when he has not seen the deceased pauper for a long time before death occurred, and in such a case the fact is carefully kept from the friends, and also from the Coroner of the District, that he has been attended by a person without medical education.

---

86 TNA IWU: ‘Points shown by the evidence of the medical officer’.
87 TNA IWU: ‘Grounds stated in Boards letter for their decision as to the medical officer of the workhouse and his deputy’.
88 Ibid.
89 The “Starvation” Case (Isle of Wight), The Lancet, 23 June 1877, 921.
90 C. H. [pseudonym], Sick Paupers and their Medical Attendants: an Expose of the Fraud Inflicted on the Sick Poor and the Ratepayer, in the Employment by Poor-Law Medical Officers of Unqualified Assistants (London: Horne and Co, 1878), 3.
91 Ibid., 6–7.
Nonetheless, the use of assistants was permitted and Beckingsale and his assistant had not acted illegally (except for bad bookkeeping which was ubiquitous among poor law medical officers). The LGB would not employ a doctor unless he was already in private practice, on the medical register, and, therefore, preoccupied—distracted with the boom and bust of private medicine. The Medical Orders of the 1840s culminated in the General Consolidated Order of 1847, inter alia to prevent ‘tendering’ for appointments and enforcing the dual qualification of poor law doctors. On the face of it, this should have provided paupers with better trained doctors than the working classes could generally access. However, until the medical register and Medical Act of 1858, guardians could not verify qualifications. After this the public expected dual qualifications in medical officers, but in reality paupers were in the main attended by unqualified assistants. Lumley’s 1871 edition of poor law rules and regulations states categorically that medical officers could employ assistants to carry out their duties.

Systemic negligence therefore stemmed from an over-reliance on doctors, such as Beckingsale, who operated a high-risk strategy of attending workhouses for the bare minimum and relied on unqualified workhouse staff and assistants. This was a pattern repeated haphazardly across the nation and sanctioned by the LGB until it led to neglect and public scrutiny. The Hampshire Independent thus asked ‘Where is the Fault?’

…It is obvious that faults, inherent in the system, are chargeable, in any given case, to the central power. And if a department be so crippled by want of resources that a failure is at any time imminent, it is manifestly unjust to visit subordinates with condign punishment when such failure occurs. To attempt to allay public indignation or divert it into a false channel by making a scape-goat of helpless officials is a practice which we had hoped to be obsolete. Anyhow, we believe it will fail in its object, and serve only to direct the public attention more closely to the actual working of a department that resorts to such vicarious atonement.

The fault, however, was more subtle. It lay in the interweaving of policy with ‘latent’ and ‘active’ failures in the organisational structure of poor law medical provision (both in and out of the workhouse). The conflation of inmates during the ‘crusade’ had buckled a strained and widely varying system of workhouse care for the disabled. This interacted negatively with the part-time employment of doctors who, in turn and par for the course, neglected their duties regularly. Such top-down and systemic (‘latent’) failures, though, translated into the outcome bias of individual (‘active’) culpability: staff were...

92A dual qualification in surgery and apothecary—‘general practice’—was supposed to ensure lifetime employment over ‘lesser’ or single qualifications. Various loopholes, however, allowed abuses to continue and a considerable number of medical officers held a single qualification only. R. G. Hogkinson, The Origins of the National Health Service: the Medical Services of the New Poor Law, 1834–1871 (London: Wellcome Historical Medical Library, 1967), 67–70, 336. A. Digby, Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720–1911 (Cambridge: Cambridge University Press, 1994), 244.

93W.G. Lumley, The Medical Officer’s Manual (3rd edn, London: Knight, 1871), 44. In contrast to private and voluntary orthodox medical practitioners, poor law assistants frequently carried out autonomous work which was beyond their training or capabilities. Price, Medical Negligence.

94Hampshire Independent, 9 June 1877, 6.

95R. Baker and B. Hurwitz, ‘Intentionally Harmful Violations and Patient Safety: the Example of Harold Shipman’, in B. Hurwitz and A. Sheikh (eds), Health Care Errors and Patient Safety (Chichester: Wiley Blackwell, 2009), 36–7.
blamed when their neglect ended in tragedy, but the environmental causes that underpin this continued. The ‘crusade against out relief’ may have been the ignition, but the ‘free-trade’ sentiments of the poor law had created a tinder-dry system of welfare.

Local general practitioners, such as Beckingsale, accepted exorbitantly low poor law salaries to keep out competition or, alternatively, to establish a private practice in a new area. Thus, they were only contracted as part-time employees and a negative stalemate between employer and employee was held in equipoise throughout the nineteenth century. Both doctor and their employer were guilty of subverting the system by concealing an over-reliance on unqualified assistants. Contemporary politicians and poor law administrators alike understood the problem, but those in power refused to alter the employment of part-time medical officers or put their salaries on a uniform basis. Free trade and competition was considered the fairer option. Each consecutive poor law authority, from the Commissioners to the LGB, believed that the market should be allowed to follow its natural course. In 1859, the (then) poor law president had defended the controversial policy to a deputation of protesting medical officers: ‘My object will be to introduce amongst you a certain amount of competition which is the principle of private practice. … I desire to introduce into the administration of medical relief to the poor exactly the same principle which is in existence with respect to private practice and I don’t wish to carry it one step further.’ The medical market, though, was flooded with practitioners willing to accept poor law vacancies with extremely low salaries. This was made possible through the use of assistants, cost-cutting and minimising time spent with pauper patients.

Conclusion

Edward’s committal and treatment reveals much about welfare, medical negligence and the standard of care in workhouses in the late nineteenth century. The withdrawal of vital benefits in the 1870s severely and detrimentally affected care in the community. The workhouse population became more sharply polarised between the aged, children, the sick and the class of inmates deemed ‘idiots’. As a result, mental and physical disability, in particular, entered a dangerous phase when these inmates were more vulnerable than other classes to morbidity or mortality stemming from neglect. The death of Edward’s father and the ‘crusade’ had combined to bring about the circumstances that led to his incarceration but his neglect stemmed primarily from the economics and

96 In contrast to voluntary, private and charitable hospitals, autocratic elements of the medical profession disallowed the official training of medical students and assistants under the poor law. The Lancet, 1 July 1865, 16; J. Rogers, Reminiscences of a Workhouse Medical Officer. Edited with a forward by Prof. Thorald Rogers (London: T. Fisher Unwin, 1889), 61.

97 R. Griffin, ‘The grievances of the poor law medical officers further elucidated in the report of the proceedings of the deputation to the Poor Law Board’ (Weymouth: Poor Law Medical Reform Association, 1859); Hodgkinson, Origins, 384–98; M. A. Crowther, ‘Paupers or Patients? Obstacles to Professionalization in the Poor Law Medical Service before 1914’, Journal of the History of Medicine and Allied Sciences, 1984, 39, 33–54.

98 For Britain and free trade, see: P. Harling, ‘The Powers of the Victorian State’, in P. Mandler (ed.), Liberty and Authority in Victorian Britain (Oxford: Oxford University Press, 2006), 27–50; J. Parry, The Rise and Fall of Liberal Government in Victorian Britain (New Haven: Yale University Press, 1993), 167–78.

99 From: Griffin, ‘Grievances’, 31.

100 I. Loudon, Medical Care and the General Practitioner 1750–1850 (Oxford: Clarendon Press, 1986), 77.
practice of poor law doctoring. His death was preventable but not entirely surprising. The system was primed for this type of neglect.

A ubiquitous systemic fault haemorrhaged the development of effective medical practice under the poor law in the late nineteenth century and led to the ‘divided loyalties’ of medical officers described by Anne Crowther.¹⁰¹ Patients, such as Edward, suffered because of the split prerogatives of doctors, who were frequently blamed and lambasted for their self-interest. The LGB publicly claimed that doctors should personally attend to all poor law duties while the rules and regulations gave free reign for medical officers to use assistants. Beckingsale had followed the same course that he had adopted for 30 years as medical officer of the Isle of Wight workhouse—during which time the poor law authorities (and Lunacy Commissioners) had regularly inspected and condoned his practice.

Edward’s experience provides a window to poor law medicine and the ‘crusade’ years, but the view is depressingly familiar. The British welfare experience has been reshaped and remoulded over centuries, but the same old dichotomous ingredients have been recycled. Ideological struggles—between lay and medical authority, private and public financing, and the deserving and undeserving—have never left the stage. Today, as disability benefits and the National Health Service face a fresh assault in the UK, the causes of medical negligence during the ‘crusade’ have acquired unnerving relevance.

Acknowledgements

I would like to express my gratitude to Professor Steve King for his invaluable guidance, and to thank three anonymous reviewers for their perceptive feedback. I would also like to thank the Wellcome Trust and AHRC for generous funding that has allowed me to carry out research that has contributed to this article.

Funding

The work was supported by the Wellcome Trust [grant number 084965/Z/08/Z]

¹⁰¹M. A. Crowther, The Workhouse System 1834–1929: the History of an English Social Institution (London: Methuen, 1983), 157.