

Surgeons and Apothecaries in Suffolk: 1750-1830

City Slickers and Country Bumpkins - Exploring Medical Myths

by

Sally Irvine, M.A.(Cantab.)

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School of History

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ABSTRACT

This thesis challenges accepted views of the development of general practice by revealing significant differences between the assumptions which have been made around many aspects of practitioner life and practice. It has achieved this through research into one provincial and rural area of England (the towns and villages of Suffolk), producing data which, while often inconclusive and incomplete, is sufficiently voluminous to raise questions. Where no firm conclusions can be made, it has often been possible to at least challenge those of others based on equally incomplete data.

This approach has produced evidence of diverse antecedents and early educational experiences, the continuing use of apprenticeships well into the nineteenth century, and a remarkable number of publications and societies for mutual exchange and development, compensating to some degree for the lack of interchange with leading edge practitioners in London and other metropolitan areas; facts not usually recognised in traditional histories. From this evidence, the lack of availability of and access to the then growing hospital opportunities appears not to have diminished the range of skills and services offered by country practitioners to their community. There is evidence of greater involvement by women in many aspects of practice than is usually recognised in orthodox historiographies; such women having significant status and income relative to the rest of the community they served.

All this leads to the tentative conclusion that rural medical practitioners may be a link between the sixteenth century healer and the nineteenth century general practitioner. The hope is that more research into comparable areas of England will establish whether the nature of the country surgeon and apothecary in Suffolk was replicated elsewhere, and therefore that this proposition is generalisable.

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All these have contributed to the end result, but I take full responsibility for the arguments and conclusions reached.

List of Abbreviations

The following abbreviations have been employed:

<i>DNB</i>	<i>Dictionary of National Biography</i>
LSA	Licentiate of the Society of Apothecaries
MD	Doctor of Medicine
MRCS	Membership of the Royal College of Surgeons
RCP	Royal College of Physicians
RCS	Royal College of Surgeons
RHS	Royal Humane Society
<i>SMB</i>	<i>Suffolk Medical Biographies</i>
SRO	Suffolk Record Office

Conventions Employed

- Dates given in round brackets for medical practitioners are birth and death, unless they are in italics with curly brackets, in which case they are dates when the practitioner was known to be active.
- The use of male forms of pronouns in general text is for convenience and ease of reading, but also reflects the overwhelming predominance of male practitioners at the time. However, evidence shows that there were some female practitioners and, where they are discussed directly, the appropriate pronoun is used.
- References prior to and including 1949 are treated in the past tense; all those from 1950 onwards are treated as present.

CHAPTER 1: INTRODUCTION

“The country doctor, such as we know him - a well-read and observant man, skilful in his art, with a liberal love of science, and in every respect a gentleman - is so recent a creation that he may almost be spoken of as a production of the present century”.¹

In 2000, Steven King and Alan Weaver described as ‘valuable’ the broad brush generalisations that resulted from the attempts of previous historians to provide an overview of the struggle between established medical theory and the rise of empiricism. At the same time, they warn that such generalisations were leading to an emphasis on national, largely London-based, developments to the detriment of regional and more local research.² Irvine Loudon recognised this when he wrote that:

“[the] perception of medical man in the eighteenth century was perhaps inevitably based on a small and highly literate elite of practitioners, most of whom practised in London”.³

Similarly, Mary Fissell admits that “the historiography of English medicine has been strongly weighted towards the metropolis”.⁴ This continuing emphasis is not surprising, as the evidential base for describing medical practice in the late eighteenth and early nineteenth centuries came to a large extent from London or other major cities such as Edinburgh, because the most successful doctors (socially, financially and professionally) worked in such large cities. Moreover, most British medical advances either started or were developed there, together with the growth of largely metropolitan hospital-based medicine which was such an important factor in the changing relationship between doctor and society in this period. However, this has sometimes led to an underestimation of provincial features and developments.

Accordingly, this thesis seeks to address a number of apparent distortions concerning the history of medical practice in the late eighteenth and early

¹ John Cordy Jeaffreson, *A Book About Doctors*, Vol. 11, (London, 1860), p.276.

² Steven King & Alan Weaver, “Lives in their hands: the medical landscape in Lancashire, 1700-1820”, *Medical History*, 45, (2000), pp.173-200.

³ Irvine Loudon, *Medical Care and the General Practitioner 1750-1850*, (Oxford, 1986), p.11.

⁴ Mary Fissell, *Patients, Power and the Poor in Eighteenth Century Bristol*, (Cambridge, 1991), p.194.

nineteenth centuries, by considering the example of the rural county of Suffolk.

A review of the areas of agreement and conflict amongst modern writers, when tested against Suffolk evidence, raised doubts about current conclusions covering many aspects of a doctor's life, suggesting the need for revisions and further research. Also, in some respects the primary evidence presented here reinforces current thinking; for example, in relation to the type and range of medical practice on offer. In other respects, it points to a need for revised interpretations of, for example, the educational background of surgeons and apothecaries, the prevalence of hospital training before 1830, and the influence and role of women. The research has provided new narratives about the lives of surgeons and apothecaries, sufficient to suggest that an approach based primarily on London and provincial cities like Birmingham or Bristol, may be distorting the picture of healthcare delivery in the country as a whole. The rural medical practitioner who emerges from the Suffolk evidence is a more complete entity than just a 'poor cousin' of the metropolitan or even large town doctors, a possible new link in the emergence of the general medical practitioner from the healer of the sixteenth and seventeenth centuries.

This inquiry is significant because only one in five of the population lived in major cities and towns in 1800, with the majority living in the countryside until about 1850.⁵ Evidence concerning this majority should therefore feature within any depiction of medical care. A county-wide survey has value in its own right, but the advantage lies not only in the amount of data available, but its consistency across a large tract of inhabited land. Any conclusions reached have legitimacy which is not achievable if based on a smaller research area. For example, histories at the local or parish level are generally based on evidence that is too narrow to allow generalisation.⁶ Conversely, national studies tend to be skewed towards urban experience where data are

⁵ Phillip J. Waller, *Town, City and Nation - England 1850-1914*, (Oxford, 1983), p.2.

⁶ Joseph L. Barona & Steven Cherry (eds.), *Health and Medicine in Rural Europe 1830-1945*, (Valencia, 2005), p.20.

more accessible, whereas a county level review also ensures a diverse range of social, economic and geographical types.

Uncovering a large amount of local material, often repetitive, has created a critical mass of data, even though the vagaries of source survival mean that in some cases there is insufficient data to characterise a particular area or subject, while in others there is too much data to handle or analyse efficiently. Generalisations presented may rest upon apparently limited evidence or a small number of case studies but, since “the past is often silent”,⁷ even where data are apparently flimsy, a review of a whole county such as Suffolk within a defined period (c.1750-1830) justifies testing and, if necessary, challenging current historical thinking.

What is not clear is whether the Suffolk evidence is replicated across other comparable counties and rural areas. There have been few wide-ranging and dedicated reviews of the delivery of healthcare across the predominantly rural counties in this period. Michael Muncaster’s valuable but unpublished thesis on Norfolk medical practice covered the period 1815-1911 and thus overlaps only between 1815 and 1830.⁸ Joan Lane, in her work on Coventry masters, tends to draw upon evidence from large conurbations or trading centres, where commercial and industrial lives prevailed.⁹ John Pickstone’s work on Lancashire concentrates on the nineteenth century, and its focus is on Manchester and industrial medicine.¹⁰ Richard Napier’s work on the South East Midlands in the early seventeenth century confirms the extent to which rural medicine proceeded outside the usual terms of historiographical definition and reinforced the point that considerable harmony and cooperation existed in the countryside between different parts of the medical profession.¹¹ Leonore Davidoff and Catherine Hall’s work on Birmingham and,

⁷ Roy Porter, *Disease, Medicine and Society 1550-1860*, (Basingstoke, 1987), p.9.

⁸ Michael J. Muncaster, *Medical Services and the Medical Profession in Norfolk 1815-1911*. Unpublished PhD, University of East Anglia, 1976, pp.121-2.

⁹ Joan Lane (ed.), *Coventry Apprentices and their Masters 1781-1806*, (Stratford Upon Avon, 1983), Worcester Infirmary.

¹⁰ John V. Pickstone, *Medicine and Industrial Society - A History of Hospital Development in Manchester and its Regions 1752-1946*, (Manchester, 1985).

¹¹ Richard Napier, *Patients, Healers and Disease in the South East Midlands 1597-1634*. Unpublished PhD, University of Wisconsin-Madison, 1986, quoted in Margaret Pelling, *The Common Lot - Sickness, Medical Occupations and the Urban Poor in Early Modern England*, (London, 1998), p.249.

more recently, Steven King and Alan Weaver's study of the delivery of healthcare in rural and urban Lancashire, provide some data, though the emphasis is on the latter.¹² Further county-wide studies would establish whether "national generalisations on a range of issues are based upon a raft of unexplored assumptions about the character and vibrancy of medical culture at local and regional level".¹³ Other works relate to specific towns or institutions, but only where instructive or relevant are they used.¹⁴

Suffolk is a particularly interesting area to study because, although relatively close to London, in the late eighteenth and early nineteenth centuries it was essentially rural and extremely stable, socially and politically. Beyond the loss of the wool industry to Yorkshire, it was otherwise almost untouched directly by the industrial and commercial developments of the Midlands and northern counties.¹⁵ The unanswered question is whether its late eighteenth and early nineteenth century experiences are peculiar to Suffolk or whether they are sufficiently important and generalisable to add further strength to any modifications of current historical thinking suggested by this thesis.

The period chosen for this review is one of transition, not least in terms of the availability of evidence upon which to base firm conclusions about medical practitioners was recorded, be it in school registers, hospital pupil lists, registers of practitioners and so on. Although some provincial doctors made names for themselves in East Anglia (for example, Ipswich surgeon George Stebbing (1749-1825),¹⁶ Benjamin Gooch (1707-76) of Shottesham¹⁷, and

¹² Leonore Davidoff & Catherine Hall, *Family Fortunes - Men and Women of the English Middle Classes 1780-1850*, (London, 1987). This book focuses on the role of gender in the construction of middle class values and family life, and contains interesting and relevant evidence of the place of medicine and medical practitioners in society.

¹³ King & Weaver, "Medical landscape", p.180.

¹⁴ For example, Fissell, *Patients, Power and the Poor*, Joan Lane, *Worcester Infirmary in the Eighteenth Century*, (Worcester, 1992), Alan Armstrong, *Stability and Change in an English County Town - a Social History of York*, (London, 1974).

¹⁵ Described further in Chapter 2.

¹⁶ David van Zwanenberg, "Interesting GPs of the past - George Stebbing of Ipswich 1749-1825", *British Medical Journal*, 283, (1981), pp.1517-1518.

¹⁷ A. Batty Shaw, "Benjamin Gooch: eighteenth century Norfolk surgeon", *Medical History*, 16, (1972), 1, pp.40-50. Gooch was the innovator of Gooch's splint, published a textbook on surgery and played a prominent role in the foundation of the first general hospital in Norfolk.

surgeons Thomas Bayly (1750-1834) of Stowmarket¹⁸ and James Lynn (1700-1775) of Woodbridge¹⁹), many more worked unsung in villages and small towns. Evidence concerning these is often very scant and open to conflicting interpretations, and sometimes all that can be offered is confirmation of a questioning of conventional views. Occasionally, evidence is so poor that no firm view can be put forward, or several interpretations might seem justified. Nevertheless, as detailed a review as possible of rural practice can contribute to the general discourse on medical care in the period, and may stimulate additional research on healthcare in Suffolk itself. The nature of the local context (rural, stable, class-based) throughout the period offers scope for reconsidering, for example, the patient/doctor relationship, how it changed and at what rate.

The dates chosen coincide roughly with the apprenticeship and early adult life as a surgeon and apothecary of George Crabbe (1754-1832) of Aldeburgh, whose experiences provide a focus for many of the arguments developed below (see Plate 1).²⁰ Preliminary research had suggested that Crabbe did not fit the typical picture of a medical practitioner, and prompted this further investigation into whether Suffolk practitioners generally did not conform to the patterns outlined in some current historiographies.²¹ Furthermore, the period under review also ends sufficiently far after the passing of the 1815 Apothecaries Act to allow reflection on its influence on the provincial medical scene.

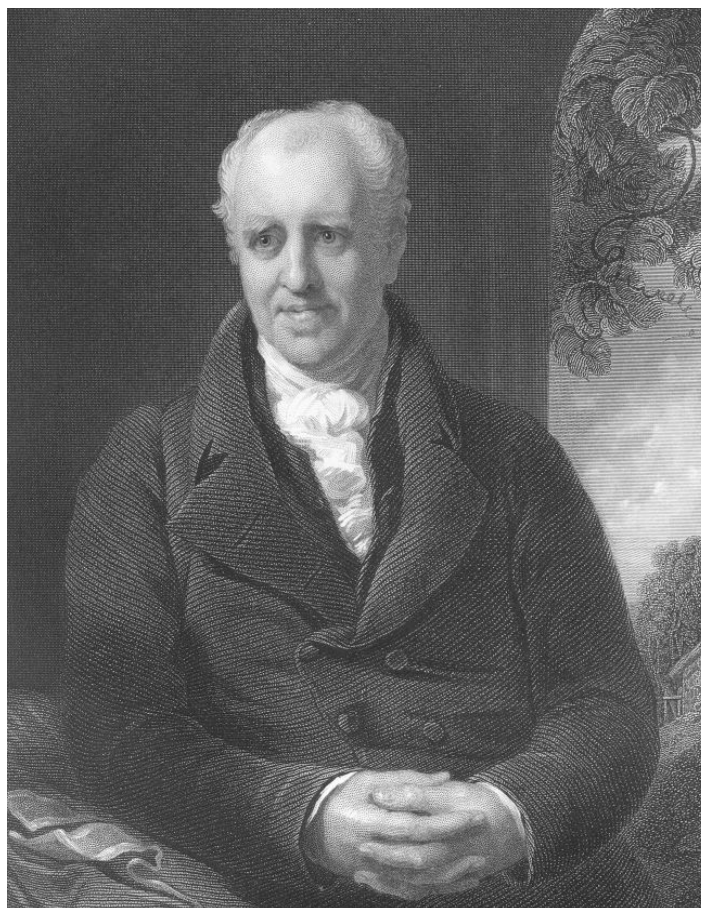
¹⁸ V. Mary Crosse, *A Surgeon in the Nineteenth Century - the Life and Times of John Green Crosse*, (London, 1968).

¹⁹ *Suffolk Medical Biographies*.

²⁰ Crabbe practised as a surgeon in Aldeburgh from 1768-1781, later became a rector, and was well-known as a Romantic poet.

²¹ The earlier research was produced as part of an Open University module on the early history of the professions. Examples of historians include Rosemary O'Day, *The Professions in Early Modern England, 1450-1800: Servants of the Commonweal*, (Harlow, 2000); Penelope Corfield, *Power and the Professions in Britain 1700-1850*, (London, 1995); and Loudon, *Medical Care*.

Plate 1: George Crabbe



1.1 Sources and Historiography

Although key texts and contributions are discussed in detail in later chapters, a preliminary overview of presented sources and interpretations is a helpful context here. A particularly important local source for creating a cohort of practitioners for the county and the timeframe chosen is the work of Dr David van Zwanenberg (1922-1991). His *Suffolk Medical Biographies (SMB)* lists both men and women who practised medicine in Suffolk from earliest times until 1970, and those known to have been apprenticed in the county.²² An early task was to check van Zwanenberg's database against the original sources, as well as utilise a range of other primary sources. With amendments and additions to this listing, a database has been established covering all those

²² David van Zwanenberg started researching his biographies in the early 1970s, but died before he could finish editing the material. The completed biographies, mainly in manuscript, together with his working notes and indices, were donated to Suffolk Record Office's local studies library collection at Ipswich by his widow, Alsyth, and the task of editing the material was completed by Eric Cockayne in 2005.

working or training in medicine in Suffolk between 1750 and 1830, totalling over 950 people.

As local archives provide much relevant material in width rather than in depth, and surviving documentation is uneven in quality, a cross-section of records was used. Source materials included the Society of Apothecaries' records, Bishops' license records, the minutes and accounts books of the local parishes and town councils, the registers and directories beginning to be produced in this period, local newspapers, individual family papers, census returns, university records, the *Dictionary of National Biography* and the *Oxford Dictionary of National Biography*, the records of the medical colleges, probate records, churchyard subscriptions, and so on. Material from patient sources is scarce, although wills, letters and family papers have produced some references to medical care. Similarly, there are few casebooks of rural doctors such as those upon which King and Weaver or Mary Fissell were able to rely. Such extant medical diaries, including those of Sir James Paget (1814-1899) and William Goodwyn (1746-1815), have been researched.

National sources of evidence included two years of Samuel Foart Simmons' *Medical Register* of the late eighteenth century, and John Raach's more modern *Directory of English Country Physicians*. For his first register of 1779, Foart Simmons relied on local contacts for county-wide information, noting also the presence of any local hospital, asylum or dispensary. His improved third register of 1783 had separate sections covering the Royal College of Physicians (RCP), the Corporation and Company of Surgeons, and the Society of Apothecaries, along with details of local medical societies and scientific and learned bodies.²³ It listed 3,120 civilian medical practitioners in provincial England - physicians, surgeon-apothecaries, surgeons and apothecaries, as well as man midwives.²⁴ Foart Simmons had a standard style for a county entry, offering a brief account of the hospital and any other institutions followed by the names of those practising in different communities, often including their qualifications and publications. Local practitioners could be

²³ Samuel Foart Simmons, *Medical Register*, (London, 1783).

²⁴ Joan Lane, "The medical practitioners of provincial England in 1783", *Medical History*, 28, (1984), pp.353-371.

also found listed by specialism as well as in their own county directory, though Foart Simmons' cross-referencing was very erratic. The majority were engaged in single-handed practice in cities, market towns, industrial centres and larger villages. The Register thus contained great detail, though Foart Simmons' own London base and status as a physician probably influenced the criteria affecting both the collection of information and its usage. Information on physicians in his registers was probably most accurate, that on surgeons less so, with material concerning apothecaries and other variants least accurate. Raach's Directory was valuable for the surprisingly large numbers of physicians he found in relatively rural Suffolk.²⁵

Many contemporary writings, both by doctors and others, have been sourced. Frequently they presented a particular view, perhaps with professional, commercial, social or religious bias, but, while giving weight to that distortion, they provided valuable contributions to the emerging picture, particularly those written about the provincial medical scene. The literature of the day and evidence from popular culture, although frequently partial, diverse and clearly depicting a fictionalised or romantic view of the past, presented a sufficiently consistent picture to offer a valid and often pertinent commentary. It is cited, in the spirit of Pam Lieske's remarks, that:

“the belief that there is a clear separation between the focus and interests of traditional medical historians and those interested in social and cultural history... is erroneous”.²⁶

Although considerable research has been carried out into the recent historiographies of relevance to the period and subject, it appears that significantly little has appeared in journals or books published in the last five years. One of the most impressive and recent compilations by William Bynum *et al.*, *The Western Medical Tradition 1800-2000*, contains a very extensive bibliography that nevertheless demonstrates that little general or specific work on this subject has been published since 2000.²⁷ References to provincial

²⁵ John Raach, *A Directory of English Country Physicians 1603-1643*, (London, 1962).

²⁶ Pam Lieske (ed.), *Eighteenth Century British Midwifery*, (London, 2007), Introduction, p.xv.

²⁷ William Bynum *et al.* (eds.), *The Western Medical Tradition 1800-2000*, (Cambridge, 2006).

medicine, East Anglia and, more specifically, Suffolk have been particularly difficult to find.

Those working in the medical field, both regulars and irregulars, licensed and unlicensed, had generally grown in number, organisation and prestige, particularly in the metropolis before the eighteenth century and, as early as 1711, Joseph Addison had warned of the danger of over-supply.²⁸ Geoffrey Holmes argued that doctors were developing a sense of corporate identity and public recognition as professionals in as early as the late seventeenth century.²⁹ For some historians, therefore, the generic medical practitioner had already arrived and Margaret Pelling puts forward the view that they were a dominant feature of the social scene well before 1640.³⁰ Rosemary O'Day agrees that medical professionals seem to have acquired an identity as a social group in the late seventeenth and early eighteenth centuries, cemented by social connections, though of course they were not necessarily in powerful positions as a result.³¹

According to Jeanne Peterson, the sort of medicine offered by these practitioners remained very much an art in the middle of the eighteenth century, in spite of the medical and physiological experiments and advances then taking place.³² For example, many physicians such as Thomas Coakley Lettsom (1744-1815) made their names by the turn of the nineteenth century rather as men of letters, philanthropists or improvers than as doctors.³³ Nevertheless, as Carl Pfeiffer writes, "the seeds of scientific medical inquiry and communications genuinely began to take hold and grow in the early

²⁸ Joseph Addison (writing as Clio), *The Spectator*, 2, 24 March 1711, quoted in Corfield, *Power and Professions*, p.25.

²⁹ Geoffrey Holmes, *Augustan England: Professions, State and Society 1680-1730*, (London, 1982), pp.203-235.

³⁰ Pelling, *The Common Lot*, pp.230-258.

³¹ O'Day, *The Professions*, p.57.

³² Jeanne M. Peterson, *Medical Profession in Mid-Victorian London*, (London, 1978), p.14.

³³ Roy Porter, *The Greatest Benefit to Mankind - A Medical History of Humanity from Antiquity to the Present*, (London, 1999), p.257.

nineteenth century”.³⁴ A few, such as John Hunter, pursued research and scientific development.³⁵

Nicholas Jewson’s work is extremely influential in gaining an understanding of the importance of patient power in the eighteenth century, albeit largely in relation to physicians.³⁶ He emphasises the role of patronage as part of the social constraints operating on medical practitioners who had insecure status and depended on the whims of wealthy patients. He suggests that fee-paying patients in a free market medical economy could, to some degree, control practitioners, as clients could go elsewhere if they were dissatisfied, or mix and match their therapeutic options. This concept of a medical marketplace has been used to explain the diversity of practitioners, though of course it might equally well be the result of it. It also defines the encounter between the sick and the potential healer in economic terms, rather than in the more likely one which Mary Lindemann describes as “medical promiscuity”.³⁷

Moreover, the system of beliefs about the human body led to a world of healing in which patients maintained a substantial level of control.³⁸ Mary Fissell supports Jewson’s schematic views of an eighteenth century dominated by the desires of patients rather than practitioners in her work on Bristol medical care. She believes that patients’ own “narratives of illness and interpretations of external signs” were the key to diagnosis until the end of that century, by which time “the truth lay deep inside the body, accessible only to the trained observer”.³⁹ Like Ivan Waddington earlier, she sees the rise of the hospital and scientific-based medicine as the levers for change in

³⁴ Carl J. Pfeiffer, *The Art and Practice of Western Medicine in the Early Nineteenth Century*, (Jefferson, NY, 1974), p.1.

³⁵ John Hunter, (1728-1793), surgeon and naturalist. Born in Scotland, he moved to London in 1748 to join his older brother, William (1718-1783) who was already making a career as a teacher of anatomy and accoucheur. John trained as a surgeon and, after a career in the army, established himself in Jermyn Street, London, as one of the leading figures in experimental medicine, making significant contributions to both surgery and natural science, including human and comparative physiology.

³⁶ Nicholas Jewson, “Medical knowledge and the patronage system in the eighteenth century”, *Sociology*, 13, (1974), pp.369-385.

³⁷ Mary Lindeman, *Medicine and Society in Early Modern Europe*, (Cambridge, 1999).

³⁸ Such as the view that ill-health was a punishment from God to be endured rather than overcome.

³⁹ Fissell, *Patients, Power*, p.11.

the patient/doctor power relationship.⁴⁰ Laurence Brockliss also describes a new breed of licensed practitioners, trained in the hospital and able to wield what he called “practitioner power”.⁴¹ More recently, Stephen Jacyna describes the hospital as “an ideal location for introducing new methods of examination and treatment. And patients could be used for pedagogic purposes”.⁴²

However, Penelope Corfield argues that interventionism was increasingly advocated along with calls for preventative medicine, leading to rising expectations concerning health and the retreat of the fatalistic acceptance of illness.⁴³ In addition, Joan Lane suggests that a recognised medical profession had emerged by the early 1800s, and the population actively sought professional attention for various medical conditions previously endured or treated at home.⁴⁴ If true, this development seemingly reflected the impact of the Enlightenment and the reign of science, with less reliance upon patients’ own descriptions of their condition and more on the medical man’s evaluation of the physical signs of disease. Certainly there was a discernible shift in authority from patient to doctor, leading to what Michael Neve calls “the mysterious sleight of hand whereby patients slowly turned from commercially powerful consumers to nineteenth century acceptors of medical orthodoxy”.⁴⁵

In the light of these changes, as well as scientific and technical advances, anatomy and physiology became increasingly important in medical education. The role of the three main specialties of medicine (physic, surgery and dispensing) and their relationship to each other consequently changed

⁴⁰ Ivan Waddington, *The Medical Profession in the Industrial Revolution*, (Dublin, 1984).

⁴¹ Laurence Brockliss, “Consultation by letter in early eighteenth century Paris”, in Ann La Berge & Mordechai Feingold (eds.), *French Medical Culture in the Nineteenth Century*, (Amsterdam, 1994), pp.79-117.

⁴² Stephen Jacyna, “Medicine in transformation 1800-1849”, in Bynum *et al.* (eds.), *The Western Medical Tradition*, pp.11-110.

⁴³ Corfield, *Power and Professions*, p.137.

⁴⁴ Joan Lane, *A Social History of Medicine: Health, Healing and Disease in England 1750-1950*, (London, 2001), p.12.

⁴⁵ Michael Neve, “Orthodoxy and fringe; medicine in late Georgian Bristol”, in William F. Bynum & Roy Porter (eds.), *Medical Fringe and Medical Orthodoxy 1750-1850*, (London, 1987), pp.40-55.

considerably over the period, though there has been disagreement amongst historians as to how and when.⁴⁶

A single medical profession did not exist during this period, but conventionally the three principal medical groupings were identified in terms of corporations, licensing bodies and a tripartite division of medical care: physicians providing theory, diagnosis and prescription; surgeons practising external dissection; and apothecaries dispensing drugs.⁴⁷ Each had its own corporate representation, mode of training and assigned areas of competency, reflecting “the typical structures of pre-industrial society”.⁴⁸ Thus, the elite physicians were the oldest group and were university men, untainted by manual aspects of surgery, midwifery or pharmacy, and “their status not reflected in high skills and utility but by their association with cultural attainments”.⁴⁹ Their job was to diagnose, attend and advise, and they sought to maintain a monopoly of ‘physic’ or internal medicine. The majority practised in London and were required to be licensed by the RCP, but the College could not enforce its rules outside London with any degree of rigour, so a large number of provincial physicians were unlicensed. In fact, according to Christopher Lawrence, “the elite corporations of physicians, surgeons and apothecaries were increasingly unable to police the practice they superintended”.⁵⁰ London physicians could not practise surgery if they wanted to retain their Fellowship and status. In 1800, the RCP registered 170 Fellows, Licentiates and Extra-Licentiates in England and, of these, only three were known to be practising in Suffolk in that year, although Raach had identified rather more in his earlier study.⁵¹ However, Rosemary O’Day challenges the

⁴⁶ Joseph F. Kett, “Provincial medical practice in England 1730-1815, *Journal of the History of Medicine*, 29, (1964), 1, pp.17-29; Sir George Clark, *A History of the Royal College of Physicians*, (Oxford, 1964).

⁴⁷ Corfield, *Power and Professions*, p.149.

⁴⁸ Jacyna, “Medicine in transformation”, p.11.

⁴⁹ *Ibid.*, p.31.

⁵⁰ Christopher Lawrence, *Medicine in the Making of Modern Britain 1700-1920*, (London, 1994), p.14.

⁵¹ William Beales (1773-1820) practising in Bungay was a Fellow 1800-1820, William Coyte Beeston (1740-1810) of Ipswich was a Fellow from 1794-1810 and Robert Hamilton (1748-1830) physician of Ipswich was a Licentiate from 1795. Of the other seven known physicians in Suffolk in 1800, Robert Cavell (d. 1837) of Bungay was denoted a physician but was apprenticed to surgeons and appears to have been more interested in surgery; Nathan Drake (1766-1836) was a physician at Sudbury and moved to Hadleigh, having been apprenticed as surgeon and apothecary, but proceeded to gain his MD from Edinburgh in 1789 and practised as a physician until his death; Richard Langslow {1790-1812} of Halesworth similarly started life as a surgeon and gained his MD but did not take up a

emphasis that Archibald Clark-Kennedy and others give to the elite status of physicians.⁵² She refers to artificial distinctions between physicians, surgeons and apothecaries, even in the metropolis, believing that the medical profession is not tidily and hierarchically arranged into these three tiers, nor is it solely defined by academic education.⁵³

Surgeons cut, manipulated and treated disorders on the outside of the body. They set bones, carried out operations, dealt with accidents, skin disorders, some forms of gynaecology and man midwifery in the eighteenth century. Much of their work depended on speed, dexterity and physical strength, and they were seen for a long time as skilled manual labour. In England at least, they were not generally university educated, but learned their skills by apprenticeship and practical training. In 1747, Richard Campbell wrote “An ingenious surgeon, Let him be cast on any corner of the Earth with but his Case of Instruments in his Pocket, he may live where most other professions would starve”.⁵⁴ However, increasingly “the English surgeons of the Enlightenment grounded their claims for recognition in their recent empirically acquired knowledge of anatomy, of operative techniques and of instrument design”, and senior surgeons argued that:

“the historical origins of the distinction between surgery and physic demonstrated not that there should be two separate disciplines but that a reconciliation was appropriate”.⁵⁵

John Hunter promoted surgery as a procedure in which the operative employed his knowledge of the body’s preservative powers to cure disease, rather than simply extirpate it.

Licentiate; Sir Lachlan MacLean (1761-1843) of Sudbury; John Martin (b. 1759) of Haverhill; Thomas Neal (1729-1806) practised surgery and midwifery in London for fifteen years and then turned up as a physician in Ipswich; Thomas Norgate (1751-1815) physician of Great Ashfield with an MD from Aberdeen; Geoffrey Thomson (1750-1830) was an MD and Physician to the Ipswich Dispensary.

⁵² Archibald E. Clark-Kennedy, *The London*, 1, 1740-1840, (London, 1962).

⁵³ O’Day, *The Professions*, p.240.

⁵⁴ Richard Campbell, *The London Tradesmen, Being a Compendious View of all the Trades, Professions, Arts, both Liberal and Mechanical, now Practised in the Cities of London and Westminster*, (London, 1747), p.57.

⁵⁵ Christopher Lawrence, “Democratic, divine and heroic: the history and historiography of surgery”, in C. Lawrence, *Medical Theory, Surgical Practice: Studies in the History of Surgery*, (London, 1992), pp.1-36. In addition to haircutting, hairdressing and shaving, barbers performed surgery, bloodletting and leeching, fire cupping, enemas and the extraction of teeth. Thus they were called

The traditional view was that surgeons' development really arose from their break with the barbers in 1745, a break which according to Lawrence partly, at least, derived from the surgeons' wish to emulate the status of physicians. Owsei Temkin suggests that more attention should be paid to the relationship between surgeon and physician, with physicians using "physiological or individual concept of disease and surgeons an ontological or disease-entity model".⁵⁶ Lucinda Beier quotes Joseph Binns as an example of a seventeenth century surgeon dealing with "the particular and hidden, intangible features of his patients' acknowledged external complaints".⁵⁷

By the end of the eighteenth century the surgeons had gained in academic status and influence, and the College of Surgeons was a vigorous institution with its membership qualification established.⁵⁸ The acquisition of a Royal Charter in 1800 for the College, whose governing body was made up of elite London practitioners practising surgery only, revolutionised the status of surgery, at least in the metropolis. Nonetheless, dressing leg ulcers remained the staple of most eighteenth century surgical incomes into the nineteenth century, and most surgeons could not make a living by such means alone.⁵⁹ They had to prescribe and dispense drugs to supplement their incomes and ensure a steady stream of patients.

Neil Powell describes the country surgeon as "a rough and ready sort of general practitioner who a generation earlier would have been indistinguishable from a barber".⁶⁰ However, this is certainly an oversimplification as J.C. Hudson, a contemporary writer, recognised that "in country practice the functions of the surgeon are much more frequently practised by the general practitioner than in London", a situation much closer

barber surgeons, and they formed their first organisation in 1094. The barber pole (red and white in a spiral) indicated the two crafts, surgery in red and barbering in white.

⁵⁶ Owsei Temkin, "On the history of morality and syphilis", quoted in C. Lawrence, *Democratic, Divine*, p.55.

⁵⁷ Lucinda McCray Beier, "The creation of the medical fringe 1550-1700", *The Society for the Social History of Medicine*, 29, (1981), pp.29-32.

⁵⁸ Ole Grell, "The medical profession - a study guide", in OU A433, *The Early History of the Professions*, (Milton Keynes, 2003), pp.13-31.

⁵⁹ Loudon, *Medical Care*, p.81.

⁶⁰ Neil Powell, *George Crabbe: An English Life 1754-1832*, (London, 2004), p.27.

to that described by Beier.⁶¹ In metropolitan areas, distinctions between barber-surgeons who practised surgery and barbers who cut hair and at most pulled teeth were rarely replicated in the provinces.⁶² Moreover, this study will show that competent and, in some cases, groundbreaking medicine took place in provincial Suffolk.⁶³

The apothecaries, the third group, dispensed the medicines prescribed by the physician or surgeon, and were responsible for the supply, compounding and sale of drugs, reflecting their earlier links with grocers from whom they separated in 1617.⁶⁴ The London-based Worshipful Society of Apothecaries, whose remit was only loosely recognised over the rest of the country, regulated them through the LSA (Licentiate of the Society of Apothecaries). The apothecaries were not a trade, but a profession or skill and thus did not appear in *A General Description of Trades*.⁶⁵ They signalled their respectability by renaming themselves the Society of Apothecaries in 1680 and, after the Rose case of 1704, won the right to diagnose and advise without the supervision of a physician.⁶⁶ Irvine Loudon argues that the decision on this case gave legal confirmation to the role of the apothecary as a medical practitioner rather than a tradesman, and “in many ways led to the merging of physic, surgery, and pharmacy”.⁶⁷ Rosemary O’Day also sees this as a “landmark development in the medical profession”.⁶⁸ However, eighteenth century practitioners without such hindsight, and certainly those in Suffolk, may not have recognised it.

⁶¹ J.C. Hudson, *The Parents’ Handbook*, (London, 1782), p.71.

⁶² O’Day, *The Professions*, p.196.

⁶³ This is discussed in Chapter 5.

⁶⁴ The word ‘apothecary’ is derived from the Greek *apotheca*, meaning a place where wine, spices and herbs were stored. London apothecaries were originally members of the Grocers’ Livery Company, but with their specialist pharmacy skills they petitioned for several years to secede from the Grocers. The Worshipful Society of Apothecaries of London was incorporated by Royal Charter on 6 December 1617.

⁶⁵ *A General Description of Trades Digested in Alphabetical Order*, (London, 1747).

⁶⁶ Apothecary William Rose had prescribed as well as supplied medicine and a test case was brought that he won on appeal. The House of Lords ruled in favour of the apothecary’s right to engage in business freely, even though he could still only charge for medicines, not for advice.

⁶⁷ Loudon, *Medical Care*, p.23.

⁶⁸ O’Day, *The Professions*, p.228.

Not surprisingly, London apothecaries tried to consolidate their status further in a ‘bottom-up’ reform movement in 1794 when they formed the General Pharmaceutical Association of Great Britain, with the primary initial concern of tackling unfair competition from druggists in particular.⁶⁹ They sought legislation to define and maintain their status, though it took another twenty years before the “Act for better regulating the Practice of Apothecaries throughout England and Wales” was passed.⁷⁰

Druggists were another important group on the healthcare scene. Until the 1780s they supplied practitioners with raw materials, but began to open shops and supply drugs and potions over the counter more cheaply than surgeons and apothecaries. According to Irvine Loudon, judging by references in trade directories and Bristol Infirmary memoirs, the druggists, “a vile race of quacks with which this country is infested”, were becoming an inexpensive source of medical care, frequently supplying not ‘quack’ remedies but the same orthodox medicines supplied by regulars.⁷¹ He concluded that by the opening decade of the nineteenth century, there were nine irregulars for every regular practitioner, an experience that King and Weaver believe to be true for Lancashire, not least because it was poorly-doctored.⁷² However, Loudon’s figures may not be generalisable for Suffolk, as Chapter 3 demonstrates that Suffolk was comparatively well-doctored.⁷³

Physicians, surgeons and apothecaries therefore constituted the broad divisions within the emerging medical profession between 1750 and 1830, particularly as seen in London. However, according to Lucinda Beier, in the seventeenth and eighteenth centuries “a patient’s choice of a medical practitioner depended upon his or her complaint, social status, economic

⁶⁹ An address was given by Mr Chamberlaine, apothecary of Aylesbury Street, London to the inaugural meeting of London apothecaries, cited by John Mason Good, *The History of Medicine so far as it Relates to the Professions of the Apothecary*, (London, 1795) p.151. He described how the income in London for apothecaries was down to £200 per year and they set up a committee to examine their difficulties.

⁷⁰ The Apothecaries Act, 1815, 55 Geo. 111 c.194.

⁷¹ Irvine Loudon, “Vile race of quacks with which this country is infected”, in Bynum & Porter (eds.), *Medical Fringe*, pp.106-128.

⁷² King & Weaver, *Medical Landscape in Lancashire*, p.72.

⁷³ Chapter 3 details the doctor to population ratios in Suffolk.

circumstances, geographical location and previous medical experiences”.⁷⁴ On the other hand, Irvine Loudon believed that orthodox practitioners were identifiable (at least to each other) by having a degree (bought or earned), by honorary appointments as a physician or surgeon at a hospital or dispensary, or by appointment as army or navy surgeons; a definition that would have excluded many ‘regulars’ who had neither. Nevertheless, most rank and file surgeons and apothecaries were recognised as orthodox by society and the state through having served an apprenticeship.⁷⁵ A few, mainly in London or the major cities, were members of the Company of Surgeons or the Society of Apothecaries, and there was some licensing of surgeons and apothecaries through the guilds, the London College of Physicians or through Episcopal licensing, all of which offered a limited degree of control over medical knowledge and practice.⁷⁶

In major cities, the separation of the orders of medicine was not only an arrangement of occupational monopolies, it defined the social order and status for the practitioners as well, and thus the demarcation lines have existed longer than in the provinces, and indeed may never have been the reality there. According to Geoffrey Holmes, these old distinctions were disappearing in the early eighteenth century and so geographic location was a more important determinant of financial rewards than the old functional divisions.⁷⁷ However, Lucinda Beier maintains that these medical divisions took a long time to die, being upheld by vested interest, the law and tradition, although even she accepts that actual medical practice was beginning to blur.⁷⁸ In Harold Cook’s view, the dynamic of the marketplace in the seventeenth century had reduced medicine to the treatment of disease and prescription, and the physician looked no different from other

⁷⁴ Beier, “The medical fringe”, p.31.

⁷⁵ Irvine Loudon, “Medical practitioners and the period of medical reform in Britain 1750-1850”, in Andrew Wear (ed.), *Medicine in Society: Historical Essays*, (Cambridge, 1992), pp.219-248.

⁷⁶ Grell, “The medical profession”, p.26; John H. Guy, “Episcopal licensing”, *Bulletin of History of Medicine*, 56, (1982) 4, pp.528-42. Licensing and monitoring of medicine and surgery was in ecclesiastical hands from the days of canon law when the concern was to ensure “no physician for the health of the body shall prescribe anything that may prove perilous to the soul”. This was supported by statute (3 Henry V111 C.11) in 1511 granting bishops the right to license physicians and surgeons, despite the RCP and the Company of Barber-Surgeons, an Act not repealed until 1948.

⁷⁷ Holmes, *Augustan England*, p.216.

⁷⁸ Beier, “The medical fringe”, p.30.

practitioners. By the end of that century, the physician's only claim to higher social status was as a consequence of a university education.⁷⁹ Indeed, Grell concludes that the tripartite division of the medical profession collapsed.⁸⁰ Margaret Pelling further questions whether it was possible to talk about a medical profession at all, given the variety of people and the forms of healthcare involved.⁸¹ More recently, Stephen Jacyna states that by the eighteenth century most medical men were *de facto* general practitioners who took on the work of physician, surgeon and apothecary, a view supported by the Suffolk evidence presented here.⁸²

The interpretation of the evidence from this period is confused by the variable use of titles for medical practitioners, both by contemporaries and by modern historians. Harold Cook indiscriminately calls medical practitioners 'physicians' because he distinguishes those who practised physic from 'medicine' or healing. Others, such as Roy Porter and Joan Lane, use the title 'surgeon-apothecary' in a way that does not necessarily reflect individual practice. This blurring was particularly noticeable in the provinces and country areas, where more general medicine was practised. As Joseph Kett says:

"Though a certain amount of merging had taken place within London during the seventeenth and eighteenth centuries, the process was accelerating in the provinces where the regulatory corporations had no authority, and where the harsh realities of rural practice prevented the division of labour attainable in metropolitan surroundings".⁸³

John Raach also looks beyond the London institutions and refers to a generic category of medical practitioners in place of the conventional tripartite division to include anyone involved in the care of the sick. He argues that many medical practitioners either practised medicine part-time or combined it with a range of associated activities.⁸⁴

⁷⁹ Harold A.L. Cook "Good advice and little medicine"; the professional authority of early modern English physicians", in *Journal of British Studies*, 33, (1994), pp.1-31.

⁸⁰ Grell, "The medical profession", p.25.

⁸¹ Pelling, *The Common Lot*, p.231.

⁸² Jacyna, "Medicine in transformation", p.31.

⁸³ Kett, "Provincial medical practice", p.27.

Rosemary O'Day agrees that full-time licensed doctors resided and practised in most communities by the end of the seventeenth century, and not all were university trained.⁸⁵ Coupled with the failure of intermittent regulation away from London, the occupation of a doctor was very flexible, and “at odds with the full-time, self-sufficient, life-long commitment characteristic of the professional as usually described”.⁸⁶ Margaret Pelling’s work on Norwich also reveals large numbers of practitioners of many types,⁸⁷ and Roy Porter feels that:

“the straitjacket of a three-tiered hierarchical structure increasingly did not conform to the facts of medical practice. In the provinces the great majority of regular medical men operated as general practitioners”.⁸⁸

Thus, the distinction between the three arms of the professions was frequently very ‘muddy’ indeed, not least because most people as patients were more concerned about having a good and effective practitioner, than worrying about qualifications as such.⁸⁹ For example, in Suffolk, William Norford (1715-1793) practised as physician and surgeon from about 1774 until his death in 1817, as did Charles Wilson Snr. (1779-1848) of Yoxford.⁹⁰ This lack of professional demarcation is illustrated by the range of advice received by John Green Crosse (1790-1850), surgeon of Stowmarket and Norwich, as he considered his future career.⁹¹ Charles Bell (1774-1842), a luminary of the Great Windmill Street School of Anatomy, was not in favour of him going to a country town with no hospital; in contrast Benjamin Brodie (1783-1862), then assistant surgeon at St. George’s, thought:

“the country was the only thing [because] a surgeon-apothecary in London never attains ye superior rank of his profession and never gets afterwards into practice as a surgeon. The pure surgeon is the only man that can do anything in London”.

⁸⁴ Raach, *English Country Physicians*, p.11.

⁸⁵ O'Day, *The Professions*, p.253.

⁸⁶ Raach, *English Country Physicians*, p.10.

⁸⁷ Pelling, *The Common Lot*, p.123.

⁸⁸ Porter, *Disease, Medicine and Society*, p.33.

⁸⁹ Chapter 3 discusses the public perception of title more fully.

⁹⁰ *SMB*. David van Zwanenberg lists seven practitioners with this dual title. Besides Norford and Wilson, they were Robert Lovell [1783-1792] of Ipswich and Bristol, Thomas Gosling Reeve (1780-1832) of Gislingham, John Syer (1761-1823) of Woodbridge, William Henry Williams (1790-1839) of Ipswich and a Dr White who was active in Eye in 1783-4.

⁹¹ Crosse, *John Green Crosse*, p.71.

William Blair (1766-1862), a surgeon at the Lock Hospital and editor of the *London Medical Review*, agreed that “if you have sufficient income to settle as a pure surgeon in London set on foot an infirmary for Distortions etc.”. Yet Dr Farre, physician to the Eye Infirmary, disagreed strongly as there was “nothing to be done as a pure surgeon in London and no chance of setting up any new institution, with which the town was crowded already”. Finally, another surgeon at the Lock Hospital suggested either settling in the country or going abroad with a rich family.

Alfred Hill supported the view that before 1800 many, maybe most, rural surgeons and apothecaries did not belong to a professional body and in remote districts anyone might practise physic.⁹² The double qualification of MRCS and LSA, which became more common in late eighteenth century London, was much less frequent in the country.⁹³ Some Suffolk evidence supports this - for example, George Crabbe held neither qualification and apparently was not licensed by a bishop to practise surgery, unlike his neighbouring colleagues Nathaniel Cooper Snr. {1721-1769} of Saxmundham and James Craddock (1723-1787) of Stowmarket, both licensed as surgeons in 1753 by the Bishop of Norwich.⁹⁴

The move towards hospital-based medicine in the cities, and the consequent profound implications for the eighteenth century model of the patient as chief arbiter and judge of a clinical encounter, further emphasised the distinction between urban and rural, especially in Suffolk which did not have a general hospital until 1826. The coming of county hospitals in the second half of the eighteenth century, although passing Suffolk by, had created more prestigious career opportunities, as each county infirmary had two to four physicians and surgeons, and an apothecary. Such honorary posts were jealously protected and therefore difficult to come by. John Green Crosse struggled for four years to gain an honorary assistant surgeon post at the Norfolk and Norwich

⁹² Alfred W. Hill, *John Wesley Among the Physicians: a Study of Eighteenth Century Medicine*, (London, 1958), p.28.

⁹³ This is described further in Chapter 4.

Hospital, and many others were unsuccessful, fuelling the later growth of dispensaries and smaller or special hospitals set up by groups of disaffected doctors.⁹⁵ There was no doubt, as Ivan Waddington says, “the hospital consultants composed the highest echelon of the medical profession, while patients were drawn from the lower classes, deferring to their judgement”.⁹⁶

Provincial physicians, surgeons and apothecaries also shared in the spoils and the rising status of the profession. Adrian Wilson’s evidence shows a strong increase in premiums for apprenticeship up to 1750, suggesting a relative shortage of medical men compared to the increasing demand for their services.⁹⁷ That they were achieving some status in rural areas at the beginning of the nineteenth century is implied by Jane Austen’s letter to a friend:

“my chief sufferings were from feverish nights, weakness & Languor.-This Discharge was on me for above a week, & as our Alton Apothary did not pretend to be able to cope with it, better advice was called in. Our nearest very good, is at Winchester, where there is a Hospital and capital Surgeons, & one of them attended me, & his Applications gradually removed the Evil. The consequence is that instead of going to Town to put myself into the hands of some Physician as I shd otherwise have done, I am going to Winchester instead, for some weeks to see what Mr Yford can do farther towards re-establishing me in tolerable health”.⁹⁸

Patients of all social classes used not one but frequently a range of healers, without making any distinction between, what Roy Porter describes as, “practitioners, proper and improper”.⁹⁹ Many historians and medical men have understandably emphasised the role of the university-dominated elite as the forerunners of the scientifically trained physicians and surgeons of the twentieth century. However, the failure of regular and scarce physicians to offer their patients much more than uncertain drugs, purging and frequent bleeding, as well as their inability to recognise with certainty the origins of human diseases, “made even those who could afford the best medical care

⁹⁴ Register of the Bishops of Norwich, *Surgeons, Phlebotomists and Midwives*, Vols. 30-33, SRO (Ipswich), JC1/5/11.

⁹⁵ Crosse, *John Green Crosse*, pp.84-116.

⁹⁶ Waddington, *The Medical Profession*, pp.215-6.

⁹⁷ Adrian Wilson, *The Making of Man Midwifery*, (Cambridge, Mass, 1995), p.192.

⁹⁸ Deirdre Le Faye (ed.), *Jane Austen’s Letters*, (London, 2003), p.340. To Anne Sharp, Thursday 22 May 1817.

⁹⁹ Roy Porter, *Health for Sale. Quackery in England, 1660-1850*, (Manchester, 1989), p.35.

sceptical of traditional medicine's authority and power".¹⁰⁰ In such a situation, it is not surprising that those who were sick or believed themselves to be so, sought remedy from "any individual whose occupation [is] basically concerned with the care of the sick".¹⁰¹ Robert Aspin describes the medical culture as "a rich matrix of overlapping spheres of competence and activity, populated by a range of claimants to medical expertise".¹⁰² In practice, there was no distinct body of 'scientific medicine' and medical fads or the whims of moneyed patients could not be ignored.¹⁰³ For example, Joseph Chamberlain {1813-1840}, surgeon and apothecary of Ipswich, was described as "inventor of several salves and potions. Dispenser of Dr Sibley's Solar Tincture".¹⁰⁴ Stradbroke surgeon William Chapell {1787} advertised that he "treats fistulas and piles. Also cures cancers, King's Evil, and scorbutic cases. The method of curing fistulas has been a secret in the family for 40 years".¹⁰⁵ Moreover, 'qualified' practitioners would themselves sell proprietary medicines with exotic titles, claiming to cure all manner of diseases. For example, James and Margaret Bickford quote an advertisement in Hull where a surgeon claimed his treatments "will cure rupture without surgery; total deafness with a few minutes treatment or a squint in 30 seconds".¹⁰⁶

What Jonathan Barry describes as "the more ostentatious quacks" were far outnumbered by the provincial irregulars.¹⁰⁷ These were less threatening to physicians than they were to surgeons and apothecaries. They were often modest, used handbills and displays to advertise and were often itinerant. For example, treatments of venereal disease in the eighteenth century indicated that "regular surgeons and 'quacks' presented themselves and their cures to

¹⁰⁰ Thomas N. Bonner, *Becoming a Physician: Medical Education in France, Germany and the USA 1750-1945*, (Oxford, 1995), pp.16-17.

¹⁰¹ Margaret Pelling & Charles Webster, "Medical practitioners", in Charles Webster (ed.), *Healing, Medicine and Mortality in the Sixteenth Century*, (Cambridge, 1979), pp.165-236.

¹⁰² Robert Aspin, "Illustrations from the Wellcome Library: who was Elizabeth Okeover?", *Medical History*, 44, (2000), pp.531-40.

¹⁰³ Steven Cherry, "Responses to sickness: medical and health care provision in modern Norwich", in Carole Rawcliffe & Richard G. Wilson (eds.), *Norwich Since 1550*, (London, 2004), pp.271-294.

¹⁰⁴ SMB, Personal communication between David van Zwanenberg and Dr Blatchly, Headmaster of Ipswich School, "a noted scholar of local history".

¹⁰⁵ *Ipswich Journal*, December 1787.

¹⁰⁶ James A.R. Bickford & Margaret E. Bickford, *The Medical Profession in Hull 1400-1900*, (Kingston Upon Hull, 1983), p.iii.

¹⁰⁷ Jonathan Barry, "Publicity and public good: presenting medicine in eighteenth century Bristol" in Bynum & Porter (eds.), *Medical Fringe*, pp.29-39.

the public in ways more remarkable for their similarities than for their difference”.¹⁰⁸ Irvine Loudon also points out the difficulties created by the absence of a clear distinction between the orthodox regular, and the unorthodox or irregular quack.¹⁰⁹

‘Irregulars’ were not regarded by regulars as qualified to practise because they did not have university (particularly classical) qualifications nor a licence to practise or undertake apprenticeship. Thomas Beddoes stated that they could be told apart from an authentic doctor by virtue of being ill-bred, uneducated, ignorant and inept, and further were “the bastard brethren of the healing profession”.¹¹⁰ James Makittrick Adair described a quack as “a pretender to knowledge of which he is not possessed; a vendor of nostrums, the powers of which he does not understand - in short, a swindler and a knave”.¹¹¹ Another contemporary, James Moore, characterised the essence of an irregular thus:

“An empiric never hesitates at making positive declarations and is never at a loss for pretexts to cover failures. Should an infant at the accession of the variolous fever be carried off by convulsions, he denies, with effrontery, that the Small Pox was the Cause and invent another on the spot”.¹¹²

George Crabbe’s “Letter on physic” in his poem *The Borough* is mainly an attack on bogus patent medicine, and he gave an account of a quack doctor probably based on the career of Nathaniel Goldbold of Bungay whom Crabbe would have come across when he was at school there.¹¹³

Practitioners of regulated learned medicine increased from the end of the seventeenth century and made inroads into certain types of lay healers to be

¹⁰⁸ William F. Bynum, “Treating the wages of sin: venereal disease and specialism in eighteenth century Britain”, in Bynum & Porter (eds.), *Medical Fringe*, pp.5-28.

¹⁰⁹ Loudon, *Medical Care*, p.28.

¹¹⁰ Thomas Beddoes in letter to Joseph Banks, quoted by Porter, *Health for Sale*, p.2.

¹¹¹ James Makittrick Adair, *Medical Cautions for the Consideration of Invalids*, (Bath, 1786), p.138.

¹¹² James Moore, *A History of Smallpox*, (London, 1815), p.269.

¹¹³ Edwin Alvis Goodwyn, *George Crabbe and Beccles*, (Beccles 1986), p.21. Nathaniel Goldbold was a confectioner who visited local fairs and had built a theatre in Bungay. He left the town in about 1788 and launched his Vegetable Balsam or oxymel from London with astounding success. Nathaniel had two sons, Nathaniel and Samuel, and it is possible that Crabbe had the father and sons in mind when writing of the tradesman who, “by a combination of luck and shrewdness, made his fortune by his quack medicine”.

found in houses and neighbourhoods, from gentry and clergy to “village nurses”.¹¹⁴ A long and sustained smear campaign against the medical fringe was carried out throughout the seventeenth and eighteenth centuries, with what Lucinda Beier calls “the anti-quack writers” who of course had their own agendas, being particularly virulent against “piss prophets, itinerant practitioners, women who practised medicine, magical healers and ministers who treated bodies as well as souls”.¹¹⁵ It is likely, as Barry says, that:

“in the struggle to be noticed and gain a reputation in provincial communities, the advantage lay with those who could exploit local associations and ‘regular’ practice”.¹¹⁶

This review of the historiography relating to healthcare in the late eighteenth and early nineteenth centuries suggests the range of views on offer. There is demonstrably little coherence in the picture of ordinary medical practice in the eighteenth century because of the diversity of medical men and the absence of a clear distinction between regular practitioners and irregulars. Those historians who try to establish such clarity are always open to challenge, particularly since the metropolitan experience forms the basis of so much of the history of the professions written to date. What is clear is that the more established groups of practitioners felt threatened by new developments in healthcare, and tended to label their competitors as ‘quacks’. Irvine Loudon believes that fear of these competitors was behind the drive for medical reform in London, with physicians regarding the apothecary as a challenge in the seventeenth century, and the surgeons and apothecaries similarly viewing the druggists and ‘hobbyists’ in the eighteenth.¹¹⁷ He identifies bitter competition between those who saw themselves as respectable medical practitioners and those who they thought of as ignorant and fraudulent irregulars, increasingly including midwives and retail druggists, particularly when such competitors operated in close and direct proximity.

¹¹⁴ Ibid., p.94.

¹¹⁵ Beier, “The medical fringe”, p.30.

¹¹⁶ Barry, “Publicity and public good”, p.35.

¹¹⁷ Loudon, “Medical practitioners”, p.233.

However, this picture does not reflect the pattern of healthcare delivery in places like Suffolk, nor did changes that took place in London during this period necessarily become widespread outside the capital until well after 1830. Less populated areas with fewer patients widely spread might create a competitive environment for practitioners. However, patients in such places generally had less choice of practitioner, less awareness of medical and scientific developments and more stable and hierarchical communities, with no clearly defined boundaries between the multiplicity of rational medical suppliers and empirics. This sort of diversity fitted a medical marketplace where, as Andrew Wear suggests, medical authority and licensing was not strong enough to impose uniformity and patients moved between different types of practitioners at will.¹¹⁸ Any changing attitudes to illness and health, generated largely in London and other major cities, were likely to reach provincial towns and finally the countryside through a slow and uneven ripple effect. This review suggests that generalisations based largely upon metropolitan practice need to be tested against the realities of country practice. In the case of Suffolk, developments in relation to patients, society, the profession and medicine itself tended to demonstrate that a conscious identifiable profession existed, differing in significant respects from current understanding and providing a potential new link to the general practitioner of the later nineteenth century.

1.2 The Argument

The major research questions to be addressed derive from this hypothesis:

- Does the predominantly metro-centric view of medical practice in the period concerned need modifying or even radically changing in the light of the Suffolk evidence?
- Are conventional beliefs about (for example) the education, training and practice of surgeons and apothecaries supported by the Suffolk evidence?

¹¹⁸ Andrew Wear, "Medical practice in the late seventeenth and early eighteenth century England: continuity and union" in Roger French & Andrew Wear (eds.), *The Medical Revolution of the Seventeenth Century*, (Cambridge, 1989), pp.294-320.

- Was medicine in Suffolk between 1750 and 1830 distinguished by doctors effectively playing ‘catch up’ with their London colleagues and those from other large cities?
- Or, did they represent a link in the development of general medical services, from the healers of the sixteenth century to the general practitioners of the mid-nineteenth century, that has been ignored so far?

Some modern interpretations are limited by the narrowness of their sources and the relative lack of detailed research carried out on the delivery of healthcare in rural counties like Suffolk. Social historians of modern Suffolk are few and far between and, as stated above, there are few references to rural counties in modern historiographies.¹¹⁹ This detailed review of medicine in such a rural county suggests the need for further parallel studies to supplement and test assumptions and conclusions. Until then, county-wide studies such as this one can illuminate misconceptions about provincial medicine that have been overshadowed until now by metropolitan-based assumptions.

As the basis of a cogent and well-worked through argument, a literature review was conducted and reflected upon throughout the thesis. Both contemporary and modern sources and commentaries have provided a framework within which to discuss and assess the primary evidence from Suffolk. Research issues and questions and some preliminary conclusions have been cross-checked with contemporary sources and commentaries. New leads for further primary source work have been further explored, particularly when established interpretations or the views of well-respected historians can be tested against local evidence.

One of the first tasks was to establish a credible cohort of practitioners. To achieve this, some well-founded assumptions had to be made, the most important of which was that the majority of doctors started practising in their

¹¹⁹ *The Suffolk Review* and other local historical societies, such as those at Woodbridge and Framlingham, produce valuable monographs on detailed aspects that are referenced throughout.

early twenties and practised to a good age.¹²⁰ Little is known about some of these practitioners, including the actual length of their working lives or even any specific year when they were practising. Some died relatively young, but evidence for the majority suggests thirty years is a defensible average length of practice for the overall cohort.¹²¹ Thus, unless otherwise specified, any use of the database in this review assumes this figure.

For example, where only the date of a Bishop's licence or only the details of a practitioner's apprenticeship is known, then thirty years of practice has been assumed from the date of the license or apprenticeship contract.¹²² On the other hand, if the only information available is that a practitioner had a particular apprentice at a given date, then five years of practice prior to, and 25 years after, the date of the contract is taken to indicate a period of active medical involvement.¹²³ If only a marriage date can be ascertained, an average of five years in practice before settling to family life, and 25 years of practice after marriage is assumed. Although somewhat rough and ready, the basis of these assumptions seems valid, and cross-checking against other primary sources gives some confidence in the outcome. These assumptions and the database derived from the sources described have identified a cohort of over 950 doctors, including the few who called themselves physician only, who were active in Suffolk at some time in the period from 1750 to 1830.

As Jacyna states, it is not possible to separate medicine from "an understanding of the social political and economic transformation that

¹²⁰ For example, Charles Dashwood of Beccles retired in November 1863 in his 90th year, having been apprenticed as a surgeon in 1790.

¹²¹ For example, George Gissing in 1821 aged 22, having just completed his professional education by walking the London Hospital; Edward King of Witnesham died in 1817 aged 26; Joshua Smith of Bury St. Edmunds went into practice with his father in January 1818, and promptly caught typhus and died also aged 26. In contrast, George Stebbing practised for 50 years.

¹²² Many names of medics are only discoverable from the list of those licensed to practise by the Bishop of Norwich, such as William Lloyd of Eye in 1753. All that is known of Harmer Carrington is that he was apprenticed to Samuel Fitch of Ipswich in June 1795, as listed by the Society of Apothecaries.

¹²³ Peter J. Wallis & R.V. Wallis (with Juanita Burnby and Thomas D. Whittet), *Eighteenth Century Medics - Subscriptions, Licences, Apprenticeships*, (Newcastle Upon Tyne, 1985) identified practitioners such as Joseph Tanner of East Bergholt, about whom the only information listed is that he had an apprentice (Thomas D'Oyley) in 1757 who paid a premium of £84. Similarly, John James of Sudbury had an apprentice James Powis on 6 September 1766. All that is known of James Askill of Hollesley is that he was married to Sarah Cobden of Beccles in March 1808, as listed in the parish marriage register.

occurred in the first half of the nineteenth century”.¹²⁴ Consequently, having identified the research questions and the cohort of medical practitioners forming the basis of this study, the geographic, social and economic background to Suffolk in the period 1750-1830, particularly as it appeared to contemporaries, is described briefly in the next chapter to set the context.

An early question to be answered is ‘who were the surgeons and apothecaries?’ The use of the title ‘surgeon-apothecary’ by modern historians has complicated and obscured the answer, and it appears that, in Suffolk, practitioners themselves were flexible and even cavalier in their use of titles.¹²⁵ Contemporary fiction by authors such as Jane Austen and George Eliot also showed how random the use of the nomenclature really was.¹²⁶ David van Zwanenberg’s gazetteer, a major source for the work’s cohort of Suffolk practitioners, was also not free from errors.¹²⁷ However, besides any incorrect allocation of title by van Zwanenburg himself, the evidence he collected demonstrates that the composite title ‘surgeon-apothecary’, used by so many historians today, was far from widely used at the time in Suffolk. Although there were a few recorded instances of boundary disputes, generally physicians, surgeons and apothecaries seemed to deliver whatever care was needed whenever and however the populace of all classes called upon them; an argument for the existence of the generic term ‘medical practitioner’. Overall, because the evidence indicates a fairly random use by practitioners and contemporary commentators alike, it is unrealistic to reach definite conclusions about the range and scope of work of a particular medical practitioner from arguments based even partly on the use of any one title.

¹²⁴ Jacyna, “Medicine in transformation”, p.25.

¹²⁵ For example, Richard Langslow {1790-1812}, physician of Halesworth, who dispensed drugs and dealt with drownings and accidents as a surgeon. Langslow accused Stebbing Revans, a local apothecary, of failing to “prepare the prescription with fidelity” and thought about establishing a druggist in the town “in order to have obviated the inconvenience the public sustained from my prescriptions being inertly compounded”, but decided instead to fit “a complete medicine chest in my own house, stored with such articles as I can depend upon”, Richard Langslow, *Address to the Inhabitants of Halesworth and the Neighbourhood July 18 1796*, (Bungay, 1800), pp.9, 12, 13.

¹²⁶ Examples are given in Chapter 3.

¹²⁷ Some examples of these small errors are: John White, surgeon of Nayland, is listed as having died in 1750 when his tomb indicates that he died on 23 March 1755 aged 25; William Cuthbert is listed as apprentice to John Growse (1796-1884) in 1796; Mallous Freeman was apprenticed from 1819-1824, not from 1812; Henry Davey was apprenticed to Robert Purvis, not Parris as listed; John Rose listed as subscribing from 1750, and having apprentices until 1827, is described as having died aged 51 in 1826.

Current historiographies also offer fairly firm but often conflicting conclusions about the antecedents of practitioners that are particularly suspect in relation to surgeons and apothecaries. Views ranged in the 1950s and 60s from Bernice Hamilton, who quoted one contrary contemporary view that “now there is not a poor Peasant or Mechanick, but if he has two Sons, one of them must be a Doctor”¹²⁸ to William Reader, who believes that the origins of medical practitioners were “not above the middle class”.¹²⁹ However, more recently, historians such as Rosemary O’Day suggest that a considerable number of medical practitioners came from the gentry and professional backgrounds, and that there was a cultural shift by the early eighteenth century to a demand for ‘middling’ rank medical practitioners.¹³⁰ Joan Lane similarly suggests that, by 1750, medicine had become the career that the gentry or ambitious parents chose for their sons.¹³¹ However, Stephen Jacyna refers to doctors as:

“self-made professionals whose claims for status and remuneration rested not on birth or connection but ability, learning, and personal endeavour – a career open to all the talents”.¹³²

The Suffolk evidence supports this by throwing doubt on suggestions that surgeons and apothecaries were largely and increasingly from the gentry and upper middle classes.¹³³

Nor is the level of social and geographic mobility described in some modern texts supported by the evidence detailed in Chapter 3. Joan Lane uses evidence from Foart Simmons’ medical registers to suggest that there was significant movement of new practitioners away from over-doctored areas to

¹²⁸ Bernice Hamilton, “The medical profession in the eighteenth century”, in *Economic History Review, Second Series*, 4, (1951), pp.141-149.

¹²⁹ William Reader, *Professional Men: the Rise of the Professional Classes in Nineteenth Century England*, (London, 1966), pp.33-4.

¹³⁰ O’Day, *Professions*, p.244. The Stamp Office Registry between 1770 and 1750 reveals that of 915 entries for whom the origin was stipulated, 32% were of lower gentry status and 55% were from “lower middling sort”.

¹³¹ Lane, *A Social History*, p.11.

¹³² Jacyna, “Medicine in transformation”, p.14.

¹³³ This is discussed further in Chapter 3.

sole practitioner communities.¹³⁴ This might have reflected a lack of immediate success in attracting patients, too small a practice population to sustain another practitioner, a declining population unable to sustain the existing established practitioners, or even knowledge of a retirement or the death of a distant practitioner. However, in contrast, David van Zwanenburg's earlier study of Suffolk apprentices concludes that medical practice in the first half of the nineteenth century was indeed fairly parochial, with most of the vacancies being filled by men who had trained in Suffolk or neighbouring counties.¹³⁵ Moving may have been difficult or risky, and perceived opportunities were less in this region. The limited mobility found in this study, particularly in the very rural areas, seems to support van Zwanenburg.

Evidence on the ratios of medical practitioners also reveals considerable discrepancies between historians. Suffolk figures suggest significant errors in Foart Simmons' medical registers, reflecting perhaps the paucity of information returned to him and the narrowness of the range of practitioners listed, both of which cast doubts on his reliability as a source. Joan Lane recognises that:

“if the 1783 Register is to be considered as more than of mere antiquarian interest, an estimate of its accuracy and completeness as a basis for modern research is important, when set alongside other, unrelated contemporary record material”.¹³⁶

Yet she relies heavily on Foart Simmons, citing the medical practitioners of the county of Warwickshire and the poorhouse records to suggest the relative accuracy of the registers, whilst acknowledging the numerous inaccuracies. These include notably listing all those with the same name as one individual, missing out individual practitioners' names and, most significantly, the large number of practitioners whose forenames were not included.¹³⁷ As a practitioner himself, Foart Simmons understood the different categories of

¹³⁴ Joan Lane, *Apprenticeship in England 1600-1914*, (London, 1996), p.131. More information is given on Foart Simmons' registers on p.6.

¹³⁵ David van Zwanenburg, “The training and careers of those apprenticed to apothecaries in Suffolk 1815-1858”, *Medical History*, 27, (1983), pp.139-150.

¹³⁶ Lane, “Medical practitioners in 1783”, p.369.

¹³⁷ For example, John Anderson was both a physician in Kingston, Surrey and a surgeon to the Newcastle Upon Tyne Dispensary.

medical status and qualifications, though his status position as a physician may well have blinded him to the significance of some of his errors, and limited his network of informers so that his data were skewed towards his own branch of the profession. Margaret Pelling demonstrates that orthodox practitioners were not uncommon, even in small towns, and that healers of all sorts were present in well-populated rural areas at least on a ratio to population of about 1:400. This implies that the numbers of practitioners used by Foart Simmons and subsequently others (such as Michael Muncaster) are understated.¹³⁸

In the same way, the education and training generally ascribed to practitioners by modern historians may also be skewed towards London and provincial large towns. Nicholas Hans analysed a random sample of 120 eighteenth century medical practitioners drawn from the *Dictionary of National Biography*,¹³⁹ identifying 34 practitioners (28 per cent) who were educated at home, 34 (28 per cent) at the 'great public schools', 29 (24 per cent) at grammar schools, seventeen (fourteen per cent) at private schools and six (five per cent) at dissenting academies.¹⁴⁰ In the same year, Bernice Hamilton stated that "the apothecary was generally the product of a grammar school, where he learned enough Latin to read and write prescription".¹⁴¹ Other later historians have reinforced this view. Michael Muncaster's work on Norfolk practitioners suggests that, before 1830, they were usually local grammar school boys, and Juanita Burnby also states that "it is probable that he [the apothecary] had attended his local grammar school".¹⁴² Irvine Loudon repeats and extends this view, describing both surgeons and apothecaries as typically grammar school boys who left school at twelve to fifteen years of

¹³⁸ Pelling, *The Common Lot*, p.242.

¹³⁹ The *Dictionary of National Biography* (DNB) is a standard work of reference on notable figures from British history, published from 1885. The updated *Oxford Dictionary of National Biography* was published on 23 September 2004 in 60 volumes and online.

¹⁴⁰ Nicholas Hans, *New Trends in Education in the Eighteenth Century*, (London, 1951), Table 3, quoted in Loudon, *Medical Care*, p.34.

¹⁴¹ Hamilton, "The medical profession", p.144.

¹⁴² Muncaster, *Health Services*, p.138. Juanita Burnby, "An examined and free apothecary" in Vivian Nutton & Roy Porter (eds.) *The History of Medical Education in Britain*, (Amsterdam, 1995), pp.16-36.

age with some knowledge of Latin and often a smattering of Greek, who could then be apprenticed.¹⁴³

Local evidence of the schooling and education of Suffolk practitioners suggests differences from these statements. Possibly the generally held belief that surgeons and apothecaries were largely grammar school boys arises partly from the lack of differentiation between grammar schools and endowed or private schools, and the rather random use of nomenclature that covers both the Royal Foundations and commercial home-based ‘crammers’. Further light is thrown on these difficulties through describing the range of schools that were available in Suffolk, though classifying them less by their given title than by the range and style of educational experience offered.¹⁴⁴ However, for the majority of practitioners, nationally and in Suffolk, there is no direct evidence as to the schooling actually obtained, suggesting that any conclusion in this area must remain tentative.

Similar doubts have been raised over accepted views on apprenticeship. Irvine Loudon believes that apprenticeship was failing after 1815 because it did not provide practical clinical experience and perpetuated the lowered status of general practice.¹⁴⁵ Experience in Suffolk, on the contrary, shows that training in the county was fairly consistent over the whole period reviewed and, based on the continuing and consistent level of apprentices and masters, was just as extensive and effective after 1815 as before. Contemporaries saw the training as a good option, under which a wider range of conditions could be experienced.¹⁴⁶ Jeanne Peterson may be right when she suggests that the 1815 Apothecaries Act would not have been needed had only country practice been considered.¹⁴⁷

Modern commentators (like Susan Lawrence, Joan Lane and Irvine Loudon) have suggested that there was an organised and consistent approach to

¹⁴³ Loudon, “Medical practitioners”, p.245.

¹⁴⁴ Schooling is explored more fully in Chapter 4.

¹⁴⁵ Loudon, *Medical Care*, p.179.

¹⁴⁶ William Chamberlaine, *Tirocinium Medicum (or a Dissertation on the Duties of Youth Apprenticed to the Medical Profession)*, (London, 1812), pp.1-66.

¹⁴⁷ Peterson, *Medical Profession*, p.28.

hospital training post-apprenticeship and particularly post-1800. However, Suffolk had no General Hospital until 1826 and few dispensary opportunities, as Chapter 5 demonstrates. To secure hospital training, Suffolk apprentices had to go to London - expensive and potentially dangerous in terms of losing patients and indeed their practice, as George Crabbe discovered.¹⁴⁸ Most newly trained doctors in Suffolk went straight into practice, either with their master or a family member, or by answering advertisements for assistants and partners.¹⁴⁹ There was clearly no perceived requirement for further training to obtain a medical living there throughout the period under review. However, the enthusiasm for learning, scientific development and inquiry and gaining new skills was significant in this county, as Chapter 5 concludes from the range of further and higher educational activity in Suffolk.

The countryside was generally considered healthier than the town, but its medicine more primitive. Yet the evidence for Suffolk, as detailed in Chapter 6, indicates local developments in the teaching of anatomy and diagnosis, and extensive treatments including heroic surgery, with East Anglia a known centre for surgery, lithotomy, the treatment of fractures, trepanning, resuscitation and ophthalmology. There is also evidence of a wide range of pills and potions of mixed efficacy, of dissection through practitioners such as John Bucke (1756-1839) and John Clubbe (1741-1811) both of Ipswich, and Mr Randall {1820} a young surgeon in Acle. Chapter 6 also describes how inoculation, a Suffolk contribution to the development of preventative medicine, was somewhat underplayed in relation to the more effective methods for smallpox vaccination developed at the turn of the century by Edward Jenner.

Another major arm of the practice of medicine was midwifery, in both its male and female forms. Female midwifery was nationally a more significant profession than hitherto believed and the contributions of figures such as Jane Sharp {1671}, Sarah Stone {1737} and Elizabeth Nihell {1750} are now

¹⁴⁸ When Crabbe returned from less than a year in London walking the wards, his locum had effectively given his practice away to his rival, Burnham Raymond. Crabbe never recovered from this.

¹⁴⁹ Loudon, *Medical Care*, p.51.

recognised. However, there is little evidence of Suffolk midwives either playing a leading role or banding together in any way to create a movement for change. As for man midwifery, Jean Donnison describes the distinct and recognised profession of obstetrics that emerged in London.¹⁵⁰ Some historians have argued that medical practitioners only attended complicated or difficult births, and that women's preference for male attenders was responsible for the rise of man midwives.¹⁵¹ However, the evidence from Suffolk, as set out in Chapter 7, challenges this interpretation, as a significant number of families (or at least those paying directly) used their 'local' doctor for childbirth, and he attended and intervened as part of his normal practice responsibilities.¹⁵²

Chapter 7 also examines the issues around women's other roles in medicine, as wives and as practitioners, and reveals that there was more direct and indirect involvement than generally thought. Modern historians have been much exercised in approaching the issue of female occupation appropriately. Since Alice Clark and Ivy Pinchbeck produced the first social histories taken from the female standpoint, historians now try to avoid the danger of just adding a female dimension into a concept of world order, in which men remain the norm and the narrative remains essentially male-centred.¹⁵³ Many also query the role of women as victims or indeed as a homogenous group. Problems are created because records of women's activities tended to be kept by men and could be seen to reflect the bias of a male-dominated society. Similarly, women's activities were often subsumed within those of their husbands, so for example little is known of women's membership of voluntary organisations or quasi-public roles.¹⁵⁴ Employment opportunities for women probably declined after the turn of the eighteenth century. Middle class women in particular began to be excluded from public life, and employment for lower class women began to be separated from the home, as

¹⁵⁰ Jean Donnison, *Midwives and Medical Men - a History of Inter-professional Rivalries and Women's Rights*, (London, 1977), pp.42-61.

¹⁵¹ Such as Wilson, *Man-Midwifery*, and Amanda Vickery, *The Gentleman's Daughter: Women's Lives in Georgian England*, (London, 1998).

¹⁵² Dorothy Porter & Roy Porter, *In Sickness and in Health - the British Experience, 1650-1850*, (London, 1988), p.54.

¹⁵³ Alice Clark, *Working Life of Women in the Seventeenth Century*, (London, 1919); Ivy Pinchbeck, *Women Workers and the Industrial Revolution*, (London, 1930).

¹⁵⁴ Robert B. Shoemaker, *Gender in English Society 1650-1850*, (Harlow, 1998), p.2.

the traditional home-based female occupations that often gave women independence and equality in terms of earning began to disappear.¹⁵⁵

Joan Lane refers to medicine as an exclusively male occupation, with wives and mothers being expected to provide medical care, usually unpaid.¹⁵⁶ Stephen Jacyna states that the idea of admitting women to the medical profession was an anathema to most doctors throughout the first three quarters of the nineteenth century.¹⁵⁷ Both statements are credible, but on the evidence from Suffolk, sketchy though it is, more women were involved directly and indirectly than is sometimes believed, and the role of female practitioners in healthcare, whether as a doctor's wife, a medical practitioner or as a midwife, merits further and more detailed investigation.

Work carried out on the income and status of practitioners in Suffolk is set out in Chapter 8, and a generally positive picture emerges here. While a number struggled to make practice pay (George Crabbe being a notable example), the majority seem to have maintained a reasonable lifestyle and some a relatively affluent one, holding a respected place in the community. Many held civic offices and supported local medical and benevolent societies. They appear to have mixed with middle and merchant classes, and even with the gentry, while at the same time serving the poor on contract from the Poor Law overseers that brought in a regular if limited income. How far this differs from the generality of London practitioners or those in large towns is difficult to judge, because there are insufficient studies on these areas for this period. Again, more research is needed into other counties to draw comparative conclusions.

Overall, the argument set out here is that insufficient attention has been paid to the rural practitioner and this has led to conclusions that, while they may be reflected in the metropolis and large urban environments, they do not appear to hold true for provincial and rural ones. The evidence from Suffolk set out in the following chapters is not only significant enough in quantity and

¹⁵⁵ Pelling, *The Common Lot*, p.242.

¹⁵⁶ Lane, *A Social History*, p.11.

quality to justify and indeed demand further research into comparable counties, but also to challenge some wider conclusions that have existed for some time about the development of general practice before, during and probably after the period under review. In some cases this may lead to no change, in some the evidence may simply qualify some statements, but in many it may lead to a re-balancing of the emphasis on city medicine for the few and provincial medicine for the many. Furthermore, the picture that emerges from Suffolk is of a more mature occupation than considered hitherto, delivering family-based medicine with a wide range of skills and expertise, and potentially a new link in the history of general practice.

¹⁵⁷ Jacyna, "Medicine in transformation", p.27.

CHAPTER 2: SUFFOLK CONTEXT 1750-1830

“...in short, here is everything to delight the eye, and to make the people proud of their country; and this is the case throughout the whole of this county”.¹

2.1 Demography and Economy

An understanding of the demography, geography and economy of Suffolk is an important framework for the argument of this thesis. They form a complex backdrop to what Steven King and Alan Weaver describe as “the development of the medical landscape”, applying as much to Suffolk as to Lancashire.² East Anglia has always been geographically and physically cut off from the rest of Britain by the Devil’s Dyke to the West, the River Stour to the South and the Wash to the North. Before 1800 Suffolk also lacked canals, either between its towns or joining them to the metropolis, though some navigable waterways (such as the Blyth and the Gipping) had been improved. Leonore Davidoff and Catherine Hall see some comparability between the industrial town of Birmingham and the agricultural towns of Ipswich and Colchester, particularly in relation to trade and transport links, as “Birmingham’s canals were matched by Essex and Suffolk’s coastal routes”.³ Yet the latter, unlike the great Midlands canals, did not provide access between major cities, and were regarded as highly vulnerable during the French Wars because they were so open to sea attack.

This general physical isolation of Suffolk contributed to a level of cultural detachment from the rest of the country that had a significant impact upon awareness of, and reaction to, technological, scientific and philosophical developments, including those relating to medicine. According to Frederick J. Foakes Jackson, children born in East Anglia were not “those inferior people born in the Shires”; they belonged to a race not a territory, they were East

¹ William Cobbett, *Rural Rides*, 11, (March 1830), pp.225-8.

² Steven King & Alan Weaver, “The medical landscape in Lancashire 1700-1820”, *Medical History*, 45, (2000), pp.173-200.

³ Leonore Davidoff & Catherine Hall, *Family Fortunes - Men and Women of the English Middle Class 1780-1850*, (London, 1987), p.51.

Anglians and all the rest were “furriners”.⁴ Yet those so labelled were by no means a homogenous grouping, since there were significant differences between life in Suffolk’s towns and the countryside, and between the rich and well-born, the merchant classes and the labouring poor. There was also a clear rivalry across the county, with bishoprics for example established at Ipswich in the east and St. Edmundsbury in the west. The port inhabitants constituted distinct communities, and Neil Powell refers to “the unbridgeable gulf between those who work by the sea and the river, on the coastal strip of Suffolk, and those who work on the land, inland”.⁵ Coastal towns like Aldeburgh and Dunwich were by this time even in danger of engulfment by the sea.

There is little new published by way of modern research about Suffolk, beyond local historical reviews. Thus, this brief outline of the county from 1750 to 1830 draws heavily upon these as well as contemporary sources and aims to indicate the environment and landscape in which healthcare was delivered, suggesting a very different context from the metropolitan areas. Suffolk covered some 748,160 acres according to John Kirby in 1735,⁶ though White’s 1844 Directory stated 969,600 acres,⁷ the largest county after Yorkshire, Norfolk, Northumberland and Lincolnshire. Figure 2.1 shows the county with its main towns, large villages and turnpike roads in 1825.⁸ The Turnpike Act of 1793 had brought improvements in major routes and the census of 1831 reported the monied or professional classes travelling by coach, especially to London, in vehicles that were “well-lighted and guarded”.⁹ The road from Great Yarmouth to London had the Royal Mail coach twice a day drawn by four horses, making communications in the North East

⁴ Frederick J. Foakes Jackson, *Social Life in England - Chiefly East Anglian 1750-1850*, (New York, 1916), p.82. Lovell Lectures delivered in Boston in March 1916.

⁵ Neil Powell, *George Crabbe: an English Life 1754-1832*, (London, 2004), p.19.

⁶ John Kirby, *The Suffolk Traveller or a Journey Through Suffolk*, (London, 1764), p.1.

⁷ William White, *History, Gazetteer and Directory of Suffolk*, (Sheffield, 1844), p.13. Presumably this difference reflected a more comprehensive and scientific approach to mapping by White than Kirby.

⁸ David Dymond & Edward Martin (eds.), *An Historical Atlas of Suffolk*, 3rd edn., (Ipswich, 1999), p.126.

⁹ *Bury Post*, 9 January 1783 “from Bear Inn, Bridge Foot, Great Yarmouth, evening at six o’clock (Saturdays excepted). Also a Yarmouth and Bury St. Edmunds Coach from London every evening at the same hour (Saturdays excepted), Sunday, Tuesday and Thursday from the Green Dragon Inn, Bishopsgate St, and every Monday, Wednesday and Friday from the Bull Inn, Leadenhall St”.

part of Suffolk less problematic than further inland. Carriers were common for “parcels and passengers” alike.¹⁰

Yet in rural areas the lanes especially remained narrow, mirey or almost impassable, so that medical practitioners had difficulties in making their rounds. John Jeaffreson felt that:

“Suffolk roads were so bad that a doctor could not make an ordinary round in them in a wheeled carriage. Even in the saddle he ran frequent risk of being mired, unless his horse had an abundance of bone and pluck”.¹¹

The prevalence of foot and horse as a means of travel and the poor quality of the roads for both practitioner and patient thus determined the size of a country doctor’s practice area, creating an important difference from metropolitan or urban practice.

Pre-census contemporary population estimates differ wildly, with the two most well-known having been compiled by Sir Frederick Morton Eden and William White. In 1800, Sir Frederick Morton Eden attempted to improve on past population estimates and believed “the proposed enumeration of the people will supersede the use of ingenious guesses and plausible speculations, drawn from such data”.¹² He was clear:

“that our numbers have increased, since His Majesty ascended the throne, others can now be in little doubt. Our towns are confessedly larger and more populous than they were forty years ago... Deserted villages in Great Britain are now only to be found in the fictions of poetry”.¹³

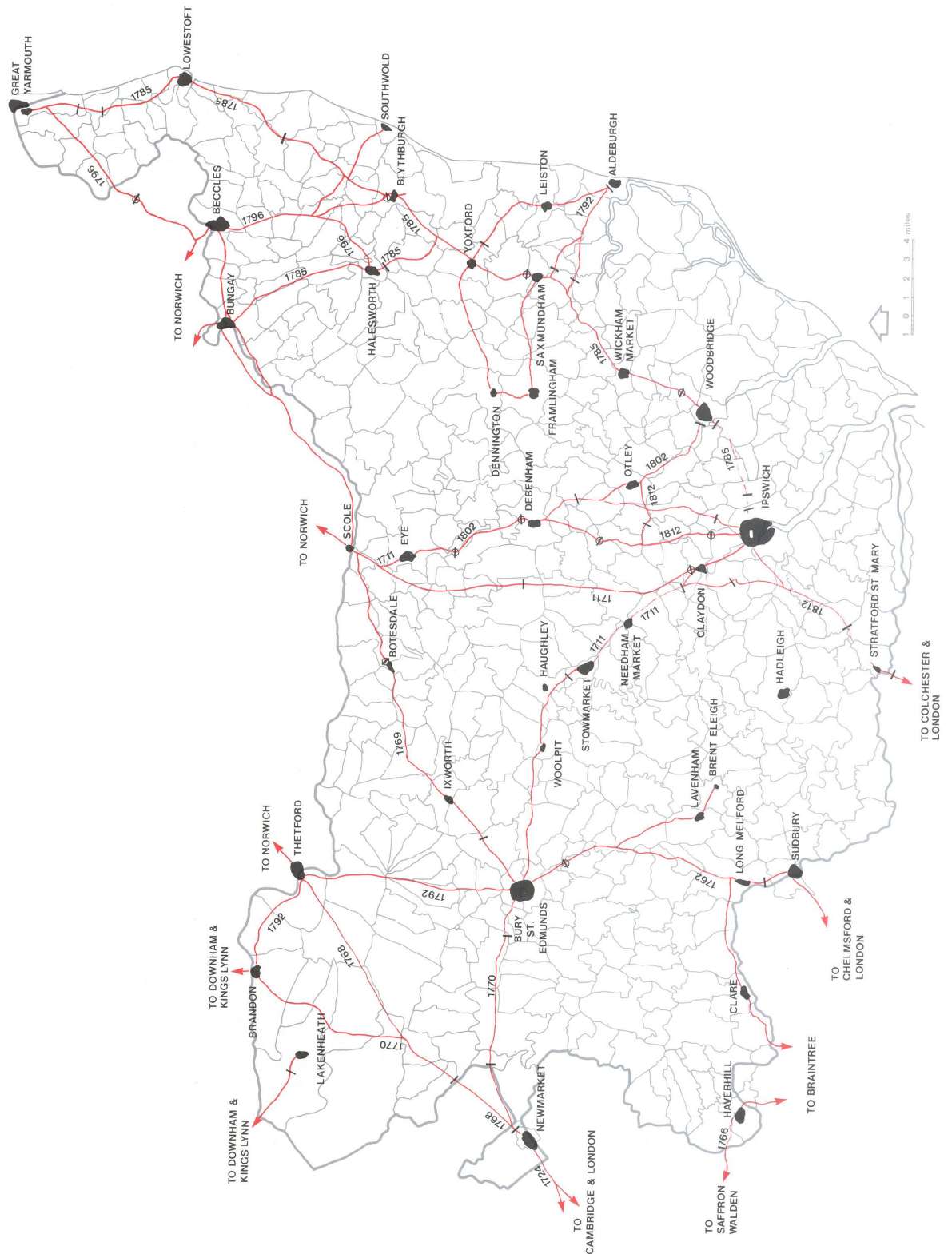
¹⁰ *Bury Post*, 11 January 1783 “Henry Fulcher, Ely and Littleport Carrier, Begs leave to inform the Public that he will set out early every Tuesday morning with a cart, from the Vine, Bury St. Edmunds, to carry Parcels and Passengers, to Ely and Littleport in the Isle of Ely, by way of Tuddenham, Frekenham, Chippenham, Fordham, Soham and Studney, and will return from Ely every Friday morning”.

¹¹ John Cordy Jeaffreson, *A Book About Doctors*, (London, 1860), p.283.

¹² Sir Frederick Morton Eden, Bart., *An Estimate of the Numbers of Inhabitants of Great Britain and Ireland*, (London, 1800), p.3.

¹³ *Ibid.*, p.48.

Figure 2.1: Map of Suffolk in 1825 Showing Main Towns and Turnpike Roads



Source: David Dymond & Edward Martin (eds.), *An Historical Atlas of Suffolk*, 3rd edn., (Ipswich, 1995), p.126.

He attributed this largely to improvements in transport and the movement of population, to increased mechanisation, inoculation against smallpox and “superior sobriety and cleanliness of the people in modern times”.¹⁴ Subsequently, White’s directories reported a population increase in Suffolk from 210,431 to 315,073 between 1801 and 1841, an increase of over 50 per cent.¹⁵ Such a rosy picture is supported by more modern estimates, showing a significant growth of 42 per cent from 152,700 in 1700 to 217,400 in 1801, out of a total population for England and Wales of 9,165,900. Comparable counties such as Norfolk showed a 34 per cent increase over the same period, while Lincoln showed twenty per cent.¹⁶ More up-to-date revisions, based on census returns, suggest a population figure of 9,061,000 in 1801 for England and Wales, and 214,000 in 1801 rising to 296,000 in 1831 and 315,000 in 1841 for Suffolk.¹⁷

There had been a pattern of higher mortality accentuated by disastrous epidemics and plague, plus bad harvests in the late seventeenth and early eighteenth centuries. However, more positive economic changes in the late eighteenth century probably led to increases in completed family size and faster population growth. For example, in Great Bradley between 1755 and 1831, the population nearly doubled from 273 to 527. The rise in the number of houses and families also illustrates the wider point, with 55 inhabited houses occupied by 70 families in 1811, and 98 houses occupied by 101 families in 1831.¹⁸ The population of Rushmere St. Andrew grew much faster than the county average between 1801 and 1831, from 287 to 568, probably reflecting the growth of the nearby town of Ipswich that itself rose from 11,000 in 1801 to 20,000 in 1831.

According to White, the number of houses in the county in 1801 was 30,805 with a 62 per cent increase to 50,139 by 1831. Ipswich, as the principal town,

¹⁴ Ibid., p.82. White also noted that there were “three females above 100 years of age!!” (p.15).

¹⁵ White, *Gazetteer*, pp.13 & 15.

¹⁶ George E. Fussell, “English countryside and populations in the eighteenth century”, *Economic Geography*, 3, (1936), pp.294-310.

¹⁷ Brian R. Mitchell with Phyllis Deane, *Abstract of British Historical Statistics*, (Cambridge, 1962), pp.8 & 20.

¹⁸ R. Stephen Ryder, “Population figures for Great Bradley during the eighteenth and nineteenth centuries”, *The Suffolk Review Bulletin*, 4, (1954), p.6.

had become a centre for the expanding corn trade, but Lowestoft was considered “a considerable large town... it is pretty well built and the chief street is paved throughout... The chief employment there is fishing”.¹⁹ Meanwhile, Bury St. Edmunds was increasingly a social capital, described by Defoe as “the Montpelier of Suffolk and perhaps of England”.²⁰

Although Colchester lay in Essex, it was a pull for middle class aspirants in Suffolk, given its relative proximity to the capital. There were 40 coaches a day to and from East London by 1820, and it was possible to be at the Bull at Aldersgate by mid-morning and return to the Essex/Suffolk border the same day.²¹ The remaining population, living in small towns and villages, often included farmers who, in the eighteenth century, tended to work for communities rather than live on their land.

Categorising the centres of populations served by surgeons and apothecaries in Suffolk is problematic. The gentry as landlords constituted a major presence in the countryside and a strong influence in the towns, where many tradesmen and professionals owed their livelihoods to aristocratic patronage. The numbers of members returned to Parliament throughout this period bore little relation to the economic, commercial, demographic or social significance of the community, because of the incidence of ‘rotten boroughs’ to distort the figures.²² The random nature of this distribution makes any comparisons between the constituencies represented invalid. Similarly, little can be gained by comparing towns that historically were corporations, as such titles bore no relation to their population size or commerce in the late 1700s and early 1800s.²³ Thus Aldeburgh, described as “a somewhat squalid little

¹⁹ Kirby, *Suffolk Traveller*, p.170.

²⁰ Daniel Defoe, *A Tour Through the Whole Island of Great Britain*, Vol. 2, (London, 1724), p.33.

²¹ Davidoff & Hall, *Family Fortunes*, pp.47-48.

²² In 1761 for instance, Suffolk was overall represented by sixteen members, two of whom were Knights of the Shire, and two each represented Ipswich, Eye, Dunwich, Orford, Aldeburgh, Sudbury and Bury St. Edmunds.

²³ Kirby also quotes Southwold “governed by two bailiffs and other sub-officers but sends no members to Parliament”, p.143; Eye was “a town corporate, governed by two bailiffs, ten principal burgesses and 24 common councilmen... It sends two members of parliament”, p.175; Sudbury was “a town corporate governed by a mayor, six aldermen, 24 capital burgesses and other subofficers. It has divers privileges and sends two members to parliament...”, p.267.

fishing town on the coast of Suffolk”, rejoiced in the dignity of a corporation and returned two members to Parliament.²⁴

Another indicator of a population centre was the holding of markets or fairs, since such places clearly had some commodity to sell or had held a charter to do so. Thus Orford, that had a market every Monday and two yearly fairs, “was certainly a much larger place formerly... and sent three ships and 62 men to the siege of Calais”.²⁵ Southwold also had:

“a tolerable market weekly, indifferently served with provisions; and two fairs yearly... It drives a considerable trade in salt and old beer; having excellent springs of good water that may be one reason why their beer is so esteemed”.²⁶

Framlingham, formerly a great centre in the fifteenth and sixteenth centuries with its magnificent church and castle, still held a weekly market with a Whitsun Fair.²⁷ However,

“it is so far removed from any thoroughfare turnpike that it has little to boast of in the way of trade, and were it not for the beauty of the church and the mouldering grandeur of the castle, it would demand little attention”.²⁸

Beccles and Bungay similarly also had weekly markets and yearly fairs, as indeed did most Suffolk towns of any size. Thus, in the west Newmarket had two annual fairs and a market, and Ixworth in mid-Suffolk could boast both a market and two annual fairs despite its small size. Woodbridge, on the other hand, a significant market town with a population exceeding 2,000, was without a corporation or a Member of Parliament.

These descriptions present a picture of a county where the population size of a hamlet or town bore little relation to its national representation, the wealth

²⁴ *The Traveller's Suffolk Directory, Containing an Alphabetical List of the Towns and Villages in the County of Suffolk*, (Beccles, 1830).

²⁵ Kirby, p.125.

²⁶ Kirby, p.144.

²⁷ Kirby quotes other towns with fairs: Yoxford - Kirby “is a very beautiful village called by way of eminence ‘the Garden of Suffolk’... there are many respectable buildings”, (p.31 of Appendix); Debenham “Here is a mean market on Fridays and a fair June 24th” (p.204); Halesworth “is a well built town... It has a considerable weekly market on Thursdays and a good fair yearly”, (p.153).

²⁸ Kirby, *ibid.*, Appendix, p.26.

of its residents, the manner of governance applied to it, nor the level and quality of services available. It also might not necessarily relate to the spread and distribution of medical services, though efforts to present ratios of population to doctor are further complicated by factors discussed more fully in Chapter 3.

One key factor in the general state of the health of the county was the economy, as the increasing population affected the demand for food, the availability of work and the incidence of poverty. Nationally lower prices and cheap food between 1730 and 1750 were not maintained in the face of an increasing population. Arthur Young, writing in the 1790s about Suffolk, suggested unrealistic expectations among the poor:

“The decrease in prices (1730-50) continued so long that a new set of commodities were now called their necessities of life and believed so to be... since 1750 the whole class is involved in great distress... the cheapness of corn from 1740-50 seems to have had a pernicious effect on the morals of the lower classes”.²⁹

However, he also noted that farms were large and enclosures caused distress.³⁰ Another contemporary writer stated that “the uniting and monopolizing of farms” led to increasing poverty that “feeds riots”.³¹ The war with revolutionary France was also a key factor in creating uncertainty and shortages.

Suffolk was predominantly an agricultural county. Weaving as an occupation had contracted because, by 1830, the woollen cloth trade had all but gone as a result of competition from mechanised industry in Yorkshire.³² Around Sudbury, some 300 men were formerly employed in the manufacture of silk, velvet, satin and bunting, and in Haverhill over 170 men and many more women and children were involved in the making of silk fabrics for parasols

²⁹ Arthur Young, *A General View of the Agriculture of the County of Suffolk 1813*, (London, 1794), p.282.

³⁰ *Ibid.*, p.279.

³¹ John Lewis, *Uniting and Monopolizing Farms, Plainly Proved Disadvantageous to the Landowners and Highly Prejudicial to the Public*, (Ipswich, 1767), p.26.

³² Thomas Baines, *An Account of the Woollen Manufacture of England in Yorkshire Past and Present*, (London, 1875), p.83. “The worsted manufacture... though for some centuries it had its chief seat in

and umbrellas. The silk and worsted mills near Bungay, Hadleigh, Glemsford and Nayland had also declined by 1800. Hemp was grown in the Waveney Valley by both farmers and cottagers, the fibres sold by sample at Diss, Halesworth, Harleston, Bungay and other nearby market towns.³³ Women and children spun this at home into yarn, bought by manufacturers and woven into Suffolk hempen, but this ancient staple also disappeared by 1830.³⁴

For some time, agricultural expansion more than compensated for these losses. From 1793 the French blockade, a contributory factor in the death of the Suffolk woollen trade, constrained grain imports that provided an impetus for farmers to switch to arable production. The eastern farms were strong on root crops interspersed with cereal and seeds associated with the four-course rotation.³⁵ Moreover, the scale of production and pull of the London markets led to advanced farming methods, such as the draining of the Eastern Brecklands, crop rotation and root vegetable growing.³⁶ Profits were golden until the early 1820s when “the cessation of the war combined with poor harvests reversed the price of corn and the less well-capitalised went to the wall”.³⁷

According to the 1831 census, 51 per cent of families in Suffolk were involved in agriculture, with 4,526 farmers employing an average of seven labourers each. Over 30 per cent were in trade, manufacture or handicraft and nearly twenty per cent engaged in professional pursuits or unemployed.³⁸ As for

Norfolk, Suffolk and Essex, has now obtained a remarkable concentration in the West Riding of Yorkshire”.

³³ Kirby, *Suffolk Traveller*, Appendix, p.18.

³⁴ Margaret Meek, “The hempen cloth industry in Suffolk”, *The Suffolk Review*, 2, (1960), pp.82-84.

³⁵ A method of agricultural organisation established in Norfolk and in several other counties before the end of the 17th century; it was characterised by an emphasis on fodder crops and by the absence of a fallow year, which had characterised earlier methods. In the Norfolk four-course system, wheat was grown in the first year, turnips in the second, followed by barley, with clover and ryegrass undersown, in the third. The clover and ryegrass were grazed or cut for feed in the fourth year. The turnips were used for feeding cattle and sheep in the winter.

³⁶ William & Hugh Raynbird, *The Agriculture of Suffolk*, (London, 1849), pp.7-25.

³⁷ Davidoff & Hall, *Family Fortunes*, p.44.

³⁸ According to White, *History, Gazetteer and Directory of Suffolk*, p.16, there were 1121 farmers who did not employ labourers, 2228 capitalists, bankers, professionals, 5336 labourers in handicraft, and 676 in manufactures. Male domestic servants over the age of twenty numbered 1342 and 690 were under twenty. Female servants of all ages numbered 11483. Taking Great Bradley as an example, in 1811, 55 families were occupied chiefly in agriculture; none were in trade, and fifteen in manufacture and handicraft. By 1821, the number in agriculture had risen to 87, a rise of some 58 per cent, but there were still none in trade and the number involved in manufacture and handicraft

associated industries, Leiston and Ipswich had become centres for the manufacture of agricultural implements and machinery, and Ipswich, Thetford and Bungay had extensive paper mills. Malting was widely carried out, and herring and mackerel fishing gave employment to hundreds of men and boys.

Information on bankruptcies suggests the relative stability and confidence of the Suffolk economy, at least at gentry level.³⁹ *The Gentlemen's Magazine* published lists of bankrupts for the country as a whole, and in the period 1731 to 1770 bankruptcies rose nationally, but there was a steady decline in Suffolk. From 1731 to 1781, 160 Suffolk men and women went bankrupt, including a dozen or so medical practitioners.⁴⁰ There was a regular seasonal pattern to the bankruptcies, with winter peaks and harvest lows. This could have been due to many factors, not least that agriculture as an industry was relatively less volatile than more commercial activities, and therefore the very dependency of Suffolk on farming, along with improved land and water transport, may have been a benefit. Also, the growing importance of London meant there was a developing market for farmers and merchants, and improvements in farming methods made the industry more economic in terms of yield per acre. Suffolk's coastal traffic included corn, barley malt, butter and cheese, exported through Yarmouth, the Alde, Woodbridge, Ipswich and the Stour.

Not surprisingly, Ipswich had a fifth of Suffolk failures, with merchants, corn merchants and linen drapers worst affected. Bury St. Edmunds, as the next commercially important centre, had almost one tenth of the total, with victuallers and inn holders the most common. Four of Bury St. Edmunds' bankrupts were connected with the wool trade and were reflected in the number of bankruptcies associated with its demise south of Bury St. Edmunds around Lavenham and Ipswich.

had fallen to ten. Ten years later, the agricultural families remained fairly static at 84, but with seventeen now in manufacture and handicraft.

³⁹ A.G.S. Jones, "Suffolk bankruptcies in the eighteenth century", *The Suffolk Review*, 2, (1959), 1, pp.4-10.

⁴⁰ Chapter 8 gives more information on these.

At the other extreme, William D. Rubinstein's study of Victorian wealth found no Suffolk millionaires or half millionaires before 1850 and only four of his "lesser wealthy" came from East Anglia. This is not altogether surprising, as the key wealth-making areas were associated largely with commerce and finance in London, and industry and manufacture in the north and Midlands.⁴¹ Thus the emerging picture is of a very rural county, heavily dependent on good harvests and steady wheat prices, but relatively stable because of the network of county families and estates that provided a strong framework of support when the economy took a downturn. This emphasis on agriculture and related industries provided a solid and relatively safe source of income, albeit vulnerable to seasonal influences, creating a social structure in which those providing medical services could largely flourish.

2.2 The Social Structure

According to Davidoff and Hall:

"large sections of professionals and merchants in London differed from manufacturing families in the Midlands or the market tradesmen and solicitors of Suffolk or the farmers they served".⁴²

Suffolk's social structure comprised a few great families with large estates (such as Sotterley Hall and Hevingham Hall), lesser gentry (such as Dudley North at Little Glemham and Richard Powys at Hintlesham), a middle class of gentlemen and professionals and increasingly of merchants and successful tradesmen, the labouring poor, and lastly the workhouse poor.⁴³ The main difference between the aristocracy and the middle classes was that the former could rely on income from estates offices and agricultural rents, whereas the latter had actively to seek an income.

Those deemed the labouring classes might be in work, but nevertheless could be earning very low incomes, sometimes as little as one shilling a day through

⁴¹ William D. Rubinstein, "The Victorian middle classes: wealth, occupation and geography", *Economic History Review*, 2nd Series, 30, (1977), 2, pp.602-623. Moreover, more than half of Britain's middle class income in 1812 was generated in London.

⁴² Davidoff & Hall, *Family Fortunes*, p.20.

⁴³ The Earl of Bristol at Ickworth and the Duke of Grafton at Euston were the presiding aristocrats of Suffolk society in the eighteenth century.

often very irregular work. Between 1740 and 1800 Suffolk experienced popular disturbances associated with poor harvests, high prices and food shortages. 'Scarcity' or food riots were almost always in the larger towns like Hadleigh in 1757 and Long Melford, Ipswich, Needham and Woodbridge all in 1766. A typical example was Bury St. Edmunds' disturbances of 11-15 April 1772, in which the crowd forced a carpenter, who had hoarded wheat and local farmers to sell at four shillings a bushel, and millers to sell flour at eighteen pence a stone.⁴⁴ The price of butter and cheese rose rapidly during the 1790s and, by 1795, William Goodwin noted that many working people were in a starving condition, so much so that people had no money to spend at the Earl Soham Fair.⁴⁵ Although the French wars had raised profits from farming and commerce, the price of bread soared and the position of the labouring and workhouse poor worsened. Given Suffolk's reliance on farming, large proportions of the population were thus particularly hard hit and the vulnerability of the population to seasonal influences was often greater than in more diversified areas.

Until the late eighteenth century, marketplaces and prices could be controlled by magistrates. Occasionally the state of the poor and their protests prompted charitable actions with the church, parish officers and gentry buying in food for the poor. For example, from January to March, a soup kitchen in Ipswich provided over 46,000 meals to upwards of 1,000 families. In the same year, the Rev. Dr Tanner of Hadleigh bought ten combs of wheat, ordering his churchwardens to do the same, and sold them to the poor at four shillings a bushel in the marketplace.⁴⁶ Similarly, in January 1795, St. Matthew's parish officers in Ipswich raised a subscription for 91 families or 313 poor.

⁴⁴ Frank Grace, "Food riots in Suffolk in the eighteenth century", *The Suffolk Review*, 5, (1980), pp.32-46.

⁴⁵ George E. Fussell, "Earl Soham Fair in George 111's reign", *The Suffolk Review Bulletin*, 8, (1956), pp.3-5.

⁴⁶ W.A. Jones, *Hadleigh Through the Ages*, (Ipswich, 1977), p.86. Hadleigh suffered none of the disturbances that occurred in other parts of Suffolk during the 1760s and 1790s because of the action of some of the town's leaders. Mr Reeve gave to the poor a fat bullock, which relieved nearly 800 people, and in 1800 the parish books show special additional allowances of flour.

However, there were less sympathetic responses. William Goodwin reported in 1795 that:

“a very large body of men and women assembled at Diss, complaining of the dearness of Provisions and their urgent necessities. - The Magistrates assembled and call'd out Capt. Maynard's troop of Yeomanry Cavalry, read the Riot Act and dispers'd them with fair but empty words - no mischief of any kind occur'd”.⁴⁷

More helpful to the poor were the clergy, such as the Rev. Richard Frank in 1800 at Woodbridge, who raised subscriptions for prosecutions, passed resolutions to ask dealers to fix prices, and offered rewards for information about market offences. Medical practitioners did not appear among the subscribers of charitable lists, possibly because their contributions came in kind, or because they simply were not interested or did not see themselves in the rank of those that ‘did good’. Anne Crowther makes a rather harsh judgement in suggesting that medical practitioners did not see sick paupers as worth investing time and money in, as they were not likely to become prospective paying patients.⁴⁸ Another possibility is that practitioners were not singularly medical folk, but professionals, ratepayers and business men who shared prevalent views concerning the unworthiness of the poor.

The other effect of the riots was to conjure up the spectre of the French Revolution in the minds of frightened property owners. As the news at the end of the eighteenth century from across the Channel became more alarming, “the radicalism of these sections of the middling ranks ebbed as fears for property grew”.⁴⁹ In coastal counties like Suffolk fear of invasion was rife, while associations such as “The Preservation of Peace and the Protection of Private Property”, set up in Ipswich in 1800 as a voluntary vigilante group, reflected confidence in the militia, magistrates and narrow domestic concerns.⁵⁰

⁴⁷ William Goodwin, *Diaries at Earl Soham, 1746-1816*, entry for 20 October 1795, SRO Ipswich, HD 365/1-3.

⁴⁸ M. Anne Crowther, “Paupers or patients? Obstacles to professionalization in the poor law medical service before 1914”, *Journal of the History of Medicine and Allied Sciences*, 39, (1984), pp.33-54.

⁴⁹ *Ibid.*, p.18.

⁵⁰ George R. Clark, *History and Description of the Town and Borough of Ipswich, Including the Villages and County Seats in its Vicinity*, (Ipswich, 1930), p.160.

Although little is known of the life of farm labourers in Suffolk, William Goodwin's diaries described the annual fairs, one of the few holidays in the year, albeit in a thoroughly disapproving tone. Thus, in 1785 the Earl Soham fair was "full and very gay"; the two pubs took about £70 each and 33 private houses two pounds each on average,

"which together amounts to £136 spent for eating and drinking to which adding ye loss of time of Servants and Labourers and the money spent for shows, fruit and trash and the Evil of Fairs will be continuous".⁵¹

The labouring poor had to pay for any medical treatment and to do so they needed to be able to save for their healthcare if they were to avoid the workhouse. Forms of saving and insurance began to appear, notably parish banks. One Suffolk example was the 'savings bank' established by Mrs Priscilla Wakefield in Tottenham and then in 1768 in Ipswich. Her 'frugality banks' were confined to the labouring classes, aiming to provide a safe and profitable place of deposit for their savings, with payments made monthly.⁵²

Friendly Societies and benefit clubs had existed since the late seventeenth century and during the last forty years of the eighteenth century their numbers increased significantly. These were unlike the 'top down' banks and were often 'front' organisations for unionised labour, illegal until 1799. Sir Frederick Morton Eden, visiting 38 counties at the end of the eighteenth century, noted that 100 communities out of 165 had at least one Friendly Society, providing healthcare and insurance, though their distribution was uneven and differed between urban and rural parishes.⁵³ The 1804 Abstract of Returns showed that Suffolk had over 300 such societies, and their 11,559 members constituted the seventh highest membership in the country, due largely to the effects of losing staple industries like wool.⁵⁴ Of these more than half were in villages, partly through little demand from townsfolk and

⁵¹ Goodwin, *Diaries 1746-1816*, entry for 20 April 1788.

⁵² John Clyde, *The New Suffolk Garland*, (Ipswich, 1866), p.60.

⁵³ Sir Frederick Morton Eden, *The State of the Poor or a History of the Labouring Classes in England*, (London, 1797), 1, Preface, p.xxiii.

⁵⁴ *Abstract of Returns Relative to the Expenses and Maintenance of the Poor, Presented to the House of Commons, 1804*.

partly because local landowners and worthies promoted them.⁵⁵ In Uggheshall and Sotherton, a Parish Bank was established sometime before 1830 by the Rev. T. Sheriff for the benefit of the poor:

“to open to the lower orders a Place on Deposit for their Small Savings with the Allowance of a Monthly Interest at the rate of 5 per cent and with full Liberty of withdrawing their Money at any Time”.⁵⁶

Since it was difficult for labourers to afford an apothecary's fees, it was not surprising to see a growth in such enterprises. At first these generally addressed sickness and funeral payments, and did not provide for medical attendance. According to the rules of the Ufford New Friendly Society:

“every person who enters himself into this Society shall be in perfect health and not exceed the age of 35 years; and every person shall pay three shillings and sixpence entrance money, sixpence of which is to be spent and three shillings to go into the box...

...if he happens to be sick, lame or blind and thereby rendered incapable of working at his trade or calling, he shall... receive seven shillings and sixpence a week during that illness if it continues not above six months... after the death of any member of this society there shall be paid forty shillings by the stewards out of the chest towards the funeral charges to the widow, friend or relation”.⁵⁷

However, medical care was increasingly provided by Friendly Societies through “expense by local surgeon and apothecary usually on a per capita basis including his travel costs”.⁵⁸ Some were of varying standards, particularly in the early years, as the preamble to the West Suffolk Friendly Society acknowledged:

“These clubs have been ill managed, and a large portion of their funds wasted in needless expenses, sick members have been grossly defrauded of those very benefits for which they had subscribed. In others all the money has been lost by the breaking or dishonesty of the Keeper of the Box”.⁵⁹

⁵⁵ Peter Clark, *British Societies and Clubs 1580-1800 - the Origins of the Associated World*, (Oxford, 2000), p.374.

⁵⁶ *Rules of Uggheshall and Sotherton Parish Bank*, Suffolk Papers, 1304 ml. No date but around 1810-1920. A similar bank in Blything 1818 “to open to the lower orders a Place of Deposit for their small Savings with the Allowance of a Monthly interest at the Rate of five per cent”.

⁵⁷ *Rules and Orders for the Government of the Ufford New Friendly Society*, 4 January 1803, Suffolk Papers, BL 10351i10, J.

⁵⁸ Irvine Loudon, “The nature of provincial medical practice in eighteenth century England”, *Medical History*, 29, (1985), 1, pp.1-32.

⁵⁹ *Rules of the West Suffolk Friendly Society*, SRO (Bury St. Edmunds), GF 502/1.

Later in the period under review here, protection also began to be provided by nationally federated bodies such as the Oddfellows which, while often viewed with some suspicion, clearly filled a gap in relief for the lower paid.⁶⁰ The Lodge of Independent Oddfellows stated that “No illiberality, no cursing, no swearing, or political arguments were allowed, loyalty, humanity, and benevolence are the foundations on which the Order has been raised”. It described how a member “having sunk beneath the bounds of fortune, humbly submits to” the director and assistant for relief.⁶¹

For those with no work or ability to gain employment, the only recourse was parish charity. Whilst Parliament was willing to legislate against beggars and vagabonds, the genuinely needy were left to the goodwill of individuals and charities and Poor Law relief was little different in the eighteenth century than the sixteenth century.⁶² The key eighteenth century change was that, after the Act of 1722, paupers were meant to seek admission to the workhouse to try to reduce the demand for places, and the ‘farming out’ of the administration of the workhouse to a third party was allowed.⁶³

Attempts to encourage individuals to maintain themselves and their dependants sought to take the strain off the Poor Law provisions, but those unable to work were dependent on the parish for relief. As bread and potatoes rose steadily in price, there was considerable fear of the poorhouse, though recurrent bad harvests threw many into seeking parish relief. The Industrial Revolution and the consequent move of the young and healthy to towns meant an increasing imbalance between the rate-paying providers of Poor Law services and the needy paupers that was not recognised fully until the 1834 Poor Law, if then.

⁶⁰ The Oddfellows Friendly Society, formed in 1810, is one of the oldest, not for profit, friendly societies in the country.

⁶¹ *Book of the Laws of Brandon Loyal St. George Lodge of Independent Oddfellows*, SRO (Bury St. Edmunds), GF500/1.

⁶² David Dymond & Peter Northeast, *A History of Suffolk*, (Chichester, 1985), p.84.

⁶³ Workhouse Test Act (9 Geo. 1, C.7) 1722-3 for amending the Laws Relating to the Settlement, Imployment and Relief of the Poor, alias the Knatchbull Act, after the politician largely responsible for its passage. This Act was repealed in 1796.

The first Suffolk parish workhouses were in Ipswich (1551) and Hadleigh (1577), with Parham among the last towns to found one in 1822.⁶⁴ All were based on the three elements of bringing up children industriously, offering work where possible, and providing materials for the poor able-bodied. One overseer, writing from Harleston in Norfolk in 1786, felt that:

“the improvement of the morals of the lower class of people should therefore not only be the first but the greatest object to be attempted by those who wish to promote the reformation of the poor”.⁶⁵

The aim therefore was both to provide a safety net for the ‘deserving poor’ and to show to the rest of the community what happened to those who failed to meet these standards. Use was made of bequeathed premises: James Vernon of Barnardston left his farm for use as a workhouse in 1747 and William Bearman of Woodbridge similarly left premises in the town. Often it was economically beneficial to have premises outside the town, as at Saxmundham in 1791 or at Boxted where land was identified as “on the waste”, the poor also being out of sight and, in terms of disease, separated from the local community.⁶⁶

Despite reasonable initial success in containing the costs of poverty, mid-eighteenth century concern at the numbers in need of relief grew. Suffolk was something of a pioneer county in tackling this and large groups of parishes merged to form ‘Incorporations’ based largely on the old administrative unit, the ‘hundred’.⁶⁷ It was also the first county to build enormous workhouses,

⁶⁴ Both towns had set aside buildings for this use by 1575, and Hadleigh was used as an example of what could be achieved. Parham became a temporary refuge for the aged poor from Framlingham Workhouse until a new Union building was constructed at Wickham Market in 1837. Parham *Loan Agreement for Workhouse Construction*, SRO (Ipswich), FC 110/G5/1&1.

⁶⁵ Edmund Gillingwater, *An Essay on Parish Workhouses: Containing Observations on the Present State of English Workhouses With Some Regulations Proposed for Their Improvement*, (Bury St. Edmunds, 1786), p.5. Gillingwater was Overseer of the Poor at Harleston.

⁶⁶ Ray Whitehand, *At the Overseer's Door: the Story of Suffolk's Parish Workhouses*, (Saxmundham, Suffolk, 2007), p.23.

⁶⁷ A hundred was the division of a shire for administrative, military and judicial purposes under the common law. All hundreds were divided into tithings that contained ten households. Below that, the basic unit of land was called the hide, that was enough land to support one family. Above the hundred was the shire, under the control of a shire-reeve (or sheriff). Hundred boundaries were independent of both parish and county boundaries, although often aligned, meaning that a hundred could be split between counties (usually only a fraction), or a parish could be split between hundreds. Over time, the principal functions of the hundred became the administration of law and the keeping of the peace and, although never formally abolished, were overtaken by counties by the nineteenth century as the most stable local government unit.

known as Houses of Industry, with twelve established between 1756 and 1790, holding from 300 to 500 inmates. The underlying rationale for these was linked to the Houses of Correction, with those seemingly unwilling or unable to work identified as semi-criminals. As Edmund Gillingwater presented it, "Ignorance seems to be the distinguishing characteristic of the English Poor".⁶⁸ Much of eastern Suffolk followed the example of Colneis and Carlford, the first incorporation to build its House of Industry in 1756: Samford, Mutford and Lothingland followed in 1763; Blything and Wangford in 1764; Loes and Wilford in 1765; Bosmere and Clayton in 1766; Stow in 1778; and Cosford in 1780.

However, this development was not consistent over the whole county. Of 179 known Suffolk parishes that adopted workhouses, only nineteen were directly affected by incorporations. For example, Plomesgate remained unincorporated, and here parishes created their own workhouses until the 1834 Act.⁶⁹ Mildenhall Workhouse came in for particular praise from Edmund Gillingwater, the overseer at Halesworth and an advocate of the system. He wrote:

"The Workhouse which principally merits our notice is at Mildenhall in Suffolk... if all our parishes were as careful to provide cleanliness and industry in their own Workhouses as there is observed in this, there would have been no occasions for parishes uniting in Houses of Industry for a whole hundred".⁷⁰

Houses of Industry were not universally accepted, particularly by the poor themselves, as they often meant inmates were a long way from home, and riots were not uncommon. The *Ipswich Journal* described the violent reactions of the poor in 1765 to the building of large workhouses in the incorporated Hundreds of Colneis and Carlford, Blything and Wangford, and Loes and Wilford. The new workhouses were distant and intimidating: the Cosford House of Industry, for example, served Kettleburgh and Hadleigh, and that at Blything served the four towns of Blythburgh, Leiston, Yoxford and Peasenhall, and they were under the control of specially appointed masters.

⁶⁸ Gillingwater, *Parish Workhouses*, p.7.

⁶⁹ Whitehand, *Overseer's Door*, p.12.

⁷⁰ Gillingwater, *Parish Workhouses*, p.21.

Rioting at Wickham Market on 1 August 1765 culminated in the destruction of the workhouses at Bulcamp, and confrontations at Nacton involved about 200 rioters and magistrates, supported by a party of Dragoons from Ipswich. The seriousness of the protest was indicated by the required support of the military to quell it, the rioters reportedly “resolved... they should be maintained in their own parishes”, that they had “come to fight for their liberties”, and that they intended to proceed from their attacks on the workhouses to “reduce the price of corn or pull down all the mills about”.⁷¹ George Crabbe summed up the situation when he described a House of Industry:

“It is a prison with a milder name,
Which few inhabit without dread”.⁷²

Incorporation was not adopted in most parts of the country, although Norfolk followed to some degree, not least because of the great social uncertainty and volatility during and after the French Revolution, and it was not until the 1830s that the bourgeoisie felt confident enough to tackle the issue of the poor again.

In the workhouse, the lay governor or manager held the most important position and the post was often contracted out, assuming responsibility for all aspects of administration, including financing and maintaining inmates, and employment.⁷³ The medical officer had a secondary role, even though epidemics, sickness and childbirth made constant demands. Parish overseers of the poor in the eighteenth century did not always use established surgeons and apothecaries, but sometimes employed empirics, quacks, bone-setters and other irregulars. Their main concern was to ensure the bills did not include too many extras (such as food or alcohol), and Anne Crowther believed it was likely that economy led them to employ whoever would accept the lowest fee.⁷⁴ Chapter 8 gives more details of the place of Poor Law

⁷¹ Edwin Alvis Goodwyn, *A Century of a Suffolk Town - Beccles 1760-1860*, (Ipswich, 1968), p.112.

⁷² George Crabbe, *The Borough - Letter XVIII: The Poor and Their Dwellings*, ll., pp.117-119, *The Complete Poetical Works of George Crabbe*, edited by Norma B. Dalrymple-Champreys & Arthur Pollard in three volumes, (Oxford, 1988).

⁷³ Whitehand, *Overseers' Door*, p.40.

⁷⁴ Crowther, “Paupers or patients?”, p.36.

activity in the income of practitioners, but full-time Poor Law medical employment was extremely rare and for many practitioners such work was merely a sideline.

2.3 Changing Morbidity and Attitudes to Illness

The third element of the Suffolk context was that of changing morbidity and attitudes to illness. It would be tempting to ascribe population changes to developments in medical care and/or the level of general practitioner services available during the period, but the evidence does not support that proposition. Population growth derived primarily from an improving birth rate rather than from a falling death rate, reflecting features such as earlier marriage and the beginnings of some notions of hygiene. Indeed, apart from efforts to prevent smallpox, only marginal inroads were made in effective medical care for the generality of conditions.⁷⁵ There were major improvements in the techniques and diagnostic skills of medical practitioners between 1750 and 1830, no doubt provoked to some degree by the changing morbidity. However, inevitably modern histories of medical advances have focused on the major cities (Edinburgh and London) where the greatest developments took place. In this period, Suffolk had no major cities or great seats of learning or power and it had no medical ‘clusters’, hospitals or teaching facilities of substance before 1826 when the Suffolk General Hospital at Bury St. Edmunds was founded. This provides an important context that may help to explain how and why its medical practitioners do not appear to exhibit the same characteristics as many of their metropolitan colleagues. Nevertheless, evidence from Suffolk shows that in the provinces and rural counties there was a level of sophistication and use of medical techniques that is not always recognised.

Life threatening illnesses were rife in the period 1750-1830. Amanda Vickery refers to London experience as “waxing dramatic on the infections swirling in the air”,⁷⁶ with smallpox, dysentery and enteric fever recurrent. In 1790,

⁷⁵ Roy Porter, *Disease, Medicine and Society in England 1550-1860*, (Basingstoke, 1987), p.12.

⁷⁶ Amanda Vickery, *The Gentleman's Daughter: Women's Lives in Georgian England*, (London, 1998), p.121.

fever was a common diagnostic tag, with doctors seeing it as a disease in itself rather than a sign of an underlying condition. It accounted for almost a quarter of all mortality between 1774 and 1793 in some London parishes.⁷⁷ Contagion was a continuing concern for all parents and epidemics of dysentery, cholera, enteric fever, spotted fever, putrid fever, consumption and smallpox scourged towns and cities, and diphtheria and typhus raged in winter. These, together with the high death rate in childbirth of women and the rate of infant mortality, made life uncertain. However, such infections were believed to be far less common in the country, another reason for assuming that country doctors were less sophisticated in handling population disease.

In spite of this perception however, disease also scythed through the provinces and instances of fever were not uncommon in the countryside. Cholera was found in a family in Wickhambrook by J. Dunthorn (1791-1856), surgeon of that parish in 1832, and four of the nine patients died. Joshua Smith (1792-1818), a surgeon of Bury St. Edmunds, caught typhus, presumably from a patient, and died aged 26 years. William Goodwin (1746-1815) reports a surgeon of Earl Soham dealing with malignant contagious fever in 1802. "The most prevailing epidemics for the last twelve months have been *typhus maligna* and *mitior*, *scarlatina anginosa*, measles and mumps".⁷⁸

Until the eighteenth century, although sickness was seen partly as the result of external forces such as 'foul airs' and predispositions including inherited risks and features, it was also seen as something personal and internal and the result of God's purpose for the individual, and thus to be endured. The services of professionally trained doctors were generally expensive and difficult to access for the majority of the population, especially in the provinces, and therefore it can be assumed that much morbidity was untreated and unrecorded. Even when patients did pay for medical help, learned physicians recommended relatively non-medical remedies to patients, such as riding, a change of air or diet, or a trip to the waters. This was the

⁷⁷ William Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, (Cambridge, 1994), p.21.

⁷⁸ William Goodwin, "Epidemics and contagious fevers", *Medical Physics Journal*, 9, (1802), p.509.

classical *regimen sanitatis* and frequently little more than the advice available from the family, or local healers and herbalists.⁷⁹ Surgeons on the other hand provided a 'fixing' type of medicine, and limited and usually painful treatments for acute episodes. Apothecaries, also fixers in their own way, provided potions and pills of varying efficacy.

However, the Age of Enlightenment, the success of science and Newton, influenced many disciplines and meant that the medical theories that were developed in the eighteenth century were no longer based on the four humours of the Greeks but on chemistry and science. The concepts of levers and pulleys, in other words engineering, were being looked at in relation to anatomy, chemical and biological discoveries on digestion, even eventually the impact of electricity on disease.⁸⁰ Ivan Illych maintained that doctors began to believe they could conquer age and attack death itself, a statement that does not entirely reflect the opposing contemporary belief that the doctor's job was not to maintain life at all costs.⁸¹ Indeed, Roy Porter maintains that well into the nineteenth century doctors were only marginally involved with death, if at all.⁸²

It is true that the theories at this stage were part of a search for a full understanding of the body and a matching medical system but, as Andrew Wear puts it, the human soul was abolished and a programme of reducing medicine to physics was underway.⁸³ The role of medicine was to re-establish lost health by dealing with the 'contra-naturals', meaning diseases, their symptoms and their causes.⁸⁴ New medical theories and new systems of classifying diseases replaced each other with startling rapidity, and despite a lack of effective cures, there was still hope that progress in medical theory

⁷⁹ Harold A.L. Cook, "Good advice and little medicine: the professional authority of early modern English physicians", *Journal of British Studies*, 33, (1994), pp.1-31.

⁸⁰ A sketch or short description of Dr Graham's medical apparatus erected about the beginning of the 1780, which claimed the cure of disease. Although largely an advertisement, it nevertheless illustrates early understanding of 'electrical ethos'. *BL Tracts*, 821.

⁸¹ Ivan Illych, *Limits to Medicine*, (London, 1976), pp.189-91.

⁸² Roy Porter, "Death and the doctors in Georgian England", in Ralph Houlbrooke (ed.), *Death, Ritual and Bereavement*, (London, 1989), pp.77-94.

⁸³ Andrew Wear, "Introduction", in Andrew Wear (ed.), *Medicine in Society: Historical Essays*, (Cambridge, 1992), pp.1-12.

would eventually have practical results. Christopher Lawrence points out that regardless of the introduction of any type of anaesthetic, early nineteenth century surgeons were expanding their operative skills, often requiring protracted periods on the bench and frequently for ‘conservative’ purposes (meaning ‘preservative’), on the basis that an early operation saved tissue from excision later.⁸⁵

By the eighteenth century there was still no sign that lay people and patients entrusted their care entirely to professionals - medical authority was often uneasily received, and the availability of medicaments fostered people’s involvement in their own care. Self-medication was part of a comprehensive lay medical culture, and John Wesley was a leading proponent of ‘do it yourself’ healing.⁸⁶ Indeed, Porter states that:

“Because personal and professional healing were essentially complementary rather than in competition with each other, the massive extension of orthodox and commercial medicine into the nineteenth century actually augmented lay medical culture and self-medication”.⁸⁷

An increasing literature of self-care and self-cures by the late eighteenth century was often written by doctors.⁸⁸ These were published with mixed motives, as often such works were linked to particular medicines, and successful home-cure books added to reputation and reward. For example, William Buchan recommended an extensive range of medicaments, including cream of tartar, gum camphor and seneka root.⁸⁹

⁸⁴ Gunter Risse, “Medicine in the age of the enlightenment”, in Andrew Wear (ed.), *Medicine in Society*, pp.149-195.

⁸⁵ Christopher Lawrence, “Democratic, divine and heroic: the history and historiography of surgery”, in Christopher Lawrence (ed.), *Medical Theory, Surgical Practice: Studies in the History of Surgery*, (London, 1992), pp.1-36.

⁸⁶ John Wesley, *Primitive Physics*, (London, 1747).

⁸⁷ Roy Porter, “The patient in England c.1660-c. 1800” in Andrew Wear (ed.), *Medicine in Society*, pp.91-118.

⁸⁸ James Parkinson, a surgeon and apothecary in Hoxton, published *Medical Admonitions* in 1799, which was addressed to lay readers and was a synopsis of the standard medical practice at the turn of the century.

⁸⁹ William Buchan, *Domestic Medicine or the Family Physician*, (Edinburgh, 1769), p.184. Wesley’s *Primitive Physic* was a good example of lay publications, recommending for example wild parsley seeds for gravel.

Gunter Risse argues that medical practice was still about magic, care and confidence, and that for many, particularly away from the heady excitement of the metropolis, “sickness remained a mysterious, often unpredictable and mostly unavoidable event, the result of blind fate or divine punishment”.⁹⁰ However, the evidence from Suffolk included considerable developments in the operation and teaching of anatomy and therefore diagnosis, extensive treatments (including some heroic surgery), and a wide range of pills and potions of mixed efficacy. There was more use of modern and developing techniques in the provinces than may have been realised.

In general, medicine remained an essentially practical discipline with great stress on communication and reportage. Surgery was largely concerned with external medicine, what the surgeon could see or feel and therefore treat. Notwithstanding William Harvey’s early seventeenth century discovery of the circulation of the blood, and despite the fact that Loeuwenhoek had seen organisms through one of his microscopes, Alfred Hill maintains that in both town and country, “eighteenth century medical knowledge was medieval medical knowledge”.⁹¹ Penelope Corfield argues that at this time symptoms were much better understood than causes, with people seeking relief of symptoms above all.⁹² An example from Suffolk illustrates the point. Dr Richard Langslow {1790-1812}, reporting the case of master Day of Yoxford, described his initial symptoms in some detail - “strong symptoms of pyrexia, namely a full and hard pulse, violent excruciating pains in his back, hips, knees and legs, rigors, alternating with heats, and his tongue white and foul”.⁹³ Langslow’s diagnosis, following his detailed statement of symptoms, was “a true inflammatory rheumatism” - he proved to be wrong in this initial diagnosis, though later he went on to diagnose correctly an abscess or tumour.

⁹⁰ Risse, “Medicine in the age of the enlightenment”, pp.149-195.

⁹¹ Alfred W. Hill, “Provincial medical practice in England 1730-1815”, *Journal of History of Medicine*, (1964), pp.165-236.

⁹² Penelope Corfield, *Power and the Professions in Britain 1700-1850*, (London, 1995), p.139.

⁹³ Richard Langslow, *The Case of Master Day of Yoxford*, Local Pamphlet 19, (1799), SRO (Ipswich), p.15.

However, diagnosis formed a relatively small part of the teaching of surgery in London and the provinces, as discussed in Chapter 4. One major reason for this was the lack of anatomical understanding, and the slow development of anatomy and dissection as part of increasing the understanding and cause of disease. Part of this was due to the need for cadavers and the bad odour into which the provision of bodies fell during the late eighteenth and early nineteenth centuries. Henry VIII had granted the Company of Barber-Surgeons an annual right to the bodies of four hanged felons, thus bringing about “the recognition in law of dissection as a punishment, an aggravation to execution”.⁹⁴ However, for William and John Hunter, the gallows were not a sufficient source, and hospital anatomists benefited directly from the high mortality rate in hospitals. Ruth Richardson claims that “the illicit process of appropriation of the dead hospital poor was widely adopted... Coffins buried in the graveyards of the major London charitable hospitals were often empty”.⁹⁵

The illegal means of acquiring cadavers before the passing of The Anatomy Act in 1831 aroused widespread horror. Dead bodies were hard to come by and body snatching became an infamous industry, with an adult male corpse fetching at least four guineas in 1811.⁹⁶ George Crabbe nearly found himself in front of the Lord Mayor as a resurrectionist:

“His landlady having discovered he had a dead child in his closet, for the purposes of dissection, took it into her head that it was no other than an infant whom she had the misfortune to lose the week before. ‘Dr Crabbe had dug up William, she was certain he had; and to the Mansion House he must go’. Fortunately the countenance of the child had not yet been touched with the knife. The ‘doctor’ arrived when the tumult was at its height and, opening the closet door, at once established the innocence of the charge”.⁹⁷

Sir Astley Cooper stated to the Select Committee on Anatomy in 1828 that “there is no person, let his situation in life be what it may, whom, if I were

⁹⁴ Ruth Richardson, *Death, Dissection and the Destitute*, (London, 1987), p.32.

⁹⁵ *Ibid.*, p.104.

⁹⁶ James Bailey Blake, *The Diary of a Resurrectionist 1811-1812*, (1896), pp.139-151, Library of Royal College of Surgeons quoted in Joan Lane, *The Making of the English Patient - a Guide to Sources*, (Stroud, 2000), pp.8-13.

⁹⁷ Rev. George Crabbe, Jnr., *The Poetical Works of George Crabbe with his Letters and Journals and his Life*, (London, 1834), p.32.

disposed to dissect, I could not obtain”.⁹⁸ Indeed, Ruth Richardson asserts that “by 1828 (if not before) the position had been reached at which the bodies of the poor had become worth more dead than alive”.⁹⁹ Although in the provinces and especially in rural areas at a distance from an anatomy school exhumation was easier, suitable bodies still tended to go to London, rather than to any local facilities.¹⁰⁰ This would support an argument that country practitioners were prevented from practising diagnosis through this means. Ready cadavers were rarely available outside of the big towns such as Ipswich and Bury St. Edmunds. Moreover, by the end of the period, the events in Edinburgh helped to make these facilities even more difficult to set up in towns let alone in the countryside.¹⁰¹ Further support for this argument came from the record of one Suffolk practitioner, John Jackson {1801-1807}, a physician, who aspired to a surgical career by:

“going to France where the training was reputable and he could not only learn French, but also dissect legally obtained cadavers. Bodies could be obtained for the modern equivalent of 15p and he could live on 75p a week”.¹⁰²

Yet there is evidence that a number of practitioners in Suffolk, perhaps more than recognised, were pursuing dissection as a means of enhancing their medical knowledge and therefore their services to patients. For example, John Bucke (1756-1839), surgeon of Ipswich, Bungay and later Mildenhall, was given the body of a murderer to dissect in April 1785.¹⁰³ The purpose is not specified, but John came from a dynastic family of practitioners, interested in developing and extending their skills and practice. Similarly, Ipswich surgeon John Clubbe (1741-1811) had bodies of murderers presented to him for dissection and teaching purposes on at least three occasions.¹⁰⁴ Other local

⁹⁸ *Select Committee on Anatomy Evidence Q 50*, 1828.

⁹⁹ Richardson, *Dissection*, p.132.

¹⁰⁰ Richardson quotes the example of a body in Beccles whom Cooper paid the resurrectionists Hollis and Vaughan seven guineas to obtain. This was an interesting subject from his point of view, as he had operated on the man some ten years earlier. He had been alerted to his death by a local surgeon, probably William Henchman Crowfoot who took an interest in anatomy. He had been at the Borough Hospital in London under Cline and Cooper, who became a lifelong friend.

¹⁰¹ In 1828, Burke and Hare carried out murders at the behest of Dr Knox.

¹⁰² Michael Crumplin, *Men of Steel*, (London, 2007), p.166.

¹⁰³ *Ipswich Journal*, April 1785.

¹⁰⁴ David van Zwanenberg, *Suffolk Medical Biographies*, (unpublished but edited on the Internet by Eric Cockayne), SRO (Ipswich).

well-established doctors with extensive practices taught morbid and comparative anatomy. Robert Abbott (1750-1830), surgeon of Needham Market, was reported as having dissected a murderer's body in 1785.¹⁰⁵ He advertised for an apprentice in February 1784, but was clearly offering a wider service than solely medicine to his own pupil with "Extensive practice. Morbid and comparative anatomy taught".¹⁰⁶ These examples demonstrate that the development of enhanced and evidence-based diagnosis through increased knowledge of anatomy was more prevalent in Suffolk than had been previously realised, an argument developed more fully in Chapter 6.

This then was the context in which Suffolk practitioners were educated and trained, a very different setting from the urbanised, crowded and socially mobile in London. Their range of opportunities in terms of schools, hospitals and dispensaries, together with the distances and cost implications of obtaining further training, clearly impacted upon the care that was eventually delivered, though not always for the worse. Similarly, the community and its structure and social hierarchy, and the lack of a developing industrial economy determined to a high degree the quality and nature of doctoring, not least because of the expectations of those seeking medical help. These varied from towns such as Ipswich to small village communities such as East Bergholt; between decaying fishing villages such as Aldeburgh and flourishing market towns like Woodbridge and Bungay. Moreover, lifestyles and medical care in all of these were likely to differ significantly from those in urban conurbations and metropolitan London itself.

¹⁰⁵ *Ipswich Journal*, April 1785.

¹⁰⁶ *Ipswich Journal*, February 1794.

CHAPTER 3: TITLES, ORIGINS AND NUMBERS

Family backgrounds and numbers provide the starting points for questioning and presenting modifications to some current historiographical thinking about what Loudon describes as “the forerunners of general practitioners” in the period of 1750 to 1830.¹ A great deal has been written on this, much of it metro-centric, and evidence from Suffolk challenges some of the current terminology and analysis. It suggests conclusions that are rather different from those of some modern historians in relation to the use of the title ‘surgeon-apothecary’, their antecedents and mobility, and the ratio of doctors to population.

3.1 Titles

“The earlier name *apothecarius* is ‘to put away/aside’. If this is vague, what have we to designate a surgeon? *Chirurgus* is the ‘hand’ and a ‘work’. As to the denizens in Pall Mall, they have no distinctive title for in Greek ‘*medicus*’ is applied indiscriminately to a physician, a chirurgion and an apothecary”.²

Much evidence about the nature of healthcare for this period is based on less than specific definitions of titles and appellations that are not only misleading but frequently interchangeable. As a result, it is important to consider the weight attributed to any particular title and the validity of any specific nomenclature when trying to establish how far the realities of medical practice in a rural county like Suffolk differed from those of metropolitan areas, particularly London. In so doing, this discussion presupposes all commentators and writers were referring to recognised and ‘qualified’ practitioners, not empirics or quacks.

One of the most confusing issues is the way many modern historians have used the title ‘surgeon-apothecary’. As a consequence, it has gained a greater significance and consistency of contemporary usage than is sustainable from the Suffolk evidence set out here. In 1951, Bernice Hamilton concluded that

¹ Irvine Loudon, *Medical Care and the General Practitioner*, (Oxford, 1986), p.28.

² George Corfe, *The Apothecary (Ancient and Modern) of the Society, London, Blackfriars*, (London, 1885), p.7.

“a new type [of doctor] was springing up, the surgeon-apothecary, a useful all-round man”.³ Forty years later, Mary Fissell classified apothecaries and ‘surgeon-apothecaries’ very distinctly, stating that the former were a remarkably constant group in eighteenth century Bristol. It is not clear whether her definition of what they were doing can be generalised, but she admits that in rural areas almost all apothecaries were practising as what she calls ‘surgeon-apothecaries’ by the latter half of the century, perhaps earlier.⁴ Roy Porter, a year later, agrees with her that the name ‘surgeon-apothecary’ was the commonest title given to country or small-town practitioners.⁵ Over ten years later, Steven Cherry also follows the trend of using the composite title, suggesting in the context of rural medical services that “surgeon-apothecaries had already begun to claim the core practice of ‘regular’ medicine for themselves”.⁶

Others have been more cautious. Joseph Kett takes the view that across the country and across social strata, both the title and practices of surgeons and apothecaries overlapped.⁷ Similarly, considering the relationship between practice and status, Irvine Loudon in 1986 also concludes that “title was rarely a certain indication of the nature of practice - that was more by family background, apprenticeship and commercial opportunity”.⁸

Usage of the hyphen in the phrase ‘surgeon-apothecary’ implies a single conjoint and distinctive occupation, whereas the phrase ‘surgeon and apothecary’ may merely be a conflation of two separate occupations, simply another example of indiscriminate usage. Kett supports this contention when he wrote “After 1730, the words, ‘surgeon’ and ‘apothecary’ were used

³ Bernice Hamilton, “The medical profession in the eighteenth century”, *Economic History Review*, Second Series, 4, (1951), 2, pp.141-149.

⁴ Mary Fissell, *Patients, Power and the Poor in Eighteenth Century Bristol*, (Cambridge, 1991), p.51.

⁵ Roy Porter, “The patient in England c.1660-c.1800”, in Andrew Wear (ed.), *Medicine in Society: Historical Essays*, (Cambridge, 1992), pp.91-118.

⁶ Steven Cherry, “General practitioners, hospitals and medical services in rural England: the East Anglia region c.1800-1848”, in Joseph Barona & Steven Cherry (eds.), *Health and Medicine in Rural Europe 1850-1945*, (Valencia, 2005), pp.171-192.

⁷ Joseph F. Kett, “Provincial medical practice in England 1730-1815”, *Journal of History of Medicine*, 29, (1964), 1, pp.17-29.

⁸ Loudon, *Medical Care*, p.28.

interchangeably in the provinces”.⁹ J.C. Yeatman goes further, arguing that there was a rising demand from middle class families for a single practitioner, suggesting that they “had long wished for a class of the faculty to whom they could apply with confidence any description of case in which medical or surgical aid was necessary”.¹⁰ The implication of this statement is that the term ‘surgeon-apothecary’ was prevalent because it described such a ‘single practitioner’. However, this argument falls as an analysis of contemporary usage and understanding makes clear that, in spite of the terminology used by modern commentators, ‘surgeon-apothecary’ was far from the most common or well-understood title at the time. Indeed, as the evidence from Suffolk reveals later in this chapter, a whole range of terms was in use.

To begin with contemporary evidence, the *General Description of Trades* in 1747 showed that a wide range of functions could be covered by the term ‘apothecary’, without any apparent need for explanation or comment:

“This [Apothecary] is a very genteel Business... Some do little else but make up Medicines according to the Prescription of the Dispensary... Others not only prepare almost all kinds of medicines, as well Galenical as Chemical but likewise deal in Drugs; with all which they supply their Brethren in Trade, and so become a sort of Wholesale Dealers, as well as apothecaries. Others practice Surgery, Man-Midwifery, and many times even officiate as Physicians, especially in the country, and often become Men of very large Practice, and eminent in their Way. There is also another Branch many of them fall into, which is that of curing Lunatics etc”.¹¹

John Aitken in 1761 noted that “it grows pretty common to unite the two professions of apothecary and surgeon...”,¹² whereas Samuel Foart Simmons in his registers of 1778, 1779 and 1783 used a full range of titles including ‘surgeon-apothecary’, ‘physicians’, ‘surgeons only’ and ‘apothecaries only’.¹³ Only a decade or so later James Lucas, writing on medical education, referred to ‘surgeon apothecary’ without the hyphen, but throughout his book referred

⁹ Kett, “Provincial medical practice”, p.17.

¹⁰ J.C. Yeatman, “The origin of the general practitioner”, *Journal of the Royal College of General Practitioners*, 33, (1999), pp.13-18.

¹¹ *A General Description of all Trades Digested in Alphabetical Order*, (London, 1747) p.79.

¹² John Aitken, May 1761, lecturer at Warrington Academy, quoted by Juanita G.L. Burnby in *A Study of the English Apothecary from 1660-1760*, (London, 1983), pp.25-6.

¹³ Samuel Foart Simmons, *Medical Registers 1778, 1779 and 1783*, (London). See page 15.

to ‘surgeons’ or ‘apothecaries’ or ‘practitioner’ fairly indiscriminately.¹⁴ On the other hand, Robert Kerrison writing in 1814 on the state of medicine, referred specifically to ‘surgeon-apothecaries’, but appeared to substitute this for the term ‘surgeons’, one he rarely used. Moreover, he seemed to use the term ‘apothecaries’ alone when referring specifically to the limited role of supplying medicines, on several occasions referring to ‘surgeon-apothecaries, apothecaries and general practitioners’.¹⁵

This lack of consistency or specificity continued with the campaign for the Apothecaries Act that was run by the Associated Apothecaries, confusingly also known as The General Association of Apothecaries and Surgeon Apothecaries of England and Wales - without a hyphen. This group comprised predominantly London apothecaries, an important point to bear in mind in any discussion of medical nomenclature at this time. Their petition to Parliament stated that:

“apothecaries, surgeon apothecaries and practitioners in midwifery form the great majority of the medical practitioners of England and Wales and are very generally entrusted with the medical and surgical care of the population of this kingdom”.¹⁶

Such contemporary evidence shows that a practitioner could and did deliver services and provide care under the titles of surgeon or apothecary, and a combination of both, with or without the hyphen. It is not surprising that some writers of the time simplified the description of a very confused situation by linking the titles ‘surgeon’ and ‘apothecary’ into a composite title. Robert Kerrison saw this conflation as the result of surgeons fearing loss of livelihood by the populace resorting to cheaper apothecaries for minor ailments, and in reverse “the apothecary, by rendering himself qualified... And adding Surgery to Pharmacy, became a Surgeon-Apothecary, or general

¹⁴ James Lucas, *A Candid Inquiry into the Education, Qualifications, and Offices of a Surgeon Apothecary*, (Bath, 1800). For example, p.70, “...pupils will find when they come to act as practitioners, many unexpected difficulties”.

¹⁵ Robert Masters Kerrison, *A Inquiry into the Present State of the Medical Profession in England*, (London, 1814), p.32. “And these persons, the Surgeon-Apothecaries, are rather compensated by the multiplicity of practice... they have thus become the general practitioners throughout England and Wales”.

¹⁶ *Hansard*, 9, 1813-1814, XXVII, Cols 164-5.

practitioner”.¹⁷ Moreover, once the Apothecaries Act of 1815 was introduced, the title of apothecary was officially recognised, forcing surgeons to take action to ensure their qualification was similarly protected from unqualified ex-military ‘jobbing’ practitioners taking over.¹⁸

Significantly for the argument that runs through this study, most of the evidence quoted so far is London-based. In Suffolk, there appears to have been no common usage of any given title. Foart Simmons’ register for 1783 listed 70 ‘surgeon-apothecaries’, ten ‘physicians’, two ‘surgeons only’, and no ‘apothecaries only’ in Suffolk.¹⁹ But his figures are not borne out by the evidence from the *Suffolk Medical Biographies (SMB)*, which itself is not free from bias.²⁰ The compiler, David van Zwanenberg, was a surgeon, and like Foart Simmons also made assumptions from the perspective of his own specialism and profession, particularly regarding the use of titles (surgeon, surgeon and apothecary, apothecary and so on). Therefore, it is not surprising that his data contains inconsistencies over dates and descriptions.

For instance, *SMB* listed Charles Syder {1815-1835} of Bury St. Edmunds and Hadleigh, practising in the early 1800s, as a ‘surgeon’, yet in 1820 he advertised “that he had opened a Genuine Medicine Warehouse at Hadleigh, with every medicine, Physicians’ prescriptions accurately dispensed - vaccine from the London Vaccine Institute”.²¹ Quite clearly he was operating as a dispensing apothecary, whatever else he was doing. Both Richard Andrews {1700-1758} of Ipswich and Woodbridge and James Bedingfield {1777} of Laxfield were listed in *SMB* as surgeons, but their death notices showed each clearly to have been dispensing drugs and using their shops as retail outlets.²² The same confusion arises from notices of dispensary and hospital

¹⁷ Kerrison, *An Inquiry*, p.26.

¹⁸ Chapter 7 discusses military medical careers more fully.

¹⁹ Joan Lane, “The medical practitioners of provincial England in 1783”, *Medical History*, 28, (1984), pp.353-371. Foart Simmons obtained his information by writing to the leading physicians of the day and relied on their knowledge and understanding of how medical care was delivered locally.

²⁰ van Zwanenberg, *SMB*.

²¹ *Ipswich Journal*, 15 January 1820.

²² *Ipswich Journal*, 23 August 1758, “To be disposed of... House of Richard Andrews, shop fixtures, drugs, mortars etc...”; *Ipswich Journal*, 14 April 1777, “a House and Shop in Laxfield”. Similarly, William Chenery/Chinnery {1801-1825}, surgeon of Bury St. Edmunds, was described in the *Bury Journal* as “formerly apothecary in Bury”. *Bury Journal*, 24 July 1825.

appointments. William Sparke (1746-1831) of Ipswich was listed in *SMB* as ‘Surgeon’ and yet was appointed Physician to the Public Dispensary in 1815-16; George Catton (d. 1829) of Bury St. Edmunds is listed as ‘Surgeon’ and yet was elected House Apothecary and Secretary to the Suffolk General Hospital in 1827.²³

A detailed analysis of titles used by Suffolk medical practitioners of the period supports the argument that the composite title ‘surgeon-apothecary’ was far less widely used than the many more simple ones. Table 3.1 sets out the overall incidence of all in use in Suffolk for the period 1750 to 1830, as found in *SMB* and other primary sources. A clear majority favoured the simple title of ‘surgeon’. None used the combination of ‘surgeon-apothecary’, and only four per cent used the title ‘surgeon and apothecary’. Table 3.2 compares the figures listed by Foart Simmons in his 1783 register with those identified in Table 3.1. For ease of comparison, the many composite titles found for Table 3.1 have been grouped into Foart Simmons’ simpler categories, in particular the titles ‘surgeon-apothecary’ and ‘surgeon apothecary’ are combined.

The percentage figures show just how much Foart Simmons underestimated for Suffolk in all categories. His registers also included inaccuracies and inconsistencies. For example, Edmund Newdigate (1702-1779) of Ipswich was listed as a physician in the 1783 register, whereas evidence shows he died in 1779.²⁴ William Palmer {1753-1789} of Mendlesham, who advertised in January 1761 “All household goods and pictures of Apothecary shop”, was styled as ‘surgeon’ by Foart Simmons in 1783. Similarly, John Nursey {1758-1791} advertised the sale of his apothecary shop at Debenham in February 1770, but then was styled ‘surgeon’ in Foart Simmons’ *Medical Register* in 1779 at Stonham. Clearly, most surgeons in the country dispensed their own medicines and often had actual ‘shops’ to do so, and the advertisements were concerned with trade and products rather than knowledge and medical skills. The point being that the data is unreliable. Although Foart Simmons’ use of titles varied considerably from that in Table 3.1, even when the numbers of ‘surgeon-

²³ *Ipswich Journal*, 12 April 1827.

²⁴ *Ipswich Journal*, 3 April 1779.

apothecary’ and ‘surgeon and apothecary’ are combined, only a little over nine per cent of the total number is recorded by either name in the second column. Most startling is just two instances of ‘surgeon only’ recorded by Foart Simmons, against the 207 identified in Table 3.2.

Table 3.1: Analysis of the Stated Principle Profession Title

Stated Principle Profession	Number	% of total
Surgeon	767	80.3
Apothecary	39	4.1
Surgeon and Apothecary	39	4.1
Surgeon, Apothecary and Man Midwife	21	2.2
Surgeon and Man Midwife	14	1.5
Phlebotomist	11	1.2
Surgeon, Physician	9	1.0
Unstated	7	0.7
Innoculator	4	0.4
Each of Apothecary and Druggist, Doctor of Physic, Man Midwife, Physician and Oculist (4)	8	0.8
Each of Apothecary Chemist and Druggist, Chemist and Druggist, Dentist, Druggist, General Practitioner, Medic, Oculist, Physician, Physician and Apothecary, Physician and Druggist, Physician and Man Midwife, Physician and Medical Officer, Surgeon and Accoucheur, Surgeon and Oculist, Surgeon and Register, Surgeon Apothecary and Druggist, Surgeon Medical Officer, Surgeon, Pharmacist and Man Midwife, Vicar (20)	20	2.1
Surgeon-apothecary	0	0.0
No recorded profession	15	1.6
Totals	954	100

Sources: *SMB* and other primary sources.

Table 3.2: Comparison of Foart Simmons' Figures of Practising Doctors in Suffolk for 1783 and those Derived from Primary Sources and SMB

Title	Foart Simmons' Numbers for practitioners in Suffolk in 1783*	Numbers of doctors known active in Suffolk in 1783#
Physician	10 (11.9%)	13 (5%)
Apothecary only	2 (2.3%)	9 (3.5%)
Surgeon only	2 (2.3%)	207 (78%)
Surgeon and Apothecary	70 ((83.5%)	23 (9%)
Surgeon, Apothecary and Man Midwife		8 (3%)
Surgeon, Physician		4 (1.5%)
Totals	84	264

Sources: * Lane, "Medical practitioners".
primary sources and *SMB*

The remarkable difference in overall numbers of practitioners is discussed later in this chapter, but these tables alone indicate that great caution is needed in relation to the use and consistency of terms used. The argument is reinforced by examples from three other key areas: the medical profession's own use of titles; the titles used by non-medical people; and from the literature of the time, illustrating how patients and some of the populace classified doctors.

What a doctor actually did and what he called himself was, to a large extent, conditioned by commercial opportunity. If there was no competition in the area then the practitioner would be required, and no doubt be pleased, to offer all branches of medicine. Irvine Loudon quotes James Clegg (1679-1755) of Macclesfield, Richard Kay (1716-1751) and Thomas Baynton (1761-1820) of Bristol as examples of this, though none of them practised in small towns, let alone rural areas.²⁵ More helpful in this context is the example of the Pulsford family of rural Wells. Although both Benjamin Pulsford (1716-1784) and his nephew William {1756-1765} called themselves surgeons, their recorded cases ranged from smallpox to ganglion, cancer, fever and dental disorders. As Irvine Loudon remarks, the common picture of an eighteenth century surgeon

frequently engaged in major operations should be substituted for “a surgeon such as William Pulsford making his rounds on horseback with two large saddlebags containing ointments, lotions, bandages and plasters as well as instruments”.²⁶

The Pulsfords were comparable to examples to be found in Suffolk, such as Ipswich surgeon George Stebbing (1745-1825), who was described as visiting such patients as the Catchpoles at Nacton in his gig.²⁷ It gives credence to the view that more research might find that the Suffolk experience described later is replicated elsewhere in the country, thus adding to the weight of the argument that too strict a use of terminology does not reflect what was actually happening outside the major cities.

Furthermore, there are many examples of public notices by practitioners adding to the confusion over titles. John Say (1735-1809) of Framlingham described himself in the *Ipswich Journal* as a surgeon, yet the notice of his death refers to him as a surgeon and apothecary.²⁸ John Green {1764-1773} of Glemsford in 1773 advertised “to be dispos’d of... fixtures of Apothecary Shop in Glemsford. Enquire of John Green - Surgeon and Man Midwife”.²⁹ One might legitimately deduce from this that John Green had decided that the title ‘apothecary’, and indeed the work associated with it, was no longer appropriate for his patients and status. Monumental inscriptions illustrated the common use of ‘surgeon’, for example at Framlingham.³⁰ In acrimonious correspondence between William Crowfoot (1751-1820) of Beccles and Richard Langslow {1790-1812} of Halesworth over Langslow’s contention that “extravasation is the general cause of apoplexy”, Crowfoot referred to Langslow and himself as surgeons and apothecaries, as did fellow

²⁵ Irvine Loudon, “The nature of provincial medical practice in eighteenth century England”, *Medical History*, 29, (1985) pp.1-32.

²⁶ *Ibid.*, p.28.

²⁷ Richard Cobbold, *Margaret Catchpole* (first published 1845), (London, 2002), p.23.

²⁸ *Ipswich Journal*, 3 August 1809.

²⁹ *Ipswich Journal*, 5 May 1773. Another example was when Thomas Firman {1741-1783}, surgeon of Sudbury, sold his residence, a description of the property included the phrase “an apothecary’s shop”, *Ipswich Journal*, 26 December 1789.

³⁰ Richard Green, *The History, Topography and Antiquities of Framlingham and Saxted*, (London, 1834). Edmund Goodwyn {1732-1757} and William Spalding {1731-1807}, p.160, and David Keer {1765-1810}, p.162 were all described on their tombstones as ‘surgeons’.

professionals caught up in the debate, but in fact Langslow was a physician. Of course, this may have been a deliberate slight on Crowfoot's part.³¹

It is not clear whether for the professionals in Suffolk their title reflected any particular type of practice. John Heigham Steggall (1789-1881) of Rattlesden, when apprenticed to a surgeon at the turn of the nineteenth century, described his work as "set limbs, teeth drawn, pills made", clearly a mixture of the surgery and apothecary business.³² Similarly, William Goodwyn (1746-1815) called himself a surgeon and yet his diaries suggest he did much non-surgical work in Earl Soham.³³ According to parish records, the Rye brothers, John {1722-1759} and Samuel {1725-1789} of Hopton were surgeons, but their Council bills indicate they were essentially dispensing apothecaries.³⁴ Robert Mayes {1778-1808} of Ipswich advertised that he had taken over the practice of a surgeon, Mr Gravenor,³⁵ yet when the Ipswich Public Dispensary opened on 3 July 1797 he was appointed as its first apothecary.³⁶

There is little evidence that professionals themselves had any difficulties in understanding what these inconsistent titles meant in terms of the skills and the services they indicated. Dr Thomas Gibbons (1731-1803) styled himself a physician, although he is listed in *SMB* as a surgeon and there is no evidence of where or how he obtained his MD.³⁷ His own *Medical Cases and Remarks* in 1799 referred frequently to medical colleagues working on the same or similar cases. He and Robert Abbott (1750-1830), whom he described as "surgeon of Needham", had a clear understanding of their respective roles. Mr Abbott

³¹ William Crowfoot, *Observations on the Opinion of Dr Langslow*, (Yarmouth, 1800). This correspondence arose over the case of Master Day of Yoxford, relating to the relationship between apothecaries and physicians, and the argument that physicians should not be called in without the approval of an apothecary. See Chapter 7 for a fuller description of the Langslow case.

³² Richard Cobbold (ed.), *John H. Steggall - A Real History of a Suffolk Man Narrated by Himself*, (London, 1857), p.189.

³³ William Goodwyn, *Diaries at Earl Soham 1746-1816*, SRO (Ipswich), HD 365/1. "June 25 1785 Began sowing Turnips and Planting cabbages in the fields".

³⁴ Hepworth, *Parish Council Town Bills*, 1749, SRO (Bury St. Edmunds), FL 582/5/32-85, The bills include "April 2 Two doses of purging Physick for Goodwife Gouldgoss Children 0:1:0; Paper with powder with ingredients 0:1:0; April 7 Goodman Bird Mixture for Cough 0:1:6".

³⁵ *Ipswich Journal*, 13 September 1778.

³⁶ *Ipswich Journal*, 23 July 1797. His monument inscription in Badwell Ash reverts to calling him a surgeon. His sister erected the plaque in 1808 at his death and may have not realised the difference, or may have felt that the term 'surgeon' had more status than 'apothecary'.

³⁷ van Zwanenberg, *SMB*.

referred a difficult case to Gibbons, who wrote “I desired Mr Abbott to try the effects of salivation from calomel; he did so”. Gibbons mentioned several apothecaries who clearly referred patients to him. In one case:

“Mr Rogers her apothecary said she was in the beginning of her disorder troubled with acute pains in the pit of her stomach... He had given her soap, rhubarb, aloes etc but the jaundice kept increasing... Prescribed more”.

Likewise Mrs Nelson, an apothecary’s widow of Manningtree in Essex, sent for Gibbons at the end of 1778, after “She had been taking pills of soap, aloes and rhubarb with saline medicines by Mr [Dr] Nunn’s direction”.³⁸ Gibbons also had cases referred to him by William Travis (1761-1835), “an ingenious surgeon at East Bergholt”.³⁹ The Constable family correspondence shows how care was divided between local surgeons and another Ipswich physician. Mary Constable wrote to her sister, Mrs Whalton, on 24 March 1815, “My dearest Mother was so low, Mr William Travis thought it proper to send for Dr Williams,⁴⁰ who came in the afternoon and really left us in better hope; Mr Travis also arrived to meet the Doctor here”.⁴¹ Interestingly however, Dr Williams had seen Constable’s father earlier that month, and commented that “he never saw a foot look so well as my father’s after that complaint all his life - he said my father was uncommonly well”.⁴² The week before, William Travis the surgeon had been treating him.

There are equal inconsistencies to be found in the way that those employing doctors used the titles. Indeed, Helen Dingwall states that “it is probable that in the minds of the general public, the term ‘apothecary’ and ‘surgeon’

³⁸ Thomas Gibbons, *Medical Cases and Remarks*, (Ipswich, 1789), pp.17-18. Gibbons describes 12 cases from his practice in Sudbury and surroundings.

³⁹ *Ibid.*, p.23.

⁴⁰ William Henry Williams (1771-1841) was a surgeon and later a physician in Ipswich. He was surgeon to the East Norfolk Militia in 1793, published his first book on *The Ventilation of Army Hospitals and Barrack Rooms* and also his *Observations on Regimental Practice, on Matrimony and on Regimental Education* and began to practise as a surgeon in Ipswich and attended in Cambridge so that in 1803 he obtained his MB, having been entered as a commoner at Caius College Cambridge in May 1798. MD Cantab 12 September 1811. Interestingly, in 1815, the date of this correspondence, he had yet to apply for membership of the Royal College of Physicians, which he did in 1816, but was clearly seen as a physician by his colleagues locally. He obtained his FRCP in 1817.

⁴¹ Ronald B. Beckett (ed.), *John Constable’s Correspondence: The Family at East Bergholt 1807-1837*, (London, 1962), p.121.

⁴² *Ibid.*, 12 March 1815, p.120.

referred to any member of the profession”.⁴³ Joan Lane believes “demarcation lines in the provinces were less bothersome”, quoting evidence from the early history of the Worcester Infirmary, where surgeon Stephen Edwards was replaced in 1767 by John Mountford, originally an apothecary.

According to Burnby, “in country and rural areas union had been taking place for many years, if in the more rural areas this artificial divide had ever obtained”. She cites Richard Kay of Lancashire (1716-1751) who practised all branches of medicine, as did the two John Westovers (Snr. 1616-1679, Jnr. 1643-1706).⁴⁴ Bailey’s Directory of 1784 referred to all medical practitioners as ‘surgeon’.⁴⁵

Evidence from Suffolk supports these views. The Wangford *Parish Meeting Notes* referred to the appointment of “the Surgeons employed by the corporation”.⁴⁶ The Blything Hundred *Minute Book* proposed that “a skilled Surgeon Apothecary and Man Midwife shall undertake the care of all the patients in the poor house”, and thereafter shortened all references to practitioners to ‘surgeon’.⁴⁷ The Aldeburgh *Parish Vestry Minute Book* referred to ‘surgeons’ when they were minuting the appointment of a medical man or payment for medical services.⁴⁸ In the same town, the parish meeting elected a medical officer to the Borough without specifying any particular title, but referred later to allowing “a surgeon to cure the Girl Hill’s leg”.⁴⁹

More evidence comes from the literature of the time that, as Loudon says, can be regarded as a reliable source for evidence of how the general public

⁴³ Helen M. Dingwall, “General practice in seventeenth century Edinburgh”, *Social History of Medicine*, 6 (1993), pp.1-29.

⁴⁴ Juanita G.L. Burnby. “An examined and free apothecary”, in Vivian Nutton & Roy Porter (eds.) *The History of Medical Education in Britain*, (Amsterdam, 1995), pp.16-36.

⁴⁵ *Bailey’s Directory; or Merchant’s and Trader’s Useful Companion*, (London, 1784), pp.823-835. The Ipswich list included John Clubbe (1741-1811) surgeon; John Rodbard and James Brookes surgeons; Jonathan Davie (1781-1858) surgeon.

⁴⁶ Wangford, *Parish Meeting Notes*, 24 January 1770. SRO (Ipswich), HA 85 3116/852917.

⁴⁷ Blything Hundred, *Minute Book*, 1786. SRO (Ipswich), ADA 1/AB3/1 & 2.

⁴⁸ Aldeburgh, *Parish Vestry Minute Book*, 11 December 1770. SRO (Ipswich), FC 129/E1/1. “Mr Raymond, surgeon, has been elected medical officer for the Borough”.

⁴⁹ *Ibid.*, 8 October 1759.

saw doctors.⁵⁰ He believes that almost all novelists who wrote about the period in question were “hopelessly lost in the complexity of the licenses, diplomas, degrees and nice distinctions between medical men that obsessed the profession”.⁵¹ They may also have been ignorant of it. This only makes contemporary writers even better witnesses, as they undoubtedly reflected the lack of concern of the populace (in rural areas at least) about such matters. Moreover, the lack of knowledge concerning titles and qualifications was not a significant part of the evidence from literature; more important was the attitude writers expressed towards the local doctor and their presentation of him as family friend and confidante, living in the community and a respected member of it.

George Crabbe (1754-1832), onetime surgeon and apothecary in Aldeburgh, referred to a fellow practitioner in his poem *The Borough* merely as “The Doctor”.⁵² Jane Austen’s domestic novels from *Sense and Sensibility* in 1811 to *Persuasion* in 1818 infrequently depicted the medical profession, but underlined Loudon’s point about the inconsistency in the use of titles. In *Sense and Sensibility* (1811) Mr Harris, “the Palmers’ apothecary”, was sent for when Marianne Dashwood was ill, and attended her every day to reassure and check her fever, without any clear treatment.⁵³ In *Emma* (1815) is described “the apothecary, ...an intelligent, gentleman like man” who offered what seemed in many respects like a physician’s regimen regarding diet and exercise.⁵⁴ George Eliot, writing in 1871 about provincial life in the 1830s in *Middlemarch*, presented Lucius Lydgate as “a new young surgeon” and “really well-connected”, clashing with older physicians, Drs Sprague and Minchin who “enjoyed about equally the mysterious privilege of medical reputation”, and Mr Wrench and Mr Toller “the long established practitioners”. The latter were described as surgeons, but Eliot rather damningly noted that:

⁵⁰ Irvine Loudon, “The Concept of the family doctor”, *Bulletin of the History of Medicine*, 58, (1984), pp.347-62.

⁵¹ *Ibid.*, p.351.

⁵² George Crabbe, *The Borough*, (1810), Letter VII, “Now see him Doctor!”, l.262.

⁵³ Jane Austen, *Sense and Sensibility*, (first published 1811), (*Oxford Illustrated Jane Austen*, R.W. Chapman (ed.), 3rd edn., 1932, reprinted Oxford 1986), p.309.

⁵⁴ Jane Austen, *Emma*, (first published, 1816, illustrated edition, Oxford, 1978), p.19. “Wedding-cake might certainly disagree with many - perhaps with most people unless taken moderately”.

“a layman who pried into the professional conduct of medical men, ...was less directly embarrassing to the two physicians than to the surgeon-apothecaries who attended paupers by contract”.⁵⁵

Did the use of titles in Suffolk change over time, particularly immediately before the Apothecaries Act of 1815? Lack of data on many practitioners in the cohort, particularly in the eighteenth century, and the assumptions made about dates and type of practice, described in Chapter 1, must be acknowledged. Given these caveats, Table 3.3 gives an analysis of doctors practising in 1800, 1820 and 1830 to demonstrate whether the frequency of title use changed significantly over time.

**Table 3.3: Analysis of Changes in Title Use in Suffolk
in 1800, 1820 and 1830**

Stated Principle Profession	1800	1820	1830
Apothecary	9	2	4
Apothecary and Druggist	1	0	0
Chemist and Druggist	1	0	0
Druggist	1	0	0
Innoculator	1	0	0
General Practitioner	1	1	1
Man Midwife	1	0	0
Phlebotomist	1	0	0
Physician	7	6	5
Physician and Medical Officer	1	1	1
Surgeon	204	208	255
Surgeon and Apothecary	15	6	5
Surgeon and Man Midwife	1	1	0
Surgeon, Apothecary and Man Midwife	6	5	4
Surgeon, Medical Officer	0	1	0
Surgeon, Pharmacist and Man Midwife	1	1	1
Surgeon, Physician	4	1	1
Vicar	1	1	1

Source: *SMB* and other primary sources.

⁵⁵ George Eliot, *Middlemarch - a Study of Provincial Life*, (Edinburgh and London, 1871) (Penguin English Library, 1965), p.212.

There is the occasional outlier such as the vicar in the numbers shown, but the important changes demonstrated are that the number of those referred to as 'surgeons' rose by twenty per cent while 'apothecaries only', and 'surgeon and apothecaries only' reduced by 62.5 per cent, probably reflecting the gradual impact of the 1815 Act and the consequent tightening of regulation, albeit limited in country areas like Suffolk. Although there was some delay in the impact of changes emanating from London reaching the provinces, these figures may reflect a gradual recognition by the professionals, if not patients, of the need to gain further recognised qualifications. It may indicate a greater extension of enhanced regulation (or the fear of it) than previously thought, though largely towards the end of the review period. The number of surgeons, apothecaries and man midwives went up towards 1801, but not surprisingly had reduced drastically by 1821 for similar reasons. It is interesting to note that, in percentage terms, those with 'physician' in their chosen title also reduced in numbers significantly.

Although there are limited conclusions to draw from this analysis, it shows that the inconsistency and range of titles used did not change in Suffolk very much until after the Apothecaries Act of 1815, and this may merely have stimulated a trend already in place, reflecting a slower change than in the metropolitan areas. Further analysis and research from other rural counties is needed to obtain evidence to give greater certainty to the widespread nature of this conclusion.

In summary therefore, there is no evidence from Suffolk to support the contention that the term 'surgeon-apothecary' was the preferred or usual title used there in the late eighteenth and early nineteenth centuries. Moreover, the popularity of the title 'surgeon' in everyday activities (newspaper reports, epitaphs and journals) may simply have been due to the use of it as shorthand and undoubtedly implied higher status and skill than that of apothecary. It may therefore have been used to enhance patient confidence and a practitioner's attraction. Maybe the longer, composite title, while used in London, had not reached provincial and rural areas like Suffolk to any significant degree, where clear-cut definitions and consistent usage did not exist. Jane Austen summed the situation up well:

“But you seem to be under a mistake as to Mr H. - You call him an Apothecary; he is no Apothecary, he has never been an Apothecary, there is not an Apothecary in this Neighbourhood - the only inconvenience of the situation perhaps, but so it is - we have not a Medical man within reach - he is a Haden nothing but a Haden... without the least spice of an Apothecary. - He is perhaps the only Person not an Apothecary hereabouts”.⁵⁶

Public and professionals appeared to understand who did what and who to call on for what, if there was a choice at hand, probably due more to the personal skills and standing of the individual doctor and his ability to reflect the needs of the community in which he lived, than on an understanding of the competencies and services contained in whatever title was used. Post-1815, even in the country, surgeons gradually subsumed apothecaries and Loudon is probably right in suggesting that the term ‘medical practitioner’ is the most helpful in trying to categorise doctors at this time, though in the end, it seems to have been of scant significance to the professional and client alike in rural Suffolk.

To avoid confusion, this paper uses the term ‘medical practitioner’ to cover the variety of terms and titles used apparently indiscriminately for those deemed to be qualified medical doctors, by both contemporary and modern writers, thus reflecting the eventual title of ‘general practitioner’ of the mid-nineteenth century.

3.2 Origins, Mobility and Dynasties

“Mr Brooke says he [Mr Lydgate] is one of the Lydgates of Northumberland, really well connected. One does not expect it in a practitioner of that kind. For my own part, I like a medical man on a footing with the servants: they are often all the cleverer”.⁵⁷

Titles are not the only matter on which there are conflicting views. Conclusions on the antecedents of surgeons and apothecaries are also diverse, but evidence from Suffolk is sufficient to demonstrate a wide range of social backgrounds, and any over-emphasis on the middle class and gentry

⁵⁶ Deirdre Le Faye (ed.), *Jane Austen's Letters*, (London, 2003), p.303. Saturday 2 December 1815.

backgrounds of practitioners could be misleading. In the 1950s, Charles Newman concluded that the origins of medical practitioners ranged from the aristocratic for physicians to petty trade for apothecaries, noting also “a distinct tendency for more of those in a lower social status seeking advancement to choose medicine at any rate after the French Revolution”.⁵⁸ William Reader, in the 1960s, puts forward the view that the origins of medical practitioners were “not above the middle class”.⁵⁹ Geoffrey Holmes suggests that there was a marked rise in the social status of apothecaries after 1660, although there were examples of apothecaries from all social categories before the Restoration.⁶⁰ Michael Muncaster feels that the “erosion of the idea that a practitioner’s place in the hierarchy was determined by his background, education and qualifications is evident before 1815”.⁶¹ Other later historians, like Christopher Brooks, in considering apprenticeship and social mobility generally after 1550, acknowledge that social backgrounds were diverse. However, since parents of would-be medical practitioners had usually to pay out a large sum of money to a master, “few recruits came from the 30 per cent of the population which lived by wages alone”.⁶² Yet he acknowledges his use of largely urban-oriented examples in arriving at this conclusion, mainly because the statutory regulations, flowing from laws such as the Statute of Artificers of 1563, were not enforced in the smaller towns and villages predominant in counties like Suffolk.⁶³ Penelope Corfield also maintains that, from the sixteenth century onwards, many of those within the professions were non-landed gentlemen.⁶⁴ Juanita Burnby similarly suggests

⁵⁷ Eliot, *Middlemarch*, p.117. Lady Chettam to Mrs Cadwallader.

⁵⁸ Charles Newman, *The Evolution of Medical Education in the Nineteenth Century*, (London, 1957), pp.2, 3, 16-17. Newman compares figures at Guy’s Hospital between 1750 and 1800, when about twice as many staff (both physicians and surgeons) came from the higher grades of society, with figures for 1800-1850 when the proportion for physicians was reversed, while the proportion for surgeons remained the same.

⁵⁹ William Reader, *Professional Men: The Rise of the Professional Classes in Nineteenth Century England*, (London, 1966), pp.33-4.

⁶⁰ Geoffrey Holmes, *Augustan England: Professions, State and Society 1680-1730*, (London, 1982), p.5.

⁶¹ Michael J. Muncaster, *The Medical Services and the Medical Profession in Norfolk: 1815-1911*. Unpublished PhD, University of East Anglia, 1976, p.9.

⁶² Christopher Brooks, “Apprenticeship and social mobility”, in Jonathan Barry and Christopher Brooks (eds.), *The Middling Sort of People: Culture, Society and Politics, 1550-1800*, (Basingstoke, 1994), pp.52-83.

⁶³ *The Statute or Ordinances concernynge artificers, servants and labourers, journeymen and prentyses* (5 Eliz. c. 4) required a seven-year apprenticeship as an essential qualification for a number of trades from blacksmith to merchant, as well as attorneys, solicitors, surgeons and apothecaries.

⁶⁴ Penelope Corfield, *Power and the Professions in Britain 1700-1850*, (London, 1995), p.12.

that the profession of the apothecary was not regarded as tainted socially by its close association with the retail trade until about 1750.⁶⁵

A number of historians have described a marked change in the eighteenth century. Joan Lane believes that by 1750 medicine had become the career that the gentry or ambitious parents chose for their sons, citing Coventry surgeons' apprentices whose parents included a carrier, a farmer and a button maker.⁶⁶ In her view, "the surgeon-apothecary [sic] is one of the eighteenth century's most interesting examples of personal and professional upward social mobility, and of steadily enhanced status, not only in London... but also in the English provinces, where their houses, marriages and affluence were worthy of contemporary comment".⁶⁷ Mary Fissell offers the example of Samuel Pye of Bristol, an eighteenth century barber-surgeon, who at the beginning of his career had apprentices coming from merchant, currier and surgeon families, but by the end took sons of gentlemen paying £200 for the privilege.⁶⁸ Rosemary O'Day also indicates that a considerable number of medical practitioners came from gentry and professional backgrounds, and suggests a cultural shift by the early eighteenth century, reflected in the demand for 'middling' rank medical practitioners.⁶⁹

Available data from Suffolk supports this view, as does some evidence from other provincial areas such as Bristol (described below). Nevertheless, although there was a predominance of professional and landowning backgrounds, the evidence of a considerable range of other more lowly antecedents from Suffolk implies greater social opportunities and aspirations than allowed by O'Day. Support for this wider social range also comes from the records of surgeon Richard Smith {1760-1830} on the parental occupation of medical practitioners in Bristol and the South West, set out in Table 3.4.

⁶⁵ Burnby, "An examined and free apothecary", p.30.

⁶⁶ Joan Lane, *Coventry Apprentices and their Masters 1781-1806*, (Stratford Upon Avon, 1983), pp.xi.

⁶⁷ Joan Lane, "The role of apprenticeship in eighteenth century medical education in England", in William Bynum and Roy Porter (eds.), *William Hunter and the Eighteenth Century Medical World*, (Cambridge, 1985), pp.57-103.

⁶⁸ Fissell, *Patients, Power*, p.49. A currier was a specialist in the leather processing industry.

⁶⁹ Rosemary O'Day, *The Professions in Early Modern England, 1450-1800: Servants of the Commonweal*, (Harlow, 2000), p.244. Stamp Office Registry between 1770 and 1750 reveals that of 915 entries for whom the origin was stipulated, 32% were of lower gentry status and 55% from 'lower middling sort'.

**Table 3.4: Parental Occupations of Medical Practitioners
in Bristol and West of England, 1760-1830**

Father's Occupation	Numbers
Medical practitioner	23
Clergy	14
Landed	12
Merchant	5
Farmer	3
Attorney, naval and army officers, HM Customs, bank employees, clothiers, schoolmasters	2 of each
Musician, master, merchant navy, brewer, ironmaster, 'in employment', sailmaker, dyer and cleaner of feathers, maltster, liquid dealer, grocer, sugar baker, wine cooper, carrier, mealman	1 of each

Source: Loudon, *Medical Care*, p.30.

Although this shows that over 55 per cent of those whose backgrounds are recorded came from professional or landed backgrounds, the remainder reflect a wide social spectrum, from merchants to mealmen. Caution is needed in using this data, as most of the doctors recorded had been apprenticed or were pupils of surgeons in the Bristol Infirmary, thus ambitious and able to afford the apprenticeship premiums commanded there.⁷⁰ If further evidence were extant on those not so fortunate, the proportions might well reflect a wider range of antecedents.

For a brief period between 1764 and 1781, the Society of Apothecaries' records for 149 apprentices included details of their fathers' occupations, summarised in Table 3.5.⁷¹

⁷⁰ Loudon, *Medical Care*, p.30.

⁷¹ *Ibid.*, p.31.

Table 3.5: Occupation of Fathers of 149 Apprentices in London, 1764-81

Occupation	Number
‘Esq.’ and ‘gent’	57
Medical practitioner	30
Clerk	9
Clergy	8
Grocer, victualler, unspecified	3 of each
Farmer, yeoman, tea dealer, mariner	2 of each
Musician, mercer, merchant, ship’s purser, mathematical instrument maker, tailor, butcher, distiller, vintner, sugar refiner, vinegar merchant, maltster, carver, innkeeper, coachman, tobacconist, coal merchant, upholsterer, painter, tinman, foundling, glover, ironmonger, poulterer, stationer, watchmaker, builder, silversmith.	1 of each
Total:	149

Source: Loudon, *Medical Care*, p. 31.

Assuming the terms ‘esq.’ and ‘gent’ covered occupations similar to farming and landowning, then 40 per cent came from such backgrounds and 26 per cent came from professional backgrounds. The remaining 34 per cent came from ‘other’ backgrounds, largely commerce and trade. If the terms ‘esq.’ and ‘gent’ included business, commercial and other non-professional, non-land-related occupations, it may be legitimate to conclude that the range of social class backgrounds was higher than shown in the Bristol data. Thus these tables, while showing the middle class antecedents of many practitioners, also reveal a significant number of commercial and tradesmen backgrounds, more than might have been expected from O’Day’s proposition.⁷²

An analysis of parental occupations of Suffolk doctors active during the period from 1750 to 1830 adds to this picture of greater diversity in antecedents.

⁷² Jane Lane, *Apprenticeship in England 1600-1914*, (London, 1996). Lane, *Apprenticeship*, p.134 gives the occupations of fathers of apothecaries’ apprentices in five southern counties, but the sample is based on very narrow categories and therefore may be unrepresentative; the data is limited; it includes a large undefined section of ‘miscellaneous’. Because of all these caveats it is not included in the main argument. Nevertheless, however limited, it also reveals a significant number of commercial and tradesmen backgrounds.

**Table 3.6: Analysis of the Occupations of Fathers of
Suffolk Practitioners, 1750-1830, Compared to Apprentices, 1815-1858**

Occupation of Father	Practitioners*	Apprentices 1815-1858#
Medical practitioners	69	83
Clergyman	8	23
Brewer/maltster	2	1
Landowner	4	9
Vintner	2	
Farmer	2	13
Attorney/solicitor	1	5
Miller	0	3
Ironmonger	0	3
Saltmaster, cordwainer, military, carpenter, usher at Bury School, yeoman, hopseller,	1 of each	
Bank clerk, brewer, brickmaker, builder, cabinet-maker, clerk, druggist, fish-curer, hatter, oatmeal manufacturer, pipe-maker, printer, soap manufacturer, silversmith, schoolmaster, treasurer of town council, vet		1 of each
Total:	95	157

Source: * *SMB* and primary sources.

David van Zwanenberg, "Apprentices", p.149.

The examples involved are relatively low in number, with secure information available for 95 (or ten per cent) of the 950 plus cohort. These are set out fully in Appendix A and summarised in Table 3.6, together with the antecedents of apprentices who completed their training in Suffolk between 1815 and 1858.⁷³ Clearly, a direct comparison is not justified because of the variation in dates, albeit with a crossover between 1815 and 1830, but nevertheless the results are of sufficient interest for some conclusions to be drawn. The available information suggests that over 85 per cent of Suffolk doctors had fathers who were from the professional classes or landowners. This supports O'Day but is higher than Fissell, where in Bristol the figure was 60 per cent. Most significantly, it shows how the vast majority had fathers

⁷³ David van Zwanenberg, "The training and careers of those apprenticed to apothecaries in Suffolk 1815-1858", *Medical History*, 27, (1983), pp.139-150.

who were themselves doctors, the importance of which is discussed further below.

Examples of Suffolk medical practitioners who considered themselves of gentry background include John Steggall who, although born of a country curate, was one who “like many thousands of others at that period, had just sufficient competency to keep the respectable appearance of a gentleman”.⁷⁴ The Steggalls were linked to the Le Grys family who traced their ancestry back to William the Conqueror, and thus they would have regarded themselves as a family of substance.⁷⁵ John Green Crosse (1790-1850) was the second son of the lessees of Boynton Hall in Great Finborough near Stowmarket. The family had, for the two generations before John, been designated ‘gentlemen’, even though prior to that the Crosses were yeomen.⁷⁶ However, other examples from Suffolk reflect the wider social spectrum argued here. For instance, the father of Samuel Finch Scarnell {1823-1847}, surgeon of Woodbridge, was a cordwainer, and the father of the Cockle brothers surgeons, also of Woodbridge, John {1794-1849} and George {1768-1864}, was a vintner.

Michael Durey suggested that even in the early nineteenth century, medicine was not a prestigious profession.⁷⁷ Other evidence shows that the medical profession was considered by those in the lower middle classes to be a good option for raising the family’s social standing and ensuring a good income, a fact that by itself might have demonstrated to the upper classes that Durey’s contention was true. William Chamberlaine, writing in 1812, stated that:

“It is no uncommon thing for Parents, dazzled with the sight of so many Medical Men riding in their carriages - or, determined (holding trade in contempt) that a son shall be brought up to a genteel profession, to destine one or more of their sons, at a very early period of life to the Medical profession, without taking into consideration, whether the boy,

⁷⁴ Cobbold, *John H. Steggall*, p.10.

⁷⁵ Pip Wright & Joy Wright, *The Amazing Story of John Heigham Steggall, “The Suffolk Gypsy”*, (Stowmarket, 2004), p.7.

⁷⁶ Victoria Mary Crosse, *A Surgeon in the Early Nineteenth Century: The Life and Times of John Green Crosse 1790-1850*, (London, 1968), p.1.

⁷⁷ Michael Durey, “Medical elites, the general practitioner and patient power in Britain during the cholera epidemic of 1831-2”, in I. Inkster & Jack Morrell, *Metropolis and Provinces*, (London, 1983), pp.257-278.

when he comes to be of proper age to be an apprentice, may like the business, or whether he has talents and qualifications for it”.⁷⁸

George Crabbe was a good example of this social climbing. His grandfather had been Bailiff or first citizen of Aldeburgh in 1733, but his father’s position in the community had reduced to that of a saltmaster at Slaughden Quay, shifting barrels and earning a pittance: “he had a large family, a little Income and no Oeconomy”.⁷⁹ Aldeburgh itself “was a poor and wretched place”;⁸⁰ “slums, ruins, tumbledown beer-shops well to the fore and the while soaked in a mixture of gin, tar and tobacco smoke”.⁸¹ Crabbe’s father sent him to be an apprenticed apothecary at Wickhambrook in 1766, as George clearly was not going to have the brawn to move salt barrels and he “built sternly upon George’s precocity to achieve the rise from surrounding ignorance and poverty that he felt he would never attain”.⁸² It is reasonable to suppose that Crabbe’s experience was not unusual, and the paucity of hard data on those practitioners with a lowly background could simply indicate an unwillingness to declare it. More research from other provincial counties is needed to determine how far this interpretation can be generalised.

Alongside this was, in Michael Muncaster’s words, “a high degree of self-recruitment” within the medical profession.⁸³ It is apparent from Table 3.6 that a large number of Suffolk practitioners came from medical dynasties. Many were not just first generation, but often second or third generation doctors with frequently more than one sibling or close relative joining the medical profession. This had a significant effect on the mobility of Suffolk practitioners, and the dynasties appear to have formed the bedrock of the overall picture - very limited social mobility and the majority of doctors practising where they were apprenticed or nearby. Although the known examples are proportionately small, it seems reasonable to conclude that

⁷⁸ William Chamberlaine, *Tirocinium Medicum; or a Dissertation on the Duties of Youth Apprenticed to the Medical Profession*, (London, 1812), p.2.

⁷⁹ Thomas C. Faulkner (ed.) with the assistance of Rhonda L. Blair, *Selected Letters and Journals of George Crabbe*, (Oxford, 1985), Crabbe to Burke undated, undated June 1781.

⁸⁰ Rev. George Crabbe Jnr., *The Poetical Works of Rev. George Crabbe with his Letters and Journals and His Life*, (London, 1834), p.8.

⁸¹ Paul Chadburn, “Crabbe’s Aldeburgh”, *East Anglian Magazine*, 3, (1937-8), pp.15-18.

⁸² Neville Blackburne, *The Restless Ocean - The Story of George Crabbe, The Aldeburgh Poet*, (Lavenham, Suffolk, 1972), p.25.

there was a high level of stability among Suffolk medical practitioners, bearing in mind that the figures may be skewed if, as suggested earlier, doctors' sons were more ready to declare their fathers' occupations in national questionnaires (such as Foart Simmons') than were the scions of parents of lower status occupations.

Whilst very marked in Suffolk, this dynastic tendency was common nationally, and was financially very beneficial, as no premium was required for a family apprentice.⁸⁴ Joan Lane's study cites strong medical dynasties, such as the Langfords of Hereford or the Bree and Welchman families in Warwickshire.⁸⁵ In Norfolk over the period, Michael Muncaster found fifteen instances where two sons followed the father's occupation, and two cases in which three sons did the same.⁸⁶ For Suffolk, such dynastic activity appears particularly high, with 70 per cent of the cohort following in the father's footsteps, when compared to Bristol and the South West (28 per cent), the London apprentices (twenty per cent) and Lane's southern counties (twenty per cent).

David van Zwanenberg, in his study of Suffolk apprentices, concluded that medical practice in Suffolk in the first half of the nineteenth century was fairly parochial, with most of the vacancies being filled by men who had trained in Suffolk or neighbouring counties.⁸⁷ The evidence of a relatively low level of movement in Suffolk before 1800, particularly the very rural parts, reinforces this view. Of the 950 or so medical practitioners identified as practising at some time over the period in Suffolk, the place of birth can be verified in 68 instances (seven per cent). Some 31 (39.5 per cent) of those with a known place of birth actually practised where they were born and many more practised within a ten mile radius. Only fifteen (eighteen per cent) were born outside the county, and why such incomers arrived is unclear: some may have had a family connection, or may have taken posts as ships'

⁸³ Muncaster, *Medical Services*, p.137.

⁸⁴ Robert Gittings, *A Life of John Keats*, (London, 1968), p.61. Thomas Hammond of Edmonton was from a long line of surgeons, but appears to have quarrelled with his son who he apprenticed to another surgeon at a premium of £210. He quickly recovered the sum by taking John Keats as apprentice for the same sum.

⁸⁵ Lane, *Worcester Infirmary in the Eighteenth Century*, p.34.

⁸⁶ Muncaster, *Medical Services*, p.137.

⁸⁷ van Zwanenberg, "Apprentices", p.150.

surgeons to gain a passage to England, or moved hopefully in the knowledge that their existing location was unfavourable.⁸⁸ It is difficult to assess how typical the situation in Suffolk was, though Michael Muncaster's study of Norfolk practitioners estimated that almost two thirds of Norfolk doctors were native, with roughly 90 per cent of the 1820s practitioners born in the county.⁸⁹

Lack of movement is not surprising, since the main routes to practice were the purchase of a partnership, or an existing complete practice, or starting a practice on speculation, or becoming a paid assistant. Most options involved a considerable capital outlay initially. The customary purchase of a complete practice was reckoned by Michael Muncaster as being the equivalent of one and a half times the gross annual income, with the premium for a partnership roughly half that amount.⁹⁰ The aspiring practitioner also needed a dwelling where patients could be seen and where medicines could be dispensed, along with a suitable means of transport and domestic servants. Succession to the family business avoided this capital outlay and also had the advantage that professional networks existed already and patients would have known the incoming practitioner, all further inducements for a young practitioner to stay at or to return to home. In return for an apprentice to stay with his master, whether a relative or not, the master gained a young partner, who was trained in his methods, who knew the patients and would keep the practice thriving as he grew older. Professional secrets (including remedies) were in safe hands, and the young man would not set up as a rival or join with a competing practitioner.

Moreover, Suffolk was essentially a rural county, with no towns approaching the size of Bristol, let alone London. Its range of career opportunities would have been narrow. Geographic and social mobility, discussed in more detail later, was more constrained than in more industrialised and metropolitan

⁸⁸ Thomas Bayly was born in Norwich and was apprenticed to his father there. He became an assistant in Stowmarket in 1775 and settled there, marrying a local girl, Anne in 1780. He remained there until his death in 1834. A.J. Bartlet of Ipswich, 1795-1847 was born in Edinburgh; W.H. Williams of Ipswich, 1790-1839 was born in Gloucester; Robert Lovell {1783-1792} came from Barbados; Malfalqueyrat (1735-1789) came from France.

⁸⁹ Muncaster, *Medical Services*, p.69.

areas, and added to the limitations of career opportunities. Communities were small and introverted, and childhood and teenage years in a medical household would have been geared around the work of the practice. Options to start afresh in another profession would have been fewer, whereas the temptations and pressures to follow in the father's footsteps were great. In more urban areas such as Bristol, such constraints were less obvious, especially for the elitist group identified by Richard Smith, and in London clearly a greater range of occupations was more readily available.

Suffolk furnishes many examples where the tradition of entering the medical profession continued for three or more generations, and across siblings. For example, three sons of Edward Bigsby Beck (1760-1845) of Needham Market were all apprenticed to him and then became his partners.⁹¹ Similarly, Yoxford surgeon Robert Denny (1738-1801) had two sons who followed him.⁹² These are detailed in Appendix B, together with all those father and son practices as have been verified.

Some of these dynasties, such as the Freeman family of Earl Stonham, had complex histories. Daniel Freeman (d. 1757) practised there, and his son, another Daniel (1742-1810), was apprenticed and then in partnership across Earl Stonham, Stonham Aspel and Stowmarket. In turn, his sons Robert (1776-1845) and John Frederick (1780-1850) went into partnership with their father and then each other. Henry Lankester Freeman (1795-1877), relationship unknown but possibly another brother, was apprenticed to Robert and then joined him in partnership in Framlingham. John Frederick, after working with his brother for twenty years, then joined his nephew, Spencer Freeman (1804-1883), himself the son of Richard Freeman, a surgeon in Stowmarket (1768-1831).

Similarly, extensive family connections occurred with the Growses. Robert John Growse (1761-1840) was surgeon, apothecary and man midwife of Boxford and Bildeston, and his youngest son, Robert (1798-1877) was

⁹⁰ Muncaster, *Medical Services*, p.68.

⁹¹ Henry (1799-1891); Francis Duggan (1804-1882); Thomas Batman (1806-1885).

apprenticed to him. An older son, another John (1796-1854) went into partnership with his father, but there is no indication of his apprenticeship and it is possible he joined his father prior to the 1815 Apothecaries Act. Robert set up in practice in Bildeston and Hatcham, and fathered two more surgeons, Robert (1828-1870) and John Lawrence (1832-1901), apprenticed to him in 1844 and 1849 respectively.

A further example is the Lynn family of Woodbridge, a significant dynasty in East Suffolk. James Lynn (1700 -1775) and his son John were listed as surgeons of Woodbridge, but John died young in 1780. A second son, James (1740-1828) became his father's partner. In turn his son, yet another James (1770-1832), was surgeon and physician in Woodbridge and then Bury St. Edmunds. This last James' brother, George Doughty Lynn (1780-1854), was also a surgeon and physician in Woodbridge, and looked after the Suffolk Asylum at Melton.⁹³

In only about 50 cases in Suffolk are both the place of apprenticeship and of birth known. Of these, there is clear evidence that 42 practitioners took their apprenticeship in their hometown, or within ten miles of it. For example, Roger Hasted (1729-1794) was born, apprenticed and practised as a surgeon in Bury St. Edmunds, and similarly William Hardy Travis at East Bergholt in the family firm.⁹⁴ Their fathers and those of Joshua (1792-1818) and Charles Case Smith (1802-1873) in Bury St. Edmunds and of William Mudd Jnr. (1804-1882) in Hadleigh were likely to have known the local 'master', whilst he and his patients might have known the potential apprentice. Others, such as William Webber (1800-1875), moved from Stowmarket where he was apprenticed from 1816-1821 to the nearby village of Hopton, to his uncle Samuel's practice. Samuel practised as a surgeon until his death in 1822, when William advertised to his uncle's patients that he intended to take over the established family practice.⁹⁵

⁹² William Denny (no dates) and Henry (d. 1805).

⁹³ Another example of this was Thomas Bayly (1750-1834) of Stowmarket, who was John Green Crosse's Master and was the son and apprentice of a Norwich surgeon. His younger brother, John Bayly, was a surgeon at Swaffham, some 40 miles from Stowmarket.

⁹⁴ Beckett (ed.), *John Constable's Correspondence*, p.26. John Constable's sister wrote to him on 4 July 1808 "Mr Travis has of late been very unwell, and has found his son Will of great use to him".

These examples range across the whole period under review, and do not reflect any demonstrable change between 1750 and 1830. Only a few apprentices went to London, notably Edmund Goodwyne apprenticed to John Page (1730-1794) of Woodbridge. He became a London surgeon and apothecary, and then obtained his MD, eventually returning to his hometown of Framlingham, where his father was in practice.⁹⁶ Samuel Bacon (1804-1856) practised in Hampstead Road, London, after his apprenticeship to Samuel Gissing (1781-1846) of Woodbridge, and died in Camden Town.

More information is available on those who practised in their place of apprenticeship, with 346 instances (36 per cent) from the 950 strong cohort, indicating the tightness of the Suffolk medical community very well. It demonstrates that the vast majority stayed where they were indentured, and an even higher percentage practised within ten miles of their master, not a surprising figure in view of the dynastic evidence. However, the only information available for a third of the 346 is the record of their apprenticeship: some may have not practised in the area for any length of time; others possibly ceased to be doctors or took up other professions (such as George Crabbe who became a rector after three years of medicine); while others emigrated or died abroad.⁹⁷ Such ‘unknowns’ arguably were more likely to have moved some distance as, if they had remained nearby, it is probable that evidence concerning their marriages, children’s births and deaths, local newspaper advertisements, contracts with Poor Law overseers and so on would have been uncovered.

The evidence from Suffolk, particularly if it stimulates further research to supplement these findings in other rural counties, bears out the argument that the range of backgrounds and antecedents of practitioners was wider than some historians have maintained, and the narrow base of the data may be distorting the overall picture. The Suffolk evidence reflects the national preponderance of practitioners from medical families, where this appears to

⁹⁵ *Ipswich Journal*, various dates in June 1822.

⁹⁶ There is a monument to him in that town, praising his great intellect.

⁹⁷ Such as Isaac Blowers Ward, apprenticed to William J. Crowfoot at Beccles in the 1820s, who went to the Marylebone Dispensary for six months, after which there is no trace.

have been a very significant factor in career choice and levels of mobility. For example, Weaver and King state that most of the medical men for whom they found data were from medical families.⁹⁸ In Suffolk, the proportion of medical antecedents seems to be higher than found elsewhere. Bearing in mind the limited nature of the sample involved, the conclusion must be that the majority of the overall cohort of Suffolk practitioners in this period stayed within the county, with few travelling any distance from home or their place of apprenticeship to practise.

3.3 Numbers

“And if health on the number of Doctors depends,
Methuselah all we shall die, my good friends”.⁹⁹

Turning to the issue of doctor-population ratios, reliable figures for rural populations are not available, particularly before the first national census in 1801. Different criteria were frequently used depending on the reasons for any survey; for example, whether to include the poor, the militia, the communicants in a parish or the inhabitants on a great estate. Furthermore, practitioner to population ratios generally only take account of inhabitants of the immediate borough in which the practitioner lived or based his practice. Several factors could have changed these figures. The range of a practice was limited less by village or parish boundary than in practical terms by the distance (about eight miles) that a horse might cover in a day, either with the practitioner on horseback or by carriage, or how far an apprentice or patient might walk.¹⁰⁰ Since many practitioners might cover more than one village, their location might in fact not be the centre of the practice population at all, with rural parishes being attended by practitioners who lived and worked in adjacent market towns.¹⁰¹ In Birmingham in 1783, 24 practitioners were listed serving a population of 52,250, but “these men saw patients from beyond the

⁹⁸ Steven King & Alan Weaver, “Lives in their hands: the medical landscape in Lancashire, 1700-1820”, *Medical History*, 45, (2000), p.192.

⁹⁹ “‘Song of Old Bungay’ as sung at the Theatre by Mr Fisher”, in Suffolk Papers, BL 10351 i24 1-136.

¹⁰⁰ Anthony Trollope, *Dr Thorne*, (first published London, 1858), (Pan Books, London, 1968), p.47. Dr Thorne set his visiting fee for a circuit of five miles, with the charge increasing proportionately thereafter.

¹⁰¹ Joan Lane, *A Social History of Medicine: Health, Healing and Disease in England 1750-1950*, (London, 2001), p.23.

town as well as those from the rest of the county who attended the new hospital there”.¹⁰² It is true that only a fraction of the population served would actually see a doctor, but nevertheless the potential area was large. There are similar examples in Suffolk. Thomas D’Oyley {1773-1780} had a practice that covered both Botesdale and part of Thetford, and Benjamin Carter {1712-1753} had a practice area including Bures, Sudbury and Nayland. William Goodwin’s journal shows an even more complicated picture.¹⁰³ He was deemed the surgeon of Earl Soham, but a list of patients ‘Under Physical Directions’ in April 1787 shows patients from a range of towns and villages in a radius of five to six miles in all direction:

“Under Physical Directions:

Mrs Beaumont, Wilby, for a Dropsy in the Ovaria
 Mr Rodwell, Broadish, Diseased liver and Jaundice
 Mr Sheet, Marlesford, Abcess on the Abdomen
 Mrs Dutton, Marlesford, Chronic Complaints
 Mr Page, Ashfield, Fever and uncommonly malignant ulcers
 A Woman from Denington, Gutta Serena
 Mr Hart’s daughter, Worlingworth, Consumption and Dropsy
 Mrs Cullum, Denington, Scorbatie Eruptions
 Mr Lenny, Wilby, Consumption
 Mr Barber, Campsey Ash, Dangerous gunshot wound with Gangrene
 A child at Framdsen, Cancerous eye
 Mrs Pallant, Wilby, Diseased urethra
 Elizabeth Chapman, Framlingham, Consumption
 Mr Francis, Framlingham, Fever
 Mr Gazzard, Laxfield, Pleurisy
 Elizabeth Spalding, Brandeston, Jaundice”.¹⁰⁴

Nor are there any ready indicators of the percentage of a local population that might reasonably have access to a medical practitioner. Although they might call on the nearest practitioner, they might also travel further afield, particularly if they were better off and could afford both the fees and the cost of travel to consult a practitioner with a particularly high reputation. Proximity and accessibility to a market town or a larger centre of population could mean that many patients used the bigger town practices, going to see the doctor as they went to market for instance, or the Town Fair. Yarmouth surgeon Sir James Paget (1814-1899) wrote that:

¹⁰² Lane, “Medical practitioners 1783”, p.354.

¹⁰³ Joanna Rothery, “William Goodwin’s diaries 1785-1810”, *The Suffolk Review*, 42, (2004), pp.2-17.

“They came frequently on market days at the times of the spring and the fall, and generally they did their day’s work in the market and then walked to the surgery”.¹⁰⁵

Access also depended upon the class structure of an area, with some patients calling a practitioner from the local town rather than the nearest doctor. The provision for the poor might further affect a doctor’s practice population, since those lacking resources to become private patients might be treated under the Poor Law or by contract practice. A practitioner with a militia permanently based nearby, or with a hospital appointment, had less need of high numbers of private patients because of the steady income those appointments might bring. These factors taken together limit the certainty of any conclusions on practitioner ratios to populations, but nevertheless Suffolk evidence throws new light on some contemporary interpretations and current historiographies.

In his 1783 *Medical Register*, Foart Simmons listed 70 surgeon-apothecaries, ten physicians, two surgeons and only one apothecary in Suffolk. This is far less than those identified and used in this study, namely 23 surgeon apothecaries, thirteen physicians, 207 surgeons, nine apothecaries, plus another twelve with other titles, a total of 255 active in that year.¹⁰⁶ The issue of the accuracy and completeness of Foart Simmons is clearly important, as a number of current historians have depended on it for their conclusions. Joan Lane uses her work on medical practitioners of the county of Warwick to support the accuracy of Foart Simmons, and partly bases her reliance on his accuracy on the fact that Foart Simmons was a practitioner himself and therefore understood the different categories of medical status and qualifications. Yet it could equally be argued that his status as a physician blinded him to the significance of some of his errors, and limited his network of informers so that his data was skewed towards his own branch of the profession. In fact, Lane recognises that the register was full of inaccuracies, pointing out for example that he listed all those with the same name under one man, largely because he did not include forenames consistently and in

¹⁰⁴ William Goodwin, *Diaries at Earl Soham 1746-1816*, entry for 23 April 1787, SRO (Ipswich), HD 365/1.

¹⁰⁵ Stephen Paget, *Memoirs and Letters of Sir James Paget*, (London, 1901), p.21.

¹⁰⁶ See Table 3.2.

addition omitted certain individual practitioners' names.¹⁰⁷ The Suffolk experience underlines the fact that numerous errors were caused by the paucity of information returned to Foart Simmons, and the narrowness of his range of practitioners.

Michael Muncaster's work on Norfolk practitioners exemplifies the potential skewing of data from reliance on Foart Simmons. He maintains that the number and proximity of rivals and the population of the immediate practice area determined the total of rural practitioners.¹⁰⁸ His figures are partly outside the period under discussion for Suffolk, but rely in large part on Foart Simmons's data. Norfolk apparently had only 129 surgeon-apothecaries, fourteen physicians, one surgeon, and doctors that Foart Simmons described as "apothecaries only", a figure that looks reasonable in comparison to his own Suffolk figures, but remarkably low when compared to the number of active Suffolk practitioners identified by the later analysis. Such a discrepancy seems unlikely, given the relative populations and the number of significant towns in the two counties, and in this respect Muncaster's ratio of practitioners to population may be suspect.

Moreover, it is not clear how narrowly Michael Muncaster defines medical practitioners, but he clearly uses a tighter definition of those 'qualified' than does this study, and arrives at a crude overall doctor-population ratio of 1:3074 for the whole county, based on an overall population for Norfolk in 1831 of 390,386. He concludes that Thetford that year, with a population of 3,462 and two practitioners, had a ratio of 1:1731. Similarly, Norwich had a population of 61,364 in 1831 and Michael Muncaster identifies 25 doctors, a doctor-population ratio of 1:2,455. Steven Cherry, for the same year in Norwich, identifies eight physicians and 24 surgeons, and two qualified apothecaries,¹⁰⁹ using the contemporary commercial directories and arriving thus at an even smaller ratio.

¹⁰⁷ For example, two John Andersons were listed as one. One was a physician in Kingston, Surrey and the other a surgeon to the Newcastle Upon Tyne Dispensary.

¹⁰⁸ Muncaster, *Medical Services*, p.69.

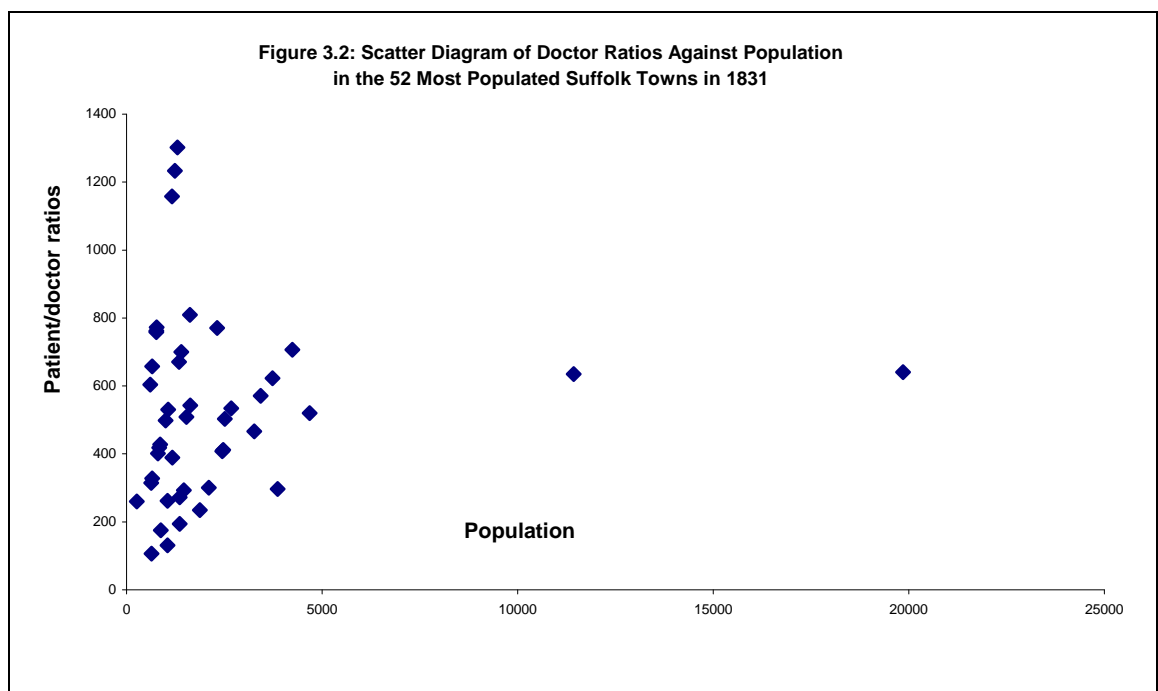
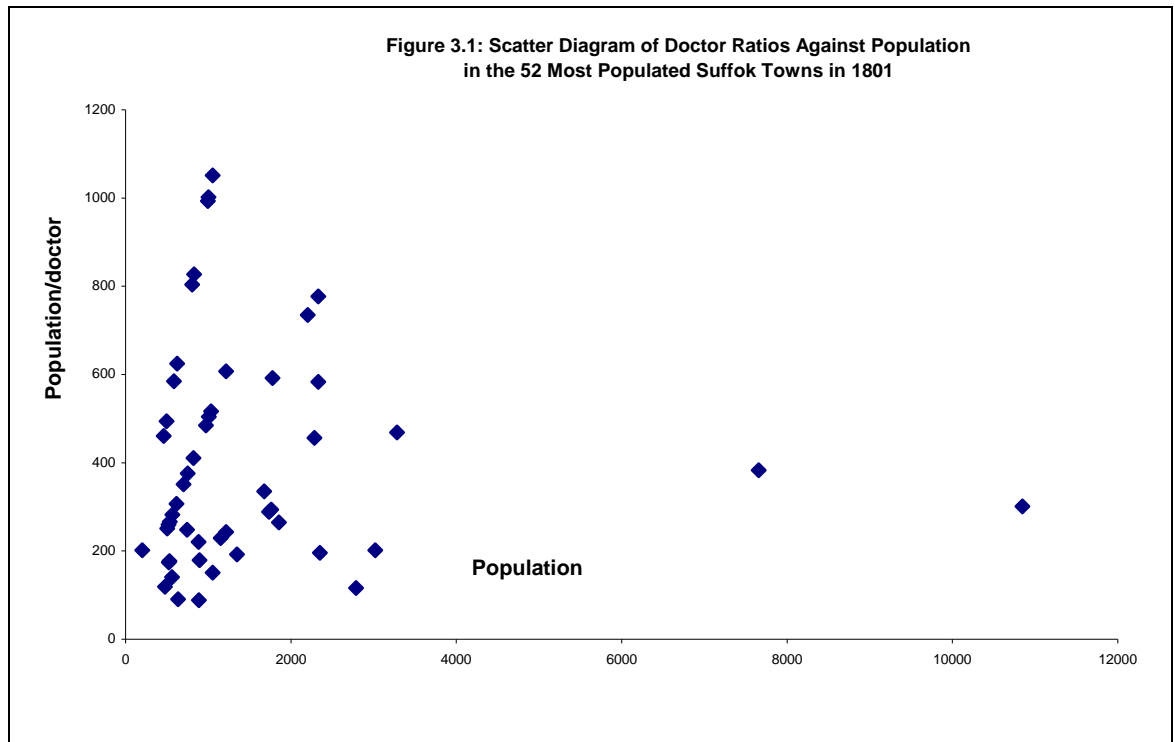
A comparison of Michael Muncaster's and Steven Cherry's figures with those derived from the Suffolk data produces remarkably different ratios for the latter. Ipswich in 1831 had a population of 19,855 and 31 active practitioners between 1825 and 1835 - a doctor-population ratio of 1:640. This compares with doctor-population ratios of under 1:500 by the 1770s and 1780s in Liverpool and Manchester.¹¹⁰ The data for Suffolk put forward here fits more closely to the figures suggested for national averages produced by Margaret Pelling.¹¹¹ She demonstrates that orthodox practitioners were not uncommon even in small towns, and well-populated rural areas had a ratio of all types of practitioners to population of about 1:400, which implies that figures used by Muncaster and Cherry, based on Foart Simmons, were very understated, even given their narrow interpretation of the term 'practitioner'.

In 1801, only ten Suffolk towns had populations exceeding 2,000, and only fourteen more had over 1,000, although the practitioner to population ratios may have risen or declined because of factors other than population changes. Overall, the crude average practitioner-population ratios for Suffolk towns and villages was 1:394 in 1801, rising to 1:506 by 1831, in line with Pelling's figures, and lower than conventionally assumed, though accepting that there are some outliers in both of those figures that may distort the outcomes.

¹⁰⁹ Steven Cherry, "Responses to sickness: medical and health care provision in modern Norwich" in Carole Rawcliffe & Richard G. Wilson (eds.), *Norwich Since 1550*, (London, 2004), pp.271-294.

¹¹⁰ King and Weaver, "The medical landscape", p.183.

¹¹¹ Margaret Pelling, *The Common Lot - Sickness, Medical Occupations and the Urban Poor in Early Modern England*, (London, 1998), pp.230-258.



Figures 3.1 and 3.2 show that of the 52 most populated towns and villages in Suffolk, 43 had practitioner-population ratios falling within a range of 1:100 and 1:700 for 1801, and 30 of them within a range of 1:200 to 1:500. By 1831 the picture was similar but the range was higher, being 39 within a range of 1:100 to 1:800.

Table 3.7 highlights the ratios in towns with populations over 2,000 and Figures 3.1 and 3.2 clearly indicate that at both dates these had doctor-population ratios towards the lower end of the scale.

Table 3.7: Doctor-population Ratios in Suffolk Towns With Over 2,000 Inhabitants in 1801 and 1831

Towns with a population of over 2,000	Doctor-population ratio 1801	Doctor-population ratio 1831
Beccles	1:115	1:297
Bungay	1:195	1:622
Bury St. Edmunds	1:351	1:636
Hadleigh	1:566	1:571
Ipswich	1:310	1:640
Long Melford	1:735	1:503
Lowestoft	1:777	1:706
Mildenhall	1:457	1:468
Sudbury	1:469	1:719
Woodbridge	1:201	1:293

Beccles and Woodbridge were the most comprehensively ‘doctored’ at both dates, with Lowestoft and Long Melford faring less well. This was almost entirely due to the reputation of individual practitioners, medical dynasties and the availability of apprentices. In the two biggest towns, Bury St. Edmunds and Ipswich, the ratio of people to doctors doubled. Possibly the rate of population growth outstripped the ability of the towns to attract new doctors, or their newly developing hospitals were attracting ambitious young doctors. New ways of treating and managing practices in the towns might have meant that one doctor could serve more patients than before, through more assistants and more apprenticeships. For example, George Stebbing of Ipswich was using his daughter Rachel as a nurse/surgical assistant from the 1820s onwards.¹¹² Moreover, by 1831, the increased need for qualifications and stricter regulations may have removed some of the quacks and empirics drawn to the towns, but who may have been included in the 1801 figures.

¹¹² David van Zwanenberg, “Interesting GPs of the Past - George Stebbing of Ipswich”, *British Medical Journal*, 283, (1981), pp.1517-1518.

Secondly, towns and villages with under 1,000 inhabitants generally did not fare any less well than bigger towns. Thus, Bildeston had a ratio of 1:271 in 1801, not very different from the neighbouring and larger Stowmarket. Indeed, some of the lowest ratios (under 1:100) appear in small villages like Boxford and Earl Soham. This gives no indication of course of the quality of practice or indeed the ease of access to the services offered.

The reputation of a practice, particularly where there was a strong dynastic ethos, may have been crucial, as for example in Woodbridge, where the Lynns and Pages worked.¹¹³ A practitioner with a high reputation would obviously have an impact. An example was the village of Ashfield, which had a population of 522 in 1801, but a high number of doctors (eight) overall in the period 1750-1830 and a doctor-population ratio of 1:178 in 1801. Yet in 1831, no doctors were listed at all, even though the population had risen by nearly 50 per cent. This apparently bizarre situation was almost certainly directly related to the practice of Roger Cooke (d. 1784), who was a surgeon there all his life, and was renowned throughout the county. He attracted apprentices continuously from 1728, and patients from well beyond the confines of the village. Once he died and his apprentices had moved on, the practice became less viable and probably by 1831 the population was served by doctors from neighbouring towns and villages.

Overall, the evidence reviewed demonstrates how some modern assumptions about the backgrounds and antecedents have created a picture of the surgeons and apothecaries in the period under review that is not entirely supported by the research for Suffolk. Additionally, it suggests that there were more medical practitioners there than previously thought and their distribution was roughly in keeping with population centres - even modest ones. Ratios of populations to practitioners were lower than assumed by some writers and more in keeping with Margaret Pelling's findings, though they are based on limited data and necessarily crude calculations. Seemingly, Suffolk

¹¹³ See Appendix B for the medical dynasties in Woodbridge.

was well doctored in terms of the numbers of practitioners and their geographical spread.

This dissonance between views may therefore distort the understanding of how practitioners were integrated within their communities, as well as how they delivered healthcare. Moreover, it raises the possibility that the provincial practitioner was not merely playing catch-up from Margaret Pelling's sixteenth century healer to Irvine Loudon's nineteenth century general practitioner, but was in fact a stand-alone link in that development. Evidence presented in the next chapter about schooling and apprenticeship experiences adds to this possibility.

CHAPTER 4: HOW THEY WERE EDUCATED AND TRAINED

“A parent who would wish a young man to follow the profession of a Surgeon-Apothecary with credit, or commendable emulation, should take a very early survey of the requisite school-learning, as well as the competency of a professional preceptor...”¹

This chapter will first attempt to shed light on the early schooling of medical practitioners in Suffolk, then determine if any meaningful conclusions can be drawn from what is limited evidence. Most research on the education and training of medical practitioners in the late eighteenth and early nineteenth centuries is focused on what might be described as higher and further education - apprenticeship, university education and experience in the emerging teaching hospitals. This may be because knowledge of primary and secondary schooling is limited, derived predominantly from urban and metropolitan areas, as well as skewed towards the renowned and successful practitioners. Therefore, it is supplemented by a review of the contemporary schooling provision in Suffolk, plus the histories of some individual practitioners. The importance of this exploration, in spite of the difficulties of the evidential base, is that it provides clear examples of the metro-centric approach this thesis is challenging at the very earliest stage of a medical practitioner’s development, and demonstrates the value of an in-depth county review with the narratives that such an approach reveals.

Secondly, the chapter discusses the next stage in a surgeon’s and apothecary’s education and training (namely apprenticeship) and raises the issue of whether that differed significantly in the provinces in its context, content and prevalence from that of London and other metropolitan areas. In both these areas, conclusions from the range of evidence and discussion are rather different from much of the current historiography.

4.1 Schooling

Any discussion of schooling is complicated by the considerable confusion over what the term ‘grammar school’ actually denotes, both to contemporaries

and in modern commentaries. This is illustrated by conflicts in evidence between the conclusions derived from the systematic study by Nicholas Hans in 1951, based upon a random sample of 120 eighteenth century medical practitioners drawn from the *Dictionary of National Biography (DNB)*, and an analysis of all those named ‘medical practitioner’ or ‘apothecary’ for the period of 1750-1830 in the *DNB*, set out in Table 4.1.²

Table 4.1: Type of Schooling from DNB Analyses

Title	Public & Royal Grammar Schools #	Endowed Grammar Schools and Dissenting Academies#	Private Schools	Home or Tutor
	%	%	%	%
* Hans’ 120 practitioners	28	29	14	28
Analysis of practitioners listed in <i>DNB</i> as active between 1750-1830	16	36	32	13

Source: * Nicholas Hans, *New Trends*

The figures for public schools and royal grammar schools, and the endowed grammar schools and dissenting academies, have each been combined into a single category for ease of display.

The later analysis shows a higher percentage of practitioners educated at endowed grammar schools and dissenting academies or at private schools than Hans’, with far fewer receiving public school and royal grammar school education or home tuition. As entry into the *DNB* had as its criteria “people who have left a mark for any reason, good, bad or unusual”, such figures were likely to be skewed towards the elite or at least well-known in the profession, and therefore constitute an unrepresentative sample if one is looking across the whole field.³

In both sets of figures, the limitation is that the *DNB* gives no clear definition of what is meant by the type of schooling listed, and although over half the medical entries were classified as physicians, the *DNB* gives no definition of

¹ James Lucas, *A Candid Inquiry into Education, Qualifications and Offices of a Surgeon Apothecary*, (Bath, 1800), p.24.

² Nicholas Hans, *New Trends in Education in the Eighteenth Century*, (London, 1951), Table 3 quoted in Irvine Loudon, *Medical Care and the General Practitioner 1750-1850*, (Oxford, 1986), p.34.

³ www.oup.com/oxforddnb/info/quickguide/who/

the medical titles, nor how consistently they were used. Further problems emerge from a wider analysis of *DNB* entries. For example, entries for physicians (82) far outweigh those for surgeons and apothecaries together (28). The former almost all attended university and were from schools that provided classical education, namely a public or royal grammar school, whose pupil lists were more likely to be extant. Thus such schools will appear to predominate.

In spite of these significant reservations about the *DNB* data, some historians have concluded that the medical practitioners of that time were predominantly public and royal grammar school educated. Thus, Bernice Hamilton, writing in 1951, stated that “the apothecary was generally the product of a grammar school, where he learned enough Latin to read and write prescriptions”.⁴ Michael Muncaster’s work on Norfolk practitioners also suggests that before 1830 practitioners were usually local grammar school boys.⁵ According to his evidence, most Norfolk practitioners attended Norwich Grammar School, with a number at Holt, Paston and Stowmarket grammar schools. Irvine Loudon, writing forty years after Hamilton, supports her view with examples from across the country. Richard Smith Jnr. of Bristol was sent to Warminster Grammar, but ran away because the discipline was too great, and then he went to Winchester School; John Padmore of Taunton was educated at Tiverton Grammar School; Trevor Morris attended Monmouth Grammar School; and Edward Jenner at Cirencester Grammar School and a small private school at Wootton-under-Edge.⁶ Juanita Burnby’s depiction of an “examined and free apothecary” similarly argues that “it is probable that he [the apothecary] had attended his local grammar school”, whilst admitting that little was known of apothecaries’ lives prior to apprenticeship.⁷ These conclusions, based as they are often on single random cases, are difficult to sustain simply because of the paucity of information and the lack of clarity of terminology.

⁴ Bernice Hamilton, “The medical profession in the eighteenth century”, *Economic History Review*, *Second Series*, 4, (1951), pp.6-9.

⁵ Michael J. Muncaster, *The Medical Services and the Medical Profession in Norfolk 1815-1911*. Unpublished PHD, University of East Anglia, 1976, p.138.

⁶ Irvine Loudon, *Medical Care and the General Practitioner 1750-1850*, (Oxford, 1986), pp.35-37.

Moreover, evidence adduced here on Suffolk doctors throws further doubt on the accepted views and suggests some alternative, more realistic and cautious ways of describing practitioners' early education. It is in the form of direct data from primary sources, evidence concerning educational provision in the county, and direct or anecdotal information from several practitioners. The information is limited, with material on just 31 individuals listed in Appendix D, just three per cent of the Suffolk cohort used in this study. Twenty of these 31 entries attended the grammar schools at Bury St. Edmunds and Ipswich, where pupil registers are extant. Registers from more transient, less well-established and endowed grammar schools or their close cousins, the private and commercial schools, were not kept or do not survive. Thus, far less is known about their pupils or the professions they eventually followed. It would be unwise therefore to conclude from such limited evidence that the majority of surgeons and apothecaries were 'grammar school boys'. Indeed, the Suffolk evidence suggests that its practitioners had a wider variety of schooling backgrounds and that a majority were as likely not grammar school boys. They could have attended private schools or been educated at home by a parent or private tutor or even, as Carl Pfeiffer suggests, had no formal education at all prior to taking out their letters of apprenticeship.⁸

Given the difficulties surrounding travel at the time, it is hardly surprising that there are few examples of Suffolk practitioners with backgrounds in the 'great public schools', as the county possessed none between 1750 and 1830.⁹ The few who did attend had to travel. They included Thomas Gery Cullum (1741-1831), surgeon of Bury St. Edmunds, who went to Charterhouse, as befitted a baronet. Among Ipswich practitioners, surgeon and medical officer George Bullen (1791-1871) was educated at Oundle; physician Edward Venn (1717-1780) went to St. Paul's London; and physician William Henry Williams (1771-1841) was educated at a private school near Beverstone Castle. They

⁷ Juanita Burnby, "An examined and free apothecary" in Vivian Nutton & Roy Porter (eds.), *The History of Medical Education in Britain*, (Amsterdam, 1995), pp.16-36.

⁸ Carl J. Pfeiffer, *The Art and Practice of Western Medicine in the Early Nineteenth Century*, (Jefferson, N.C., 1974), p.14.

constitute only seven per cent of the overall cohort whose schooling is known, much lower than the percentage in Nicholas Hans' survey, and indeed so low as to be inconclusive.

The nearest foundation to a public school was King Edward's School at Bury St. Edmunds, founded in 1550 under Royal Charter granted to "the Free Grammar School of King Edward VI for the education, managerial and instruction of the boys and youth in grammar forever". 'Free' meant that all boys were to be treated alike, except that a poor man's son would be excused from making the admission payment, the school being required to "teach poor men's children with as much care and diligence as rich".¹⁰ Evidently it had a good reputation, and some of the sons of the Lynn medical dynasty of Woodbridge attended as 'foreigners' (i.e. from outside Bury St. Edmunds), rather than taking places at the local Free Grammar School at Woodbridge. Boxford was another town with a Free Grammar school, founded in 1595 by Royal Charter. It was technically a royal foundation, but was actually maintained by local worthies, until it fell into decline in the early nineteenth century.¹¹

Cardinal Wolsey, a native of Ipswich, proposed to build a College there, aping the Royal Foundation at Eton, but his plan died with him. However, it was established by Charter from Elizabeth I in 1566 as "a certain general and free Grammar School... within our town of Ipswich".¹² John King, father of Suffolk physician William King, was Master from 1767-1798 and Town Preacher or

⁹ Some ancient schools like Winchester or Eton owed their origins to a charter of foundation granted by a royal or eminent person, or were attached to a cathedral or collegiate school, such as King's School Canterbury and St. Peter's at York.

¹⁰ C.W. Elliott, *King Edward's School*, p.171. *Statutes of Bury School, 1665* "concerning the free grammar school of Kind Edward VI at Saint Edmund Bury agreed upon and subscribed by the Governors and confirmed by the Right Rev Father in God, Edward Lord Bishop of Norwich 1665".

¹¹ *Boxford Queen Elizabeth Free Grammar School, Governors Papers*, (1778). SRO (Bury St. Edmunds), GD 503/8, eight boys were taught as free scholars, two each from Boxford, Edwardstone, Groton and, after 1771, Assington. In fact, the Governors' Minutes of 10 September 1778 make clear that it was not designed for the aspiring middle classes, "they shall be taught spelling, reading, writing and arithmetic".

¹² Jane Fiske (ed.), *The Oakes Diaries - Business, Politics and the Family, Bury St. Edmunds 1778-1827*, (Bury St. Edmunds, 1990), p.39. No trace of the original document reported, only that the text is inscribed on Patent Rolls in the Record Office.

Lecturer until 1792,¹³ a “venerable Master... who raised the reputation of this school to the highest pitch during the 31 years he presided over it”.¹⁴ All four King boys, William, Robert Carew, George and Edward, all of whom became medical practitioners in Suffolk, probably attended their father’s school.¹⁵ Other local medical men may well have attended the school, simply because of King’s reputation.¹⁶

Beyond the ‘royal’ foundations there was a wide diversity of education provision in Suffolk, ranging from charity schools such as that at Nayland, organised by Church and Chapel Ministers and funded by appeal and Sunday collections; grammar schools such as those founded at Sudbury and East Bergholt; endowed grammar schools in the bigger towns; and academies such as Botesdale Grammar School, a private commercial establishment. Moreover, the title ‘grammar school’ covered a wide range of foundations and titles, and were seemingly used without common definition and with an eye to enhancing their marketability. Thus, distinguishing one type of school from another by its chosen name alone is as problematic as use of the title ‘surgeon-apothecary’.

During the eighteenth century most great public schools experienced fluctuating fortunes, although opportunities for a more liberal education were increasing. Classical education held little appeal for the growing middle classes, who derived much of their prosperity from trade and demanded a more practical training.¹⁷ Moreover, it was reported that boys at public

¹³ Irvine E. Gray & William Potter, *Ipswich School 1400-1950*, (Ipswich, 1950), pp.77-80. In the age of pluralism King was also Rector of Witnesham from 1776-1822, 28 years of which he was not resident in the parish.

¹⁴ George R. Clarke, *History and Description of Town and Borough of Ipswich, Including the Villages and Country Seats in its Vicinity*, (Ipswich, 1830) p.285.

¹⁵ Several of the King boys became surgeons, though William went from Ipswich School to Westminster, Oxford and Cambridge and St. Bart’s to be a physician. Robert Carew (1781-1842) became a respected surgeon in Saxmundham where, according to a memorial inscription in Witnesham Church, he “resided nearly 40 years... and attained great eminence by his skill in surgery and medicine”. George was active in Hartest from about 1820 and the *Ipswich Journal* noted that he was still in practice there in 1870. Edward obtained his MRCS in 1810 and died aged 26 in North Hyderabad while serving with the Honourable East India Company, his death being announced in the *Ipswich Journal*.

¹⁶ William described how, “there was no legal fagging in the school but a good deal of bullying... A schoolmaster then always had a stick in his hand... All ignorance was imputed to wilfulness, not incapacity; for this reason flogging was the order of the day...”.

¹⁷ John William Adamson, *A Short History of Education*, (Cambridge 1919), p.219. Eton in the period 1754-1765 had over 500 pupils, but by the period 1765-1788 this fell to 230.

schools were very unruly; for example, at King Edward VI's at Bury St. Edmunds, where boys of the Royal Foundation locked out their headmaster, and "afterwards left their master's House in Triumph".¹⁸ One result was that families were tending to send their sons to private or endowed schools, in moderately urban centres such as Ipswich and Bury St. Edmunds, but also the many smaller country towns, or having them educated at home.¹⁹

There were also notable endowed schools at Woodbridge, Colchester and Eye.²⁰ Robert Drury {1750}, surgeon of St. Osyth, was listed as a pupil at Colchester Grammar School, for which school registers are extant. Woodbridge Free Grammar School was founded in 1577 during the Civil War, but was re-established in 1662, as part of the new expression of confidence with the restoration of the monarchy in 1660.²¹ It flourished in the eighteenth century, when the East Anglian gentry (including some most likely younger sons destined for a medical career) sent their sons there in great numbers.²² Thus, in 1800 it advertised in the *Ipswich Journal* for:

"a Master for the Free Grammar School at Woodbridge - stipend £50 plus house and garden - very commodious for the reception of boarders, and other advantages; for which the Master is required to instruct Ten Boys gratis, in writing and arithmetic, and in the learned languages, if required by the parents".²³

¹⁸ Bury St. Edmunds Grammar School, *Minutes 1776-1836*, SRO (Bury St. Edmunds), E/5/9/202.2, 28-29 April 1784.

¹⁹ Fiske, *The Oakes Diaries*, p.39.

²⁰ Colchester Grammar School began as a chantry school, when revenues from the chantries of St. Mary's Church and St. Helen's Chapel were passed to the bailiffs, burgesses and commonality of Colchester on condition that they devoted a portion of the monies "to found and maintain within the said town a Free School". Eye Grammar School also started as a chantry school in 1495, becoming an elementary as well as a secondary school in 1593, with an endowment from Francis Kent of Oxbrough in Norfolk to maintain an usher or second master to teach grammar and writing to the junior school. By the mid-seventeenth century it was at a low ebb, until Thomas Brown was appointed Master and Usher. He had opened a private school in the town and was invited to bring his boarders with him "which it is hoped may bee a good means to restore the scholle, which is nowe decayed and near to nothing". The school continued essentially as a private school until 1822 when Rev John Kent was appointed master at twenty pounds a year, to teach boys to read, write, common rules of arithmetic, to Catechise. Education was free and he was allowed to take a further twenty fee-paying boys and four boarders for his own profit.

²¹ Robert Marryott, a local worthy, sought to raise money and gain interest and support for the new school. Local citizens contributed generously and helped in the appointment of a headmaster who "hath a good house, in which is a large room for a school and conveniences for boarders". He was commanded to teach "ten sons of the meaner sort of the inhabitants of the town" without charge, and additional pupils paid an annual fee of one pound.

²² www.woodbridge.suffolk.sch.uk/history.html (January 2008).

²³ *Ipswich Journal*, 22 November 1800.

No registers are extant, but it is reasonable to assume, given the nature of the curriculum, that potential medical practitioners would have been pupils there.

Beccles confusingly had both a Free School (Sir John Leman's School), and a Grammar School (Fauconberge School).²⁴ These illustrate the different needs and aspirations of parents. Pupils at the Free School had to be eight years old to apply, be able to read fluently and would be taught "writing, costing accounts and ciphering, for the four years they were there".²⁵ Fees were set at twelve pence a year for those able to pay and sixpence for the less well off and schooling was free for those adjudged by the Port Reeve to be suitably deserving cases. In contrast, Fauconberge School taught Latin and Greek, and prepared boys for university. It advertised in 1806:

"Board and English Education 25 guineas p.a., Entrance one guinea. Latin and Greek by Rev. L. Girdlestone, five guineas pa. Drawing, Dancing, and French by eminent Masters four guineas per annum and half a guinea entrance".²⁶

This was a curriculum to appeal to parents of would-be professionals and medical practitioners. However, the divide in terms of later careers between the two schools in the one town was not clear cut. Fauconberge pupils in the late 1780s included practitioners H.S. Davey (1781-1855), Charles Assey {1800} and Joseph Arnold (1782-1818), later to become a naval surgeon, and none of whom were physicians.²⁷ Fauconberge School declined in the early eighteenth century relative to the Free School, and the newer Beccles Academy. It also suffered from the decline in interest in classical education, although:

²⁴ John Kirby, *A Suffolk Traveller, or a Journey Through Suffolk*, (London, 1764) p.179. Sir John Leman, an alderman of London in the reign of James I left in his will "Lands and tenements in Beccles, Barsham and Ringsfield and adjoining villages for the continuation of the school he had founded in Ballygate Street", this providing a Free School, endowed with an hundred acres of land. Dr Henry Fauconberge, an estate owner of Beccles gave his land "...for the endowment of a grammar school here: the master whereof is to be elected by the bishop of Norwich, the archdeacon of Suffolk and the rector of Beccles for the time being".

²⁵ Pam Hardman & Maureen Saunders, *The Book of Beccles and its Hospital: a Century of Caring*, (Tiverton, 2004), p.46.

²⁶ *Bury Post*, 1806 variously throughout the year.

²⁷ Henry Sallows Davey became a surgeon in Beccles; Charles Assey had an adventurous career in India and died early; Arnold served for a time on HMS Victory just prior to Trafalgar; he also wrote extensively on Natural History, and he is immortalised in the specific name of the genus 'rafflesia' which honoured the founder of the British colony of Singapore. Arnold was Raffles' botanist on the

“it could readily have found pupils in a town with the families of four or five doctors, four or five solicitors, several substantial merchants and with numerous clergy and landed gentry in the neighbourhood”.²⁸

Limited though the data is, the style and reputation of the school again made it likely that more pupils became medical practitioners than can be directly identified.

Bungay Grammar School originated in 1565 as an endowed school, whose ordinances were based on those of Eton, and was well endowed by the local Feoffees.²⁹ The only surviving record of surgeons and apothecaries attending the school was that of Aldeburgh surgeon George Crabbe (1745-1832). Such subscription schools could have fairly short lives, such as the Friends School in Ipswich that opened in 1790 and closed ten years later for lack of subscribers.³⁰ Their transient nature adds to the complexity of the data.

Other schools were founded by individual philanthropists such as Thomas Mills (1623-1703) who moved from Grundisburgh to Framlingham to learn wheelwrighting, making a good fortune by hard work, inheritance and a good marriage. He left his estate to the needy and elderly, and to educate the children of the town and district. The first Mills school established in 1751 flourished for over a century.³¹ Similarly, in Wickham Market, Anne Roberts in

voyage. He is said to have died too young to have fulfilled his early promise, Eugene A. Ulph & Muriel McCarthy, *The Sir John Leman School, 1631-1969*, (Beccles, 1970), p.14.

²⁸ Edwin Alvis Goodwyn, *The Fauconberge School, Beccles 1770-1926*, (Beccles, 1980), p.11.

²⁹ Richard R. Houghton, *Bungay Grammar School 1565-1965*, (Bungay, 1965), pp.38-46.

³⁰ Leslie Johnston, “The Friends School in Ipswich 1790-1800” *The Suffolk Review*, 1, (1957), 4, pp.69-72. Representatives of the Quarterly Meetings of Friends in Essex, Suffolk and Norfolk met in Ipswich in 1773 to “consider the propriety of establishing a Boarding School for the education of Friends’ children” where “none but the children of friends” be admitted”. It was felt “most expedient first to establish a boys’ school and that endeavour be speedily used to effect the same” but “one for girls would be very desirable”. A Committee was set up to raise money through donations and to look for a suitable house. William Candler was appointed as Master. The School opened in late summer 1790, and the Committee had to approve all the books used. Its fees were increased to try to make it independent of subscribers, but Candler had had enough by 1799, and no-one would take it on. So on 20 January 1800 a General Meeting of Subscribers acknowledged “that the purpose for which the School Premises were bought is now passed by, and there being no probability of its being renewed, This Meeting is of the Judgement that the same be sold for the most money that can be made thereof”.

³¹ www.thomasmills.suffolk.schools.uk (January 2008).

1730 left a bequest with which lands were acquired for amongst other things the teaching of children.³²

In summary, the Royal and major foundation schools like Colchester, Bury St. Edmunds and Ipswich, and small proprietary or Free Grammar schools were for the middling sort of people and those with aspirations and the means to rise in station through their children. Such educational routes were obviously attractive to those seeking a medical living for their sons, if they could afford and appreciated the need for the expenditure. They provided some or all of what James Lucas listed as the minimum educational attainments for medical practitioners: grammar, Latin, Greek, French if possible, handwriting (“neat and intelligible”), composition, arithmetic, shorthand, public declamation and letter-writing.³³ Latin and Greek were in the main the prerogative of the would-be clergy and other professionals (like doctors), usually to prepare them for university and apprenticeship as a surgeon or apothecary. Most also met William Chamberlaine’s stricture that future doctors must have Latin, with a formal education before their apprenticeship.³⁴

However many, perhaps most, practitioners had early schooling in one of the county’s many private boarding schools that had grown in number, benefiting from the measure of freedom conferred on non-conformist teachers in 1779. These were deemed more ready to experiment than more prestigious establishments.³⁵ The disadvantage was that this often meant no common curricula or standards and their courses usually provided vocational training rather than education, often designed to fit pupils for future business careers. Typical subjects therefore were grammar, writing, arithmetic (both vulgar and decimal), merchants’ accounts and book keeping, along with rudimentary Latin and those parts of mathematics that could be applied to business or on

³² www.british.history.ac.uk/report Wickham Market School and Anne Roberts (January 2008).

³³ Lucas, *Candid Inquiry*, pp.5-8.

³⁴ William Chamberlaine, *Tirocinium Medicum (or a Dissertation on the Duties of Youth Apprenticed to the Medical Profession)*, (London, 1812), pp.2-7.

³⁵ Protestant dissenters had been forbidden to teach in all but the more humble schools after the Courts of Law ruled in the Cox case of 1700 that the ancient Episcopal control of teachers was limited to teachers of grammar and the ecclesiastical courts had no jurisdiction over writing schools, reading schools, dancing schools etc.

board a ship. A typical advertisement for an early nineteenth century private boarding school read:

“At the Literary and Commercial Academy, Northgate St, Bury St Edmunds, Young Gentlemen are Boarded and carefully instructed in the various branches of Commercial and Mathematical Education. By Mr Sewell On the following terms

Entrance One Guinea	
Boarding and Lodging per annum	
Under 8 years of Age	16 Guineas
Above 8 and under 10 years	18 Ditto
-----10 and under 14 Years	21 Ditto
-----14 Years of Age	21 Ditto

Education

One Guinea per quarter under which is comprehended - Reading, Recitation, English Grammar (Lindley Murray's System), Composition, Writing, & Arithmetic.

Book keeping, Merchants and Bankers Accounts, Practical Geometry, Mensuration, Mapping, Geography, and the use of the Globe are separately considered.

Mr Sewell with a lively sense of gratitude to those Friends who have indulged him with the care of their Children respectfully informs them and the Public that the avocations of his Seminary terminate this Day and will be resumed on Wednesday the 26th July next.

The proximity of the above situation to that of the Free Grammar School will facilitate the views of those Parents who may wish their Children to Unite a Classical with a Commercial situation”.³⁶

Some private schools offered a curriculum that fitted in with Lucas' and Chamberlaine's requirements and would have been likely to attract pupils destined for medicine.³⁷ Nayland, a preparatory school run by Alexander Smith in Fen Street in about 1815, offered tuition, board and minimal laundry for twenty pounds a year, with extra charges for Italian, French, Latin, Greek, and Drawing. According to the parish census for 1821, his school had ten males and three females. There is no evidence as to who the pupils were, but the fee and the requirement of “white stockings and neckerchiefs” suggests pupils from monied and professional classes, including the children of surgeons and apothecaries.³⁸

³⁶ *Bury and Norwich Post*, 21 June 1809.

³⁷ M.E. Clegg, “Some eighteenth century Suffolk schools”, *The Suffolk Review*, 1, (1957), 3, pp.55-58.

³⁸ Mary George, *A History of Nayland Schools 1707-2004*, (Nayland, 2005), p.8.

A large number of houses became day or boarding schools of variable quality, some even sharing extra curricula subjects such as dancing and drawing.³⁹ In Suffolk and East Anglia generally, hardly a town or larger village was without such a boarding school, to judge from advertisements in the local journals.⁴⁰ According to the *Ipswich Journal*,⁴¹ Edmund Rogers and his wife Frances ran “a respectable boarding school” in Walsham le Willows from the early 1760s.⁴² Philip Carter of Cross Keys Street in Ipswich in 1741 was teaching, among other subjects, writing and accounts “with a continual View to Business, the Ultimate End and Deign of Instruction in these Arts”.⁴³ Sir James Paget (1809-1892) dismissed them all rather disparagingly, but probably correctly, as:

“the greater part of private schools in small towns were kept by persons who had failed in other callings in life and were generally deemed unfit for the public service or any more active business”.⁴⁴

Fees of between ten and sixteen guineas per term restricted the clientele to those with parents on secure and relatively high incomes.⁴⁵ Paget’s father was only paying eight guineas a year for each of his seven sons. He was originally a successful brewer and the three elder sons went to one of the chief boys’ schools in Great Yarmouth (his home town), “kept by Mr Bowles, a careful,

³⁹ Goodwyn, *Fauconberge*, p.30. Peter Routh, the first master at Fauconberge School in 1770, had given up a private school which was taken over by Charles Brightley, but Routh continued to take classes there for classics. His successor, John Girdlestone, taught Latin and Greek at five guineas a year as an extra to boys at the Free School. The ‘proper’ masters for Dancing and Drawing came to Beccles once a week and were shared between several schools.

⁴⁰ *Bury Post*, Thursday 6 June 1783. “At Stetchworth a very pleasant and healthy village... a large mansion is fitted up for the reception of Young Gentlemen who will be genteelly boarded and carefully educated by the Rev John Crowe (graduate of Oxford) and able Assistants, at Sixteen Guinea per annum and One Guinea Entrance. The strictest attention will be paid to the health and morals of the scholar, and the utmost endeavours to prepare them in the proper manner for the University or Business”.

⁴¹ *Ipswich Journal*, September 1743. Robert Twigger of East Bergholt advertised that youth be “carefully educated and expeditiously qualified for business”. Richard Scrivener at Framlingham in 1760 taught Latin, Greek and Hebrew as extras, together with dancing as required. In 1761, Samuel Haddon of Ipswich St, Stowmarket was teaching writing, arithmetic, mensuration, geometry, trigonometry, navigation etc.

⁴² *Ipswich Journal*, 17 January 1807. In an obituary to Mrs Rogers, the school was described as a girls’ school, and indeed an advertisement in the *Bury Post* for January 1787 referred to a school for young ladies, so it seems likely that they ran a girls’ school alongside the boys. The boys’ school seems to have continued under their son, Arthur, who advertised in both the *Ipswich Journal* and the *Bury Post*, soliciting a continuance of favours afforded to his parents.

⁴³ *Ipswich Journal*, 1741 variously throughout the year.

⁴⁴ Stephen Paget (ed.), *Memoirs and Letters of Sir James Paget*, (London, 1901), p.11.

⁴⁵ Sometimes there was an entrance fee of one guinea and an extra quarterly charge for optional subjects. For example, Mr Causton of Lavenham charged ten guineas in 1770 for pupils aged six to ten years, twelve guineas for pupils aged ten to twelve years, and fourteen guineas for those between twelve and fourteen years.

well-mannered and generally well-informed man, who had been an actor and was now minister of the Unitarian Chapel”. They then went to Charterhouse, but their father fell on hard times and could only afford the lesser academy for James.⁴⁶ Fees for Suffolk schools compared well with the national average price of 25-30 guineas in 1771, perhaps reflecting the level of competition and sheer number of schools there, as well as lower average earnings.⁴⁷

Additionally, there were schools founded by the National Society for the Education of the Poor in the Principle of the Established Church, founded in 1811. The second annual report of its Suffolk Branch recorded Beccles School with 120 boys and girls as the largest in the county next to Ipswich and Bury St. Edmunds. Individuals could nominate a child for each five shillings subscribed, Feoffees granted fifteen pounds per year from 1815 and the Corporation ten pounds from 1822. Parents were expected to pay one penny a week for instruction in reading and two pence if writing and arithmetic were also taught. Grants made by the National Committee towards the building, enlargement or improvement of schools in Suffolk ranged from £20 to Nayland in 1813 to £100 to Sudbury in 1823.⁴⁸

This diversity of educational opportunity suggests that the potential schooling of surgeons and apothecaries in Suffolk was wider than current historiographies would lead one to believe. For example, Joan Lane asserts that until the nineteenth century there were three main sources of education outside the home for boys of less prosperous families: the grammar schools for skilled artisans and the children of the emergent middle class; the charity schools frequently founded by a Tudor or Stuart philanthropist; and Sunday schools. This review shows that such a statement, while in broad terms encompassing the pattern in Suffolk, over-simplifies the definition of a grammar school and does not reflect that diversity. In addition, although by no means reaching the criteria of prosopographical research, a concept that can be easily inflated, the study of the common characteristics of a group of

⁴⁶ Paget, *James Paget*, pp.9-10.

⁴⁷ Adamson, *History of Education*, p.230.

⁴⁸ Ibid., pp.253 ff. In 1817 East Bergholt received £30, Bramford £90, Glemsford £20, Mildenhall £120, Stowmarket £20; in 1819 Aldeburgh received £125.

individuals gives further support for this argument.⁴⁹ These following examples illustrate that the use of private boarding and day schools was a common educational route for practitioners.

George Crabbe wrote to Edmund Burke that “I had partial Father who gave me a better Education than his broken fortune wou’d have allow’d”.⁵⁰ Crabbe first went to a dame school and then to Mr Hervey’s commercial school at Bungay, “to fit him for similar employment” to his father, as bailiff and saltmaster, and like many practitioners he was not originally intended for medicine. Richard Hervey advertised that youths were “boarded and taught Reading, and English Grammar; also writing in all the Hands now practised, Common Arithmetic, Merchants Accounts in the Italian method”.⁵¹ However, Hervey did not include classics in his curriculum. “As prospects brightened” in the Crabbe household,⁵² his father saw an advertisement in the *Ipswich Journal* from schoolmaster, Richard Haddon, proprietor of a “Country boarding School” in Stowmarket.⁵³ Thriving farmers sent their sons to Haddon to be “polished out of the worst ignorances of yokeldom”.⁵⁴ As Haddon was both a mathematician and a Latin and Greek scholar, Crabbe obtained “that portion of the learned languages that might qualify him for the profession of physic in the capacity of surgeon and apothecary”.⁵⁵ By the time he left Stowmarket in 1768 with “the foundations of a fair classical education”, it had been decided that he should become a surgeon.⁵⁶

The next example, John Steggall (1789-1881), was born at Creting St. Mary and his nearest school was Needham Market, a grammar school provided by

⁴⁹ Such research looks at patterns of relationships and activities through the study of collective biography, and proceeds by collecting and analysing statistically relevant quantities of biographical data about a well-defined group of individuals.

⁵⁰ Thomas Faulkner (ed.) with the assistance of Rhonda L. Blair, *Selected Letters and Journals of George Crabbe (Crabbe to Edmund Burke February/March 1781)*, (Oxford, 1985), p.5.

⁵¹ *Ipswich Journal or Mercury*, 27 March 1762.

⁵² George Crabbe, *Cullings from Crabbe with a Memoir of his Life and Notices of his Writings*, (Bath, 1832), p.3.

⁵³ Faulkner, *Crabbe*, p.9.

⁵⁴ Neville Blackbourne, *The Restless Ocean: the Story of George Crabbe*, (Lavenham, Suffolk, 1972), p.28.

⁵⁵ Crabbe, *Cullings*, p.3.

⁵⁶ George Crabbe Jnr., *The Poetical Works of George Crabbe with his Letters and Journals and his Life*, (London, 1834), p.15.

subscription, offering free education for sixteen or so needy local boys. John's father was considered too wealthy to have his son admitted there and, like many others of his rank and aspiration, may have believed his son's future prospects would be diminished by attending such a school. John was sent at the age of seven years to the school run by Mr Edmund Rogers of Walsham le Willows, mentioned earlier, who boarded 50-60 sons of gentlemen and tradesmen, offering more status and presumably more suitable companions. The school was well-founded and "considered a good one and in much repute", though Steggall stated that "terror was the system under which we were all trained".⁵⁷ Yet on Rogers' death, some 30 feather beds from the school were auctioned off - a small sign perhaps that he provided some degree of physical comfort for the boys.⁵⁸

Steggall was whipped and breached within his first weeks and so he ran away and spent some time living with gypsies, before being sent to another private school, this time the Reverend Hepsworth's establishment at Botesdale.⁵⁹ Here, Steggall says, "In one year I gained more knowledge than in all former years and that which I gained I retained".⁶⁰ The Reverend Hepsworth was an encouraging and festive figure, and Steggall used to play cricket and fish, and:

"to hurrah at the coaches as they drove up to the Crown... we had holidays for loyalty, holidays for victory, and holidays for the King's birthday and of course for our good master's, on which day we had sumptuous fare and heart-felt fun".⁶¹

It is interesting to note that although, like the Crabbe's, the Steggall family's first choice for their son was a Free Grammar school, their natural instinct appears to have been to find a private school, a pattern that is likely to have been repeated over the county.

⁵⁷ Richard Cobbold (ed.), *John H. Steggall: A Real History of a Suffolk Man Narrated by Himself*, (London, 1857), p.13.

⁵⁸ Pip Wright & Joy Wright, *The Amazing Story of John Heigham Steggall, "The Suffolk Gypsy"*, (Stowmarket, 2004), p.9.

⁵⁹ Botesdale Grammar School, an example of the misleading use of the term 'Grammar' at the time - see above.

⁶⁰ Cobbold, *John H. Steggall*, p.187.

John Green Crosse (1790-1850) went first to an unknown school in Stowmarket to which he walked from his home. No classical Latin was offered, only reading, arithmetic, writing and a severe regime.

“My first lessons....were received from a master of whom I entertained the greatest horror for the ferocity of his conduct and the severe discipline by which he drove us into the simplest fundamentals of knowledge”.⁶²

At the age of twelve years, he went to another school run by a Welsh gentleman, who “making some mistake at College found it well to rusticate” and opened a school in Stowmarket. “I got out of him all the instruction I ever received as a schoolboy in the learned languages”. He also had music lessons, becoming an efficient pianist, organist and flautist. When he was fifteen he broke his leg and as a result of the treatment he received was inspired to become a doctor. He therefore persevered “longer with Latin, Greek, French and Euclid, but also read through *Hooper’s Medical Directory* every Sunday afternoon”, another example of largely self-taught medical men.⁶³

The last example is John Mann of Badingham, who was educated in his father’s charity school until he was apprenticed to a bookseller and printer. From his acquired knowledge of Latin he gradually started to treat others with patent remedies he devised, although “the irregularity of my practice excited no attention; and as I was an amateur, it was not objected to by the medical practitioners of Moreton”.⁶⁴

In these four illustrations, the would-be practitioners were sent to local boarding or day schools for basic education of variable standards, but including the classics and commerce. All four demonstrated how much mobility there was within the educational system, with pupils moving from one school to another, until finding one to suit.

⁶¹ Ibid., p.189.

⁶² V. Mary Crosse, *A Surgeon in the Early 19th Century - The Life and Times of John Greene Crosse*, (London, 1968), pp.4-5.

⁶³ Ibid.

⁶⁴ John Mann, *Recollections of my Early Professional Life*, (London, 1887), p.62. Mann was the son of a Suffolk man, his father having been born in Badingham, and became a minister in Moreton-in-Marsh near Shipston on Stour.

Evidence from Suffolk therefore throws doubt on the assertion that medical practitioners were invariably grammar school boys, as indeed does evidence derived from elsewhere in the shire counties. For example, in Shropshire, both Edward Jenner and Caleb Hillier Parry attended the Reverend Dr Washbourn's school in Cirencester. Most importantly, much evidence prayed in aid of this statement is skewed or insufficient for positive conclusions to be drawn. As demonstrated, the national data based on the *DNB* is distorted, given its emphasis on those who became distinguished or renowned as physicians and surgeons, particularly in urban centres and London. In addition, as noted earlier, the survival of school registers was serendipitous, and it is difficult to identify from those lists all those who were later to become medical practitioners.⁶⁵

It is clear from Appendix D and the discussion here that no definitive conclusions should be drawn from such small samples, both in Suffolk and nationally. It is valid however to conclude that the educational backgrounds of surgeons and apothecaries were more varied than current historiographies would imply and that, arguably, a large proportion of practitioners had attended the small independent private boarding schools that were plentiful in Suffolk.

4.2 Apprenticeship

“AN APPRENTICE wanted by a SURGEON AND APOTHECARY in a good Business. A Youth, properly educated, may meet with a Situation, attended with peculiar Advantages. He will be treated as one of the family. An adequate premium will therefore be expected. *Coventry Mercury* 23 December 1799”.⁶⁶

As is the case nationally, information on apprenticeship in Suffolk is more extensive and reliable than that for schooling. As with schooling, it leads to different conclusions from those drawn from largely London and metropolitan based historical writing, particularly in relation to the prevalence and

⁶⁵ *King Edward VI's School List*, SRO (Bury St. Edmunds), 373.42644; *Suffolk Green Books*, XIII (1900), SRO (Bury St. Edmunds); *Colchester School Admissions*, SRO (Bury St. Edmunds), 373.426723; *Ipswich School List*, SRO (Ipswich), 373.42649.

continuing value attached to it. After reviewing current research literature and setting the general background to apprenticeship nationally leading up to and immediately after the 1815 Apothecaries Act, this section considers the evidence from Suffolk in depth. It suggests that there was far less change in the nature, cost or length of apprenticeships in Suffolk than occurred in London and other urban areas.

The advantages and benefits of the apprenticeship system were both economic and social. It theoretically guaranteed the level of competence and controlled the entry of new recruits, though this implies a much greater degree of overall planning and strategy than could be identified with any certainty in the rural areas. It maintained a qualified man's income, reduced competition and reassured customers or clients.⁶⁷ Its effectiveness in these respects depended heavily upon the quality and motivation of the master concerned, whether in town or country, and there were examples from Suffolk where both were questionable.⁶⁸

A number of eighteenth and early nineteenth century writers seem to have recognised the difference in the likely training experience of practitioners in London and the provinces, and had varying opinions on the implications. Some were horrified at what they saw as the lack of rigour in training outside metropolitan areas. For example, James Lucas asked:

“Is it not to be wondered that Practitioners, who conjointly and remote from the seat of Legislation (London) profess all the several branches in the science, should be permitted to practice unmolested, without any inquiry into their qualifications?”⁶⁹

Sir Robert Kerrison also felt that “the number of uneducated persons who exercise the profession of Medicine and Surgery in its various departments, is

⁶⁶ Joan Lane (ed.), *Coventry Apprentices and Their Masters*, (Stratford-upon-Avon, 1983), Introduction, p.x.

⁶⁷ Joan Lane, “The role of apprenticeship in eighteenth century medical education”, in William Bynum & Roy Porter (eds.), *William Hunter and the Eighteenth Century Medical World*, (Cambridge, 1985), pp.57-103.

⁶⁸ George Crabbe was apprenticed to Mr Smith (d. 1802) of Wickhambrook from 1768-69 for a premium of £70 but “my master was also a farmer and I became useful to him in that his principal occupation... There was... no other distinction between the boy at the farm and myself but that he was happy in being an annual servant and I was bound by indentures”. Faulkner, *Crabbe*, p.5.

almost incredible to those who have not investigated the subject". Using evidence from the counties of Lincoln and Essex, he stated that:

"it is... most unlikely that until the first two decades of the nineteenth century were passed, more than half of those attending the sick in the country (England) as a whole had had more medical education than apprenticeship to apothecaries or surgeons".⁷⁰

John Jeaffreson retrospectively noted that:

"even as late as 1816, the law required no medical education in a practitioner of the healing art in country districts, beyond an apprenticeship to an empiric, who frequently had not information of any kind, beyond the rudest element's of a druggist's learning to impart to his pupils".

However, it inadvertently suggested that the physicians' and London doctors' prejudices were alive and well in 1860.⁷¹

On the other hand, the *London Medical Repository and Review* reported in 1816 that:

"In private practice there are not many opportunities of teaching but in country practice especially attendance on the sick poor often affords this advantage and should never be neglected".⁷²

Six years later, it re-asserted the practical advantages of country practice:

"A Country Surgeon-Apothecary's apprentice has a situation well calculated for improving his mind... he has no manipulation to perform but what he may accomplish in his drawing room dress... As to midwifery no adequate substitute can be found for Country Apprenticeship in this department, pages might be filled with the numerous and ludicrous blunders of those who have attempted it from a full course of lectures".⁷³

For some contemporaries, apprenticeship in a rural practice led to experience of a wider range of conditions and complaints among living patients, a much

⁶⁹ Lucas, *A Candid Inquiry*, p.43.

⁷⁰ Robert Master Kerrison, *An Inquiry into the Present State of the Medical Profession in England*, (London, 1814), pp.33 & 38.

⁷¹ John Cordy Jeaffreson, *A Book About Doctors*, (London, 1860), p.276, though Jeaffreson was not himself a doctor but a lawyer.

⁷² "Report on progress of medical science", *London Medical Repository and Review*, 5, (1816), p.65.

⁷³ "Nectemere", *London Medical Repository and Review*, 16, (1822), pp.186-9.

more reliable training than any amount of specialist work in London based on cadavers. Sir James Paget, who was apprenticed in his hometown of Great Yarmouth in 1830 underlined this point, reflecting that he “gained a much better knowledge of practice in medicine and surgery than [most students] do in their first two years [of hospital study]”.⁷⁴ Some contemporaries lauded the benefits of practical apprenticeship and queried the value of education based purely on ‘scientific principles’. A Mr Tupper wrote that “All the truly useful and scientific knowledge we can ever hope to gain, can only be had by observation and experiment”.⁷⁵ Similarly, John Mann recalled from his professional life in London that “the common disorders of general practice were best pursued in country practice” where the apprentice “can best see the ultimate results of treatment. In the country he can study men as well as patients”.⁷⁶ Indeed, it is tempting to speculate that the 1815 Apothecaries Act might never have happened if country practice had been the only consideration.

Amongst the more modern writers, Jeanne Peterson observes that:

“At the universities the students of physic devoted themselves to the classical medical texts, theories of disease, symptoms, materia medica, and treatments. Apprentice surgeons and apothecaries learned the practice of their respective arts of diagnosis, operative techniques and the prescribing and preparation of drugs at their master’s side”.

She went on to contrast the classical learning of the physicians with the “broom-and-apron apprenticeship in an apothecary’s shop... [which] sometimes involved no recognizable education at all”.⁷⁷ Irvine Loudon also appears to argue that the London apprentice experience was based on anatomy and the new knowledge being taught at the new medical schools, whereas country apprentices were old-fashioned and based their medicine on the old myths and beliefs. He goes further by arguing that, by 1815, apprenticeship had failed because it did not provide practical clinical

⁷⁴ Paget, *Sir James Paget*, p.23.

⁷⁵ Mr Tupper, “Comment”, *Medical and Physical Journal*, 8, (1802), pp.500-504, quoted in Ffeiffer, *The Practice of Medicine*, p.12.

⁷⁶ Mann, *Recollections*, pp.95-96.

⁷⁷ Jeanne M. Peterson, *The Medical Profession in Mid-Victorian London*, (London, 1978), p.13.

experience and perpetuated the lowered status of general practice.⁷⁸ However, the evidence set out here shows that apprentice training in Suffolk was fairly consistent over the whole period under review, and as active after 1815 as it was before.

Susan Lawrence describes the diversity of post-school training for those who provided medical care for the vast majority of the provincial population after 1815. Her view is that it could range from *ad hoc* experience picked up from clergymen, farmers and part-time midwives, to years of formal instruction at Edinburgh or Leyden, though with the latter less common largely because of expense and geography.⁷⁹ However, the evidence from Suffolk indicates that this diversity was not prevalent there, so research in other counties is needed to test the generality of Lawrence's conclusion.

Apprenticeship had the advantage of providing formal control by a responsible adult at far less expense than a university education which was seen as unaffordable or too substantial an investment to be rewarded only by the income of a country surgeon or apothecary. The system by 1815 had hardly changed since 1772, when James Makittrick Adair advised the student apothecary not to take for granted everything he was told but to form his own opinion chiefly on his own experience.⁸⁰ Although the apprentice's indenture specified that the master would prepare his pupil for his occupation, in practice the training and opportunities provided by masters varied widely, and neither its content nor the level of expertise required by the master was regulated. Nevertheless, apprenticeship to an apothecary (or surgeon and apothecary) was widely recognised as the first step in medical education for "those who wish to perfect themselves in the practice of physic and surgery having served a regular apprenticeship to a surgeon or apothecary but who did not necessarily intend to take a degree".⁸¹

⁷⁸ Loudon, *Medical Care*, p.179.

⁷⁹ Susan C. Lawrence, "Private enterprise and public interest - medical education and the Apothecaries Act 1815", in Roger French & Andrew Wear (eds.), *British Medicine in an Age of Reform*, (London, 1991), pp.45-73.

⁸⁰ James Makittrick Adair, *Commentaries on the Practice of Physic... to Which is Prefaced an Essay on the Education and Duties of Medical Men*, (London, 1772), p.40.

From the public point of view, service under a master of good reputation was almost the only guarantee of reliability, whether in town or country. Parental, community and cultural expectations, in addition to the master's concern for his reputation, helped to determine whether the apprentice was fitted to care for the sick. There was plenty of advice as to how to go about finding a master. Lucas urged that those suitably inclined or their parents should seek a recommended and successful practitioner, since:

“Unless such a master be himself a scholar, he can scarcely form a proper judgement of the qualifications of a pupil, much less invite a retention of school-learning, or encourage proficiency: except a practitioner have served a regular apprenticeship himself he cannot be so well qualified to conduct an apprentice through every gradual advancement necessary; unless he be in full business and his practice successful, the time of the youth may be unoccupied and the recommendations of a master be eventually useless”.⁸²

Many apprenticeships were arranged by word of mouth and the most prosperous of masters did not need to advertise.⁸³ However, as the capacity and range of medicine expanded and attracted new recruits by the 1750s, advertising for apprentices became common, usually in the local press. The apprenticeship document was binding and public, certifying that the relevant education had been received, though of course it did not guarantee the quality or extent of that education.⁸⁴ Above all, apprenticeship was the time-honoured route to the apothecary's trade or the surgeon's craft, reflecting a guild-controlled system for passing on the skills of one generation of experts to another, and designed to prevent an over supply of workers.

For many, the life was hard and unrewarding. In Suffolk, George Crabbe had a disappointing experience during his apprenticeship from 1768-9 to Mr Smith of Wickhambrook, who was a farmer as well as a surgeon. Crabbe wrote that “There was indeed no distinction between the boy on the farm and myself but that he was happy in being an annual servant and I was bound by indenture”. His father eventually “put an end to my slavery, he took me home and with

⁸¹ Joan Lane, *Apprenticeship in England 1600-1914*, (London, 1996), p.51.

⁸² Lucas, *A Candid Inquiry*, p.10.

⁸³ Joan Lane, “Medical apprentices in eighteenth century England” in R. Rolls, Jean & John Guy, *A Pox on the Provinces*, (Bath, 1990), pp.119-128.

me two thirds of the money he advanced”. Some 60 years later, William Lucas, an apprentice in London was “constantly bemoaning his miserable and physically uncomfortable life”, suggesting few differences between town and country in these respects.⁸⁵

By living in his master’s house, the young apprentice was likely to gain a thorough understanding of practical life, which was particularly important if he was from a non-medical family. Households and practices were arranged to accept pupils as a matter of routine where there was a commitment to regular apprentices, though there were more *ad hoc* arrangements when there was only one. Suffolk examples include John Green Crosse (1790-1850), surgeon of Stowmarket and Norwich, who was particularly integrated into Thomas Bayly’s (1750-1834) family since he married the master’s daughter.⁸⁶ In the same year, George B Lynn (1780-1854) married the eldest daughter of Robert Abbott (1750-1830), surgeon of Needham Market, his master from 1795.

The apprentice also learnt of the erratic working hours - how to deal with patients, keep case notes and other records, assess urgency, and plan a round of visits and charge accordingly. In addition, he would learn about buying, stocking and dispensing drugs, applying a scale of fees according to patients’ wealth and negotiating for parish Poor Law work. In a large and successful practice, he might also learn how to supervise other apprentices as well as non-medical staff including the groom, coachman or servant, none of which appeared in contemporary apprenticeship manuals or textbooks. Pupils were thus prepared for an occupation as much business as profession and, as the practitioners spent more and more time visiting their patients, apprentices were increasingly left to look after the shop, dispense medicine and take messages. When they were sent out to visit the sick, it was largely to the

⁸⁴ Thomas Neville Bonner, *Becoming a Physician: Medical Education in Britain, France, Germany and the United States 1750-1945*, (Oxford, 1995), p.45.

⁸⁵ Joan Lane, *A Social History of Medicine: Health, Healing and Disease in England 1750-1950*, (London, 2001), p.13.

⁸⁶ *Ipswich Journal*, 18 May 1816. John Green Crosse to Dorothy Bayly, daughter of Thomas Bayly. She died 17 July 1870, aged 78.

poor, as private patients were not keen on paying to be treated by “learners”.⁸⁷

Many had positive experiences. Henry Jephson followed his master, a Nottinghamshire parish surgeon, on his rounds:

“I can with just pleasure add that he behaved like a Gent and has promised to let me visit alone. I assure you this has happened exactly right in my last year, as I can visit them more than I did before, indeed he advised me to pay attention to the various diseases I see, and you may depend upon my taking it”.⁸⁸

Among the Suffolk examples of constructive training is that recorded by John Green Crosse, as his master Thomas Bayly had a good class of practice, including country families within posting distance. Crosse rolled pills, kept the books and tended the leeches; he tidied the surgery and “made pledget and put it into a boy’s ankle: made 38 pills in the afternoon. Painted the bottles in the surgery”.⁸⁹ Bayly’s requirements were sufficiently light that he could loan his apprentice to his brother in Swaffham. Indeed, Crosse only recorded 51 cases in his journal during his five year apprenticeship, though he accompanied his master on his rounds and visited the poorhouse where a certain amount of surgery was practised.⁹⁰

Another view comes from John Steggall, articled to Mr Prettyman, a surgeon in Bacton in the early 1800s, though it is unlikely that he served more than three years of his term.⁹¹ According to Steggall, “Here I had to make myself useful, to mix up medicine, hold men’s heads, legs and arms, and to bind up wounds”.⁹²

To illustrate that little changed over the 80 year period of this review in respect of apprenticeship, there is the example of Sir James Paget who was apprenticed in 1829, long after the Apothecaries Act of 1815, to a local

⁸⁷ Loudon, “Medical care”, p.221.

⁸⁸ Lane, *A Social History*, p.13.

⁸⁹ John Green Crosse, *Journal*, 13 September 1806, NRO (Norwich), MSS 465, 466, 467.

⁹⁰ Crosse, *John Green Crosse*, p.13.

⁹¹ *Bury Post*, 24 November 1808, S. Denny took over Prettyman’s premises in 1808, judging by an advertisement that year in which he trusted “that he could rely on the previous surgeon’s custom”.

Yarmouth surgeon, Mr Charles Costerton {1806}. Paget concluded that the term was too long for learning dispensing, a practical knowledge of medicine, account keeping, the organisation of the practice and the essential elements of anatomy, and that the routine was “dull and at times tedious and apparently useless”. He was required to stay in the surgery daily from 9.00 a.m. to 1.00 p.m. and from 2.00 p.m. to 5.00 p.m. dispensing, seeing a few patients of the poorer classes, receiving messages, making appointments and, once a year, making up the bills. When his master returned from his rounds, Paget was required to take dictation concerning visits and any prescriptions to be made up and despatched. Since he had no specific instruction, Paget rode ten miles to Acle each week to attend an anatomy class held by a young surgeon, and taught himself botany and zoology in his spare time. There is little difference in his description from those of 70 and 30 years earlier.

Apprentices had, as John Mason Good noted, “no restrictive regulations to keep at a distance the ignorant and the unskilful, no form of public examination or test of medical ability”.⁹³ Such concerns linked with those of the London apothecaries over an increasingly health-conscious populace that was turning to care of any kind for relief. They were alarmed at the effects of competitive but irregular providers upon their incomes and, by the end of the eighteenth century, felt the need to consolidate their status. Their grievances were expressed in an address by Mr Chamberlaine, apothecary of Aylesbury Street, London at an inaugural meeting in 1794, where it was noted that the average apothecary income in London was down to £200 per year.⁹⁴ In order to improve the standards of entry and regulation, the ‘regulars’ sought to promote tighter controls on education and therefore entry to the profession, with little immediate impact. The petition for the Apothecaries Act was revived in 1812 by the Associated Apothecaries.⁹⁵ This resulted in the first imposition of national regulations concerning entry to the medical profession, in the form of the Apothecaries Act of 1815. Section 14 of the Act specified

⁹² Cobbold, *John H. Steggall*, p.189.

⁹³ John Mason Good, *The History of Medicine, so far as it Relates to the Profession of the Apothecary*, (London, 1795), p.145.

⁹⁴ *Ibid.*, p.151.

⁹⁵ Also known as The General Association of Apothecaries and Surgeon Apothecaries of England and Wales, formed on 3 July 1812.

that it was unlawful for any person to practise as an apothecary in any part of England and Wales unless he had been examined and received a certificate. Thus the License of the Society of Apothecaries became, at least nominally, a prerequisite for legitimate practice. Section 20 of the Act imposed a penalty for unlicensed practice - a £20 forfeit for each offence. Furthermore, apothecaries could not recover fees and charges in a court of law unless they had a certificate from the Society of Apothecaries under Section 20. Although a licensed apothecary was entitled to recover charges, the Act did not indicate the basis upon which charges could be made, since payments based upon drugs or products would degrade their status by implying that their livelihood still derived from trade. Eventually this was rectified by a case brought in 1830.⁹⁶ The *Lancet*, commenting on a specific case, concluded that:

“General practitioners will no longer be regarded in families as plunderers... they will now be looked upon as men of experience and skill, and their ability to prescribe appropriate remedies for disease will be valued rather more highly than the ability to mix those remedies in a bottle”.⁹⁷

In terms of training, the Act in practice established a legal requirement for some kind of apprenticeship, but any dramatic change was less obvious in the countryside, as evidence from Suffolk shows that apprenticeship had been in fact both common and valued before 1815. On the face of it, this situation was out of keeping with a county that had few organised facilities for provincial medical education, no uniform courses of study, no restrictions on entry to the licensed branches of the medical profession and little formal recognition of what qualifications a practitioner ought to possess.⁹⁸ Yet more detailed analysis of who the masters were and where they practised, how much they were paid for providing apprenticeship and for how long suggests that in Suffolk a remarkably coherent, well-structured and thorough preparation for apprenticeship was already extant before 1815, with the whole training process by no means as random as Susan Lawrence implies.⁹⁹

⁹⁶ James Handey, a person in practice prior to the Apothecaries Act of 1815, successfully obtained a judgement before Lord Tenterden for a bill of £7.6s of which £2.15s was for attendance alone.

⁹⁷ *The Lancet*, 1, (1829-1830), p.538.

⁹⁸ Good, *The History of Medicine*, pp.230-1.

⁹⁹ Lawrence, “Private enterprise and public interest”, pp.45-73. See page 129 above.

Moreover, relatively little changed over the period of this study. In rural and provincial areas, where patients generally had less choice of practitioner and practitioners had to be versatile, there were fewer opportunities for quacks or irregulars to operate and thrive. There was little in the way of a mass market, and the social closeness of communities, where professionals held social and civic responsibilities and were easily available, may well have provided subtle pressures to ensure a remarkably consistent and robust training for a large number of Suffolk young doctors.¹⁰⁰ As shown earlier, many of those who wanted their sons to become medical practitioners came from a section of society neither able nor willing to pay for school-based education of their sons beyond the age of fifteen or sixteen. Thus, a practical training like apprenticeship at less cost and leading to a relatively prestigious and reliable profession was attractive.

Moreover, the struggle between physicians, surgeons and apothecaries was far less detectable in Suffolk for some time after the 1815 Act than in metropolitan areas. The lack of consistency and clear demarcation between the various practitioners who called themselves apothecary or surgeon or variations on that theme (including physicians practising in rural towns) was more obvious in the countryside.¹⁰¹ Furthermore, opportunities for hospital-based development were also limited in Suffolk by the lack of such facilities.¹⁰² The Barber-Surgeons Act of 1747 may have meant that more qualified practitioners were available to staff hospitals and thereby enhance the training, as Joan Lane asserts, but this was less relevant to those counties such as Suffolk still without hospitals.¹⁰³ Once the local hospitals were founded at Bury St. Edmunds in 1826 and Ipswich in 1836, together with the town dispensaries, the practitioners working there could offer training opportunities to apprentices, providing more clinical experience and material than offered in the local practices. It was not long before hospital staff were allowed, even encouraged, to take on pupils, and the Rules and Orders for the Government of the Suffolk General Hospital, 1826, stated that:

¹⁰⁰ See Chapter 8 on Status and Civic Roles.

¹⁰¹ David van Zwanenberg, "The training and careers of apprentices in Suffolk", *Medical History*, 27, pp.139-150.

¹⁰² See Chapter 4.

“each surgeon be allowed to have two Pupils to attend the Hospital for instruction; but that no Physicians’ Pupils be permitted to see the practice of the Surgeons, nor the Surgeons’ Pupils that of the Physicians, without their respective concurrence. - That no Pupil perform any operation, but shall have liberty to dress the Patients under the direction of the Surgeon”.¹⁰⁴

In overall terms, the more than 950 doctors listed as active in Suffolk between 1750 and 1830 included 210 known to be masters and 369 known to be apprentices. Such numbers, as explained in Chapter 1, are derived from databases that are incomplete and undoubtedly understated, but they indicate that apprenticeship was desirable and common, although there are a few examples showing it was not always enforced as a route to practice. Stowmarket surgeon James Bedingfield (1787-1860) was deemed as not requiring the LSA because he had been “in practice prior to 1815”.¹⁰⁵

Some apprentices had two masters for numerous reasons, including the death of a master. For example, John Page (1730-1794) of Woodbridge took on a part indenture in 1795 when Daniel Freeman (1742-1810) became his apprentice for £21 for a shorter period of five years, having been apprenticed to his father. After the latter’s death, Daniel’s mother had publicly requested that:

“A gentleman of the Profession wanting a Youth of sixteen who is well-qualified and capable of serving the shop and putting up physic - would do a kind charitable act in taking a son of the said Mr Freeman”.¹⁰⁶

Similarly Frances Pyman (1805-1838), the house apothecary at Suffolk General Hospital in 1829, took an apprentice for three years and seven months, since that apprentice had already served one year and five months with another

¹⁰³ Joan Lane, *Worcester Infirmary in the Eighteenth Century*, (Worcester, 1992), p.4.

¹⁰⁴ Rules and Orders for the Government of the Suffolk General Hospital, *Suffolk Tracts No. 51 and 52*, (Bury St. Edmunds, 1825).

¹⁰⁵ *The Provincial Medical Directory*, (London 1847). Bedingfield nevertheless trained ten apprentices in his lifetime, and in 1825 opened what he called a medical academy to receive young gentlemen for preparation for the medical profession by combining apprenticeship with instruction in medical anatomy, surgical demonstrations etc. Unusually, he had two or three contracted at the same time. He regularly advertised in the local press.

¹⁰⁶ *Ipswich Journal*, 1829.

recently deceased practitioner.¹⁰⁷ Other reasons for such multi-contracts might include dissatisfaction with a situation or a conflict of personality.¹⁰⁸ Double masters were often partners in the same practice, which further distorts the data.¹⁰⁹

Of the 210 known Suffolk masters in the period, there is evidence that 77 had more than one apprentice in their practice lifetimes, with some having as many as ten. The frequency of multiple apprenticeships in itself is evidence of the value placed upon it, often a reflection of a master's short-term appointment to a workhouse or the local militia, under which an apprentice could mind the shop while the master was away. John Assey (1742-1798) was surgeon to the poor in Beccles and inoculated 350 of them, as well as surgeon to the Shipmeadow House of Industry.¹¹⁰ His interest in continuous apprentices stemmed partly in their carrying out his duties with the poor whilst he concentrated on his wealthier patients. He had seven apprentices through his lifetime, generally for five year terms and for a fee of £100-105.¹¹¹ All his apprentices overlapped and between 1782 and 1790 he always had two simultaneously. There were numerous militia and other appointments that made additional demands on the time of a practitioner, and encouraged the use of apprenticeship to increase the number of hands available.¹¹²

Apprentices could also reflect the reputation of a particular surgeon or practice, or family membership. The histories of five masters from periods before and after the 1815 Act illustrate the value of such narratives. They show how masters gained apprentices and possible reasons for the multiple

¹⁰⁷ James Wynard Gooch {1813-1874}, surgeon of Stradbroke, was apprenticed to Lancelot Davie (1783-1816) from 1813-1816 at Bungay, but then taken on by Arthur Browne {1816} also of Bungay after Lancelot Davie died.

¹⁰⁸ George Crabbe was apprenticed to Mr Smith of Wickhambrook from 1768-69, but the situation did not suit and he was moved by his father to John Page (1730-1794) of Woodbridge for four years for £10. See page 131.

¹⁰⁹ John Harcourt (no dates), surgeon of Beccles and Great Yarmouth, was apprenticed to both J. Leath of Beccles and Thomas Leath of Great Yarmouth in 1759 for a premium of £90 for four years; John Isaacson (no dates) was apprenticed to both John and James Lynn, surgeons of Woodbridge, in 1774 for six years at a premium of £105; Edward Gross (1805-1865), surgeon of Earl Soham, was apprenticed from 1822-1825 to Henry (1795-1877) and Robert Freeman (1776-1845) of Saxmundham.

¹¹⁰ Edwin Alvis Goodwyn, *Beccles and Bungay: A Georgian Miscellany*, (Beccles, 1969), p.10.

¹¹¹ June 1776 Robert Camel; April 1780 Robert Sherrife; March 1782 Joseph Termy; January 1785 Raphael Gillum; January 1785 John Ward; December 1790 Charles Dashwood; 1792 William Pierson.

¹¹² See Chapter 8 on sources of income.

indentures, thus giving insights into the way that apprenticeship worked and was valued in Suffolk.

The Ipswich surgeon Nathaniel Bucke Snr. (1717-1786) took his first apprentice in 1745 and his ninth in 1780, most staying for five years.¹¹³ His fees started at £94.10s, rising to a relatively high £150 for several years before dropping again to £100. Only exceptionally was there an overlap between each apprentice, but occasionally there was a two year gap, perhaps to allow the family to have the house to themselves again for a while, or because business declined briefly. He had two apprentices called Baddeley - Gil in 1759 and John in 1764 and, as he already had two apprentices when he took on John, conceivably it was the good work of Gil that persuaded the master to accede to family pleadings to take his brother. Bucke's last two known contracts as a master in 1780 included his own son who succeeded to the practice, Nathaniel Jnr. {1767-1810}, who was originally an 'inoculator' for thirteen years, before becoming a surgeon and apprenticed to his father.¹¹⁴ Earlier in 1763, another apprentice, John Kerridge took partnership with him but only for three months, though no reason for the dissolution is known. Bucke Snr. became ill in 1780, but assured the public the following year that although "he had so often been reported as dead, his physicians now thought him to be out of danger".¹¹⁵ When he eventually died in 1786 Nathaniel Jnr. took over the practice, although the notice in the *Ipswich Journal* indicated that the father had been ill for some time, and that the full apprenticeship arrangements had not been fulfilled.

Bucke Snr. had been associated with the new method of inoculation against smallpox being carried out by Robert Sutton (1707-1788), although Nathaniel Jnr. was listed in the *Ipswich Journal* as being in partnership with Daniel Sutton "to inoculate for small pox at Freston Tower", even before his

¹¹³ 1745 Richard Wastell for six years at £94 10s; 1750 John A. Kerridge for £100; 1759 Gil Baddeley for six years at £150; 1763 Mordous Frost for five years at £150; 1764 John Baddeley for six years at £150; 1769 Sam Clarke for five years at £150; John Clute for four years at £100; 1780 Thomas Hunter and Nathaniel Bucke Jnr. for five years at £100.

¹¹⁴ See Chapter 6, pp.200-212.

¹¹⁵ *Ipswich Journal*, 18 March 1781.

apprenticeship to his father had started.¹¹⁶ This seems to have been some free enterprise on the part of two ambitious young trainee doctors. Bucke Snr's second son, John, was also a surgeon, although there is no evidence of him being apprenticed to his father or anyone else. As a renowned surgeon in a busy town, Bucke's familiarity with the latest medical thinking on inoculation and canine madness would have enhanced his popularity and reputation as a master in northwest Suffolk, Ipswich and Bury St. Edmunds.

In a quite different and more rural setting, Great Ashfield surgeon Roger Cooke {1704-1784} also had ten known apprentices in just over forty years. This seemingly resulted in a disproportionately large number of doctors in that area, although they probably serviced a wider area than just the local village, including neighbouring Woodbridge or even Wickham Market, though both these towns already had successful medical dynasties.¹¹⁷ Cooke's first apprentice was Robert Caleb Rose {1728}, about whom nothing else is known, and his last was Richard Stewart from Ashfield in 1777. Their average length of apprenticeship was also five years, but Cooke's fees were higher than Bucke's, rising quickly to a peak from £84 in 1731 to £150 in 1772. Cooke occasionally had overlapping apprentices, with George Chinery {1759} starting in 1759 while Baptist Spinluff {1757} was only two years into his term. Similarly, in 1770 he took on John Rush {1770} for five years while John Gibbs Clarke {1767} was only three years in, and in 1772 he also took on John Phillips {1772-1779}. Some masters used overlapping apprentices to enable the more senior one to educate and teach the new boy, and thus relieve the pressure on themselves. A senior apprentice might also have left more mundane tasks to his junior while he accompanied his master on his rounds or even saw patients on his own. Moreover, such an arrangement offered support and comradeship, as well as joint study opportunities that would benefit the apprentices and thereby the master. Probably this congenial and well-organised setting, plus Cooke's local status and longevity in practice, explains his large number of apprentices and high premiums.

¹¹⁶ *Ipswich Journal*, 23 March 1767.

¹¹⁷ Chapter 3 Table 3.7 shows the apparent distortion of the doctor:population ratio.

A third example is John Rose {1750-1826}, surgeon and freeman from Eye. He had six apprentices in his lifetime, four paying premiums ranging from £105 to £31 between 1770 and 1806, and his two sons, George and John, who paid none.¹¹⁸ Rose Snr. was a respected figure in the local medical world: Dr William Hamilton consulted him on cases of scarlet fever according to the *Ipswich Journal*¹¹⁹ and he was cited in John Green Crosse's account of the 1819 smallpox outbreak in Norwich.¹²⁰ Like Bucke and Cooke, his reputation would have attracted apprentices, or more importantly their parents.

These three examples are from before the Apothecaries Act; among post-1815 Suffolk examples was Ipswich surgeon John Denny (1774-1835). He had been a Regimental Surgeon's mate from 1795 and surgeon to the 62nd Foot in 1809, leaving on half pay in 1811. He was the Chief Magistrate in Ipswich for some years which, together with his surgical reputation, probably accounts for his continuous record of apprentices. His surgery at Tower Ditches, known as 'Denny's passage', became the meeting place and school for local apprentices, not just his own. Between 1819 and 1840 he trained seven apprentices, one quarter of the town surgeons.¹²¹ The first, George Green Sampson (1804-1885), was his nephew, and the last was his own son who followed him in the practice in 1835, confirming the importance of family connections in choosing a master. Since John Denny died that year, Denny Jnr. (1818-1891) and another apprentice John Ranson (1817-1850), who was two years into his ticket, both transferred their articles to William Mumford (1806-1877), Denny's recently acquired partner.

Robert Carew King (1781-1842), surgeon of the small market town of Saxmundham, was another example of a post-1815 master with multiple

¹¹⁸ 1770 John Metcalf for seven years at a premium of £105; 1779 Thomas Smith for four years at a premium of £31; 1782 Thomas Isaacson for six years at a premium of £100; 1802 Robert Andrew Waugh (apprentice to both John Rose Snr. and Jnr.) at a premium of £84; 1810 George Rose; 1820 John Rose.

¹¹⁹ *Ipswich Journal*, May 1802.

¹²⁰ John Green Crosse, *A History of the Variolous Epidemics Which Occurred in Norwich in the year 1819, and Destroyed 530 individuals, With an Estimate of the Protection Afforded by Vaccination*, (London, 1820), p.278.

¹²¹ As recorded in *SMB*. The apprentices were 1819 G.G. Sampson; 1823 John Pitcher; 1827 Webster Adams; 1831 George Fred Meadows; 1831 William Elliston; 1833 John Ranson; 1835 John Denny (Jnr.).

apprentices. He had been apprenticed in 1798 to Ipswich surgeon Alexander R. Bartlet (1763-1847), for a limited three year period at a premium of only £100. Bartlet had inherited the practice of the well-known surgeon John Clubbe (1741-1811) and attained considerable status during his 36 working years, providing a strong role model for him. Why Carew King served only a three year term is not clear, though it was not uncommon and did not prevent him from leaving Ipswich in 1805 to go into partnership with Henry Denny [1798-1805], and a surgeon from Saxmundham who himself was part of a large medical family.¹²² Initially, Carew King planned to live and practise from the nearby town of Yoxford, where Denny's father, Robert had formerly practised until 1801. The closeness of the medical community is exemplified by the fact that Carew King moved into the house of the Yoxford physician, Dr William Hamilton, when Hamilton moved to the bigger town of Halesworth in 1805. Yoxford was probably a branch of the partnership's main surgery at Saxmundham, so when Denny died in November 1805, King moved back to practise for over 40 years. Once established he attracted seven apprentices from 1819, including four who overlapped.¹²³ Possibly this reflected his reputation derived from his specialist activities: he was a noted lithotomist with two successful operations publicised in the *Ipswich Journal* of November of 1822. His penultimate apprentice, George Pretty (1818-1883), became his partner, taking over the indentures of their last apprentice when Carew King died in 1842.

Among those practitioners training several doctors was William Henchman Crowfoot (1794-1848), surgeon of Framlingham and Beccles, who trained eight apprentices, including his son, William Edward (1807-1887).¹²⁴ The Growse family in Hadleigh, an example of a strong medical dynasty, had similar patterns of apprenticeship through several generations.¹²⁵ John Growse Snr.

¹²² Henry Denny was the son of Robert Denny, a surgeon of Yoxford, the father of Henry Freeman Denny, his only son who died aged 25 in May 1825, having moved to High Wycombe, and brother of William Denny, surgeon of Yoxford.

¹²³ 1819 William Kett; 1822 Edward Acton; 1822 John Barker; 1823 Edward Bond; 1833 John Mitford Long; 1834 George Wilson Pretty; 1835 Thomas Barfoot Gildersleeves.

¹²⁴ 1813 Edward Arthur Arthy; 1815 Barrington Bloomfield; 1823 William Edward Crowfoot; 1825 Philip Samuel Carpenter; 1832 William Bransby Francis; 1835 Horace Henry Button; 1845 William Henchman Clubbe.

¹²⁵ See Chapter 3, p.97 and Appendix B.

(1761-1840) surgeon, apothecary and man midwife of Boxford and Bildeston, had six apprentices between 1796 and 1843.¹²⁶ After a 25-year break between his first and second apprentice, he maintained thereafter regular and overlapping pupils. The long interval was not linked to any uncertainty surrounding the 1815 Act, but reflected a period when both his sons were working with him. His eldest son, John (1761-1840), also styling himself surgeon, apothecary and man midwife, moved to Hadleigh and took on four apprentices, the first being his son Robert and the last of which, Charles Parker Man, was apprenticed to both John and his brother Robert. Robert had gone into partnership with his father in 1821, and within seven years was taking apprentices, including both his sons. The Growses demonstrate the link between established successful dynastic practice (even in adjoining villages) and the provision of good modelling as a master.

An analysis of the residence or location of apprentices and masters indicates that proximity to home and the familiarity of known masters probably exerted a strong influence on location and mobility. Attempts to map this limited mobility are undermined precisely because of this proximity. Therefore, Appendix E simply details apprentices by place of birth, place of apprenticeship and place of practice where known. It demonstrates that while the numbers of those identified as born, apprenticed and working in the same place are relatively few, over two thirds went on to practise where they had been apprenticed. This figure increases to over three quarters when those who moved to adjacent villages or nearby towns are included.¹²⁷

To present some indication of distribution over the county, Appendix F lists apprentices in a number of population centres, for the 43 years before the 1815 Act, compared to those for the 43 years after, the latter derived from van Zwanenberg's study of Suffolk apprentices.¹²⁸ It is clear that the number of apprentices was not related directly to the size of population, since before 1815 35 per cent of those identified worked in villages of between 200 and

¹²⁶ 1796 William Cuthbert for six years at a premium of £70; 1827 Robert Manuel Sims; 1829 Robert Blyth; 1833 Arthur Blyth; 1839 George Pickess; 1843 John William Harper.

¹²⁷ For example, Yoxford and Saxmundham are within 6 miles of each other, Beccles to Halesworth is less than 8 miles, and East Bergholt and Hadleigh are similarly close.

550 people, while only 24 per cent were apprenticed in Ipswich and Bury St. Edmunds. Moreover, after 1815 the percentage of apprentices in the small towns rose to roughly 43 per cent, compared with just nineteen per cent in Ipswich and Bury St. Edmunds.

Table 4.2: Apprentices 1772-1815 and 1815-1858
in Some Centres of Population

Place of practice	Pop. in 1801#	Apprentices 1772-1815	Average ratio	Pop in 1831#	Apprentices 1815-1858*	Average ratio
Beccles	2788	21	1:133	3862	22	1:176
Bungay	2349	8	1:294	3734	16	1:233
Bury St. Edmunds	7655	12	1:638	11436	25	1:457
Hadleigh	2332	1	1:2332	3425	14	1:245
Halesworth	1676	1	1:1676	2473	11	1:225
Ipswich	10845	20	1:522	19855	39	1:509
Lowestoft	2332	n/a	n/a	4238	12	1:353
Norton	533	1	1:533	802	10	1:800
Saxmundham	885	2	1:443	1048	12	1:870
Stowmarket	1761	1	1:1761	2672	16	1:167
Woodbridge	3020	13	1:232	4769	16	1:290

Sources: # Peter Northeast, *The Population of Suffolk Parish by Parish*, compiled from Government Census Returns, SRO (Ipswich), 312.0942, unpublished.

* David van Zwanenberg, "Apprentices", p.142.

Table 4.2 focuses upon key population centres to illustrate this lack of correlation between apprentices and population numbers, and the remarkable difference a renowned master could make, irrespective of the size of the village or town.

Thus, Beccles appeared to have had a high number of apprentices relative to its population during the period 1772-1815 and in relation to comparable towns like Bungay or Hadleigh, though averaging out the ratio shows less difference. It had a remarkable collection of practitioners: John Chambers {1753-1776}, John Assey, Tim Carter {1753-1786}, Robert Purves {1763-1803} - all maintaining fairly continuous apprenticeships throughout their practice

¹²⁸ van Zwanenberg, "Apprentices", p.142.

lives. However, this number barely increased over time (from 21 to 22), whereas numbers in nearby Bungay rose significantly from a much lower level (eight to sixteen) that could reflect a number of issues, not least that Bungay had been under-doctored for a middle-sized town in the earlier period.

A village like Great Ashfield with a population of only 270 in 1801 could attract a disproportionate number of apprentices with the presence of a significant figure like Roger Cooke. Woodbridge similarly attracted a great many apprentices. Apart from the Lynn dynasty, John Page and John Syer (1745-1823), respectively a surgeon and physician, had four apprentices each. Nathaniel Moore (1780-1868), another surgeon, had six. Thus, Woodbridge appeared to have a disproportionate number of apprentices in relation to Sudbury, a town of comparable size with twelve apprentices over the whole period. As with Great Ashfield, this undoubtedly reflected the presence of a popular and well-known master, large family firms, and was undoubtedly due to the many medical dynasties already noted. For example, in Woodbridge the Lynns were in family partnership for a century and a half after 1700, confusingly favouring the forenames James and John.¹²⁹ In all, the Lynn family accounted for eleven apprentices and four generations of medical practitioners in this period.¹³⁰ In Needham Market, the Bigsby Beck family was similarly dynastic: Edward (1760-1845) practised all his life there and had four sons, one of who, another Edward (1794-1862), became a physician in Ipswich. Francis Diggan (1804-1882), Henry (1799-1891) and Thomas Batman (1806-1895), were all were apprenticed to their father and became partners in his practice.

¹²⁹ James the elder was in practice until 1765, handing it over to his two sons, James (II) and John. This partnership was dissolved in 1771 because of John's ill-health, and indeed John died in 1780. James (II) took his son James (III) into partnership in 1795. The latter was already in partnership with Thurston Whympier, previously an apprentice to both James (II) and John, and when he died in 1794, Mrs Whympier engaged James (III) to carry on her late husband's practice. James (III)'s partnership with his father was no happier and he went abroad, before being elected as physician to Suffolk General Hospital in 1825. However another brother, George Doughty Lynn, also a physician, took over James (II)'s practice in Woodbridge in 1805 and remained there until his death in 1854.

¹³⁰ 1723 Lance Davy for seven years at a premium of £52 10s; 1728 Joseph Thomas Raff of Levington for seven years at a premium of £52 10s; 1744 Sam Smith of Bosingham for six years at a premium of £105; 1751 Robert Ashley for seven years at a premium of £105; 1761 John Syer for five years at a premium of £105; 1774 John Isaacson for five years at a premium of £105; 1767 Thurston Whympier for five years at a premium of £105; John Rodbard in 1740s; 1781 David Keer for five years at a premium of £105; 1811 C.W. Henschman; 1816 S.F. Scamell.

Seemingly, while large towns like Bury St. Edmunds and Ipswich offered advantages in terms of wider discussion, the availability of seminars and lectures and social interaction with others, it does not appear that most apprentices were attracted by such opportunities. More influential were features such as the premiums of the apothecary or surgeon and the length of tied contract. The former indicated the master's status, the scope of his business and/or the wealth of the apprentice's parents. As it usually reflected a bargain between practitioner and the apprentice's father, a critical factor in career choice was what parents could afford or obtain by way of a special rate. Where the apprenticeship was within the family, as frequently occurred, there was usually no fee involved.

For London, an early eighteenth century career guide indicated fees of £20 to £200 a year for apprenticeship to a master apothecary, and an example of this was John Keats (1795-1821), like Crabbe a reluctant and short-term medical practitioner prior to making his name as a poet, who paid £210 in 1810 for binding to an Edmonton apothecary, Thomas Hammond.¹³¹ The same guide indicated fees of £20 to £100 to a master surgeon, but there are examples of higher premiums.¹³² Sir Astley Cooper was apprenticed to a London surgeon in 1784 for seven years at the very high premium of £535 for the term.¹³³

According to Lane, in the provinces premiums appear to have ranged from £20 to £80, with £60 or so most commonly recorded.¹³⁴ However, contemporary publications quoted up to a hundred guineas.¹³⁵ In counties like Suffolk or Sussex with no large hospital, sums of £20-£60 were common during the same period. A master with an honorary hospital post charged substantially more

¹³¹ Robert Gittings, *A Life of John Keats*, (London, 1968), p.72.

¹³² As early as 1736 Caesar Hawkins, a surgeon at St. George's Hospital, took £200 with a Lancashire gentleman's son. A leading practice at Salisbury, Thomas Tatum and Co. received £140 with one apprentice in 1753 while Edward Goldwyre in the city took 200 guineas with each of his two apprentices at the same time. Bradford Wilmer of Coventry (1744-1813) took four apprentices in 1773-1795 and their premiums ranged from £130 for a seven year term, the next (1792) was £120 for only three years (presumably assigned from another master), and the last one took £200 guineas for only a five year term.

¹³³ Joan Lane, *The Making of the English Patient - a Guide to Sources*, (Stroud, 2000), p.5.

¹³⁴ Jane Lane, *Apprenticeship in England 1600-1914*, (London, 1996), p.133.

¹³⁵ *The London Tradesmen* quoted premiums of £10-£100, and Joseph Collyer in *The Parents and Guardians Directory and Youth's Guide in the Choice of Profession or Trade*, (London, 1845) quoted sums from 20 guineas to 100 guineas.

than one only in private practice, and several times that of the local country surgeon. At Pewsey, local surgeons charged premiums of £35, much less than the hospital consultants, whereas in 1767-75 Bristol apprenticeships averaged £86 a year for apothecaries and £205 for surgeons.¹³⁶ When John Green Crosse became established in Norwich with a hospital appointment, he noted that “four apprentices lived in his family house at £100 a year each”.¹³⁷

There was no such enhancement in Suffolk, but still there were great differentiations in premiums, indicating a strong supply and demand locally, and a range as great as London. Suffolk had a higher than average premium of £76, but ranging from just five pounds for John Gibb Clarke who was apprenticed to Roger Cooke at Great Ashfield in 1769, and six pounds for Joseph Kett to William Denny Snr. In 1767 to the £210 paid by Benjamin Eyre who was apprenticed to Wolfram Lewis in 1770. John Green Crosse was himself apprenticed to Thomas Bayly of Stowmarket for the relatively high premium of £200 in 1806; whether because Crosse’s father was a successful landowner and willing to pay, or because Bayly was a respected master is not clear.¹³⁸ In contrast, George Crabbe’s father negotiated a figure of ten pounds with Mr Page of Woodbridge in 1771 for taking his son two years into his tenure on the basis of very limited support and menial duties.

As for length of contract, Joan Lane states that medical apprentices “invariably completed their terms”, namely five years.¹³⁹ However, in Suffolk this average length was less precisely adhered to, even after the 1815 Act, another function presumably of London authorities’ unwillingness or inability to spend time and money enforcing the new regulations beyond the key towns and areas. About 30 per cent of the whole cohort of active practitioners in Suffolk during the period 1750-1830 was at any one time known to be indentured, and the length of the apprenticeship is known for nineteen per cent of these. Although nationally the usual length was up to seven years, the

¹³⁶ Adair, *Commentaries*, quoted in Loudon, *Medical Care*, p.42.

¹³⁷ Crosse, *John Green Crosse*, p.102.

¹³⁸ *Ibid.*, p.14.

¹³⁹ Lane, *English Patient*, p.2.

range in Suffolk ran from two to eight years, mostly between three and seven years, with five years predominating.¹⁴⁰

Table 4.3 summarises the Suffolk evidence on premiums and length of apprenticeship over the period under review.

**Table 4.3: Average Premium for Each Length of Apprenticeship
for Surgeons and Apothecaries in Suffolk**

Length of years where premium known	Instances found	Average premium (£)
2	1	52.00
3	9	68.50
4	15	69.50
5	79	88.00
6	41	70.00
7	60	55.00
Overall average		76.00

The average premium for the five year apprenticeship was considerably higher than overall, but it is not clear if this was because the majority of these reflected surgeons charging a higher rate.¹⁴¹ These figures are also distorted by outlying cases, such that of the Ashfield surgeon Roger Cooke who took John Rush as an apprentice in 1770 for five pounds for five years, out of the norm for this famous surgeon who usually charged between £84 and £150.¹⁴² At the other extreme, Nathaniel Bucke, surgeon of Ipswich, took Gil Baddeley as an apprentice at a premium of £150 for six years, and Dansie Carter was apprenticed to surgeon John Creed of Bury St. Edmunds for £210 for five years in 1803.

¹⁴⁰ George Cockle (1768-1854) had just two years as apprentice to surgeon John Newsom (1754-1829) in Woodbridge, but nevertheless succeeded John Page (1730-1794) as surgeon to the Nacton Workhouse in 1796 until 1800, and met the requirements of the overseers. John Lawton (d. 1868) from Boxford was seemingly apprenticed to surgeon Frances Mudd (d. 1835) at Gedding for eight years, from 1815-1823.

¹⁴¹ The average premium over the whole period for surgeons was £80 for an average length of term of five years. Apothecaries averaged £56 but for an average term of seven years. 'Surgeon, apothecaries' and 'surgeon, apothecary and man midwife' figures show an average of six years' apprenticeship, and £59 and £78 respectively. But the data set is very small.

¹⁴² See p.139 for details.

**Table 4.4: Analysis of Average Premium for Each Length
of Apprenticeship by Decade in Suffolk 1760-1810**

Length	1760-69	1770-1779	1780-1789	1790-1799	1800-1809
4 years	£50	£24	£71	£105	£100
5 years	£101	£90	£96	£85	£119
6 years	£79	£87	£93	£34	£51
7 years	£63	£69	£47	£67	£94
Average	£67	£68	£77	£70	£104

Table 4.4 considers these arrangements by decade, but no figures are shown for 1750-59 as these would include some apprenticeships that began prior to the period under review. Similarly, no figures appear to be extant for 1810-1829, possibly because premiums became standardised after the 1815 Act or because records were not undertaken or maintained. Apprenticeships that appear to have lasted only two or three years are also excluded, as these may have been because of transfers between masters, or special circumstances in a local area, or simply those who decided to leave medicine. From the remaining evidence there appears to be a jump in premiums on at least three of the terms (four, five and seven years), and in the overall average after 1800. Joan Lane states that provincial surgeons with good practices could attract the far larger premiums that were paid to them, and this may have been true in large towns such as Coventry and Worcester.¹⁴³ However, the evidence from Suffolk does not support this as a generality prior to 1800.

Table 4.5 summarises the average length and premium of apprenticeship by decade between 1760 and 1810. Unsurprisingly, the length is remarkably consistent, including after 1815. There is an interesting hike in the premiums at the turn of the century, likely to be the result of inflation after the French Revolution and the threat of continuing war, coupled with the resultant general inflation, due to the rising price of consumables and that apprentices were hungry mouths to feed. However, due to the unreliability of evidence

¹⁴³ Lane, *A Social History*, p.12.

about the use of titles, any conclusions derived from an analysis of length of indenture would be meaningless.

Table 4.5: Summary of Average Length and Premium by Decade

	1760-1769	1770-1779	1780-1789	1790-1799	1800-1809	1810-1819	1820-1829
Average length in years	5.7	5.4	5.9	5.5	5.4	5.4	5.2
Average premium in £s	73	76.4	76.5	74.8	113.92	-	-

In summary, therefore, as far as schooling is concerned, given the social and mobility limitations already discussed in Chapter 3, the majority of boys probably attended local boarding schools initially, run by masters of varying quality, and without clear intention as to a career. A number of potential medical practitioners may also have been educated by their parents or home tutors, as with John Mason Good of Sudbury or John Mann of Morton. All this leads to the conclusion that education was based more on opportunity, availability, geographical convenience and financial security, rather than the status or title of any school, a rather different view from that taken by some historians. Misconceptions about schooling may be due to the confused data and nomenclature, not least of those listed in *DNB* and the range of educational opportunities available in a rural country like Suffolk.

Similarly, apprenticeship experience depended on a range of factors that made the rural experience, especially after 1815, rather different from a large town where the arm of the new law was more likely to reach. There appeared to be no appreciable changes in the nature, placing, price or length of apprenticeship through the period in Suffolk, although an increase in the average premium was noted at the turn of the century. The conclusion remains that after 1815, over 250 of those known in Suffolk were in apprenticeship for at least five years.

It does not appear that the benefits of apprenticeship were being questioned in the way they were in London, or as historians such as Irvine Loudon have

stated.¹⁴⁴ The advantages for parents and masters, as well as apprentices and patients, seem to have outweighed the haphazard nature of the system. The evidence cited here supports the view that apprenticeship was alive and well after the 1815 Act in Suffolk and still providing a very practical range of skills and knowledge for a style of practitioner, peculiar to the provinces that did not merely reflect the backwards nature of the countryside but met the circumstances and needs of its community. Such a different approach and training could have meant that the populations served in the country were not necessarily benefiting from new skills and knowledge available to those living in the major urban conurbations. It is demonstrated later (in Chapter 6) that this was not the case but, before that, it is important to describe and discuss the importance of further training opportunities in hospitals and dispensaries, plus the role of higher qualifications and professional societies.

¹⁴⁴ See footnote 78.

CHAPTER 5: FURTHER AND HIGHER EDUCATION

“A great number of young men annually come to the metropolis from various districts of England and Wales....to complete their education by a course of study, which can be proved by the certificate they possess of Lecturers and Hospital Surgeons... These persons... return to their local connections usually as well qualified to practise as their age will permit”.¹

The approach to a professional medical career following early education and apprenticeship that was generally promoted by contemporaries at the end of the eighteenth and the beginning of the nineteenth centuries involved going to London hospitals to attend lectures and follow the great names in ward rounds, acting as dresser or assistant if sufficiently wealthy or favoured.² Commentators such as Irvine Loudon have argued that, by 1800, an essentially modern type of medical education centred on the hospital was already firmly established in London. Increasingly, aspiring practitioners followed up their apprenticeship, both before and after the 1815 Apothecaries Act, by attending at the metropolitan hospitals.³

However, this pattern did not necessarily apply in provincial and rural areas like Suffolk, and Loudon himself cites an inquiry in 1804 into the medical profession in Lincolnshire by a Dr Fawcett, that showed that only one in nine of those practising there had any further education at all.⁴ This was the case in Suffolk, both before and after the 1815 Act, since most apprentices went straight into practice, either with their master, family members or by answering advertisements for assistants or partners. Further education based on hospitals was limited by the county’s topography that restricted easy access to metropolitan facilities. The resulting insularity was part of the reason for numerous local post-apprenticeship societies and opportunities for further education that helped to substitute for the lack of hospital education and anatomy classes, and were not merely for social benefit or commercial gain. The evidence from Suffolk shows very few following the course that Irvine Loudon maintains was the accepted one for medical practitioners after

¹ Robert Masters Kerrison, *An Inquiry into the Present State of the Medical Profession in England*, (London, 1814), p.33.

² For example, William Chamberlaine, *Tirocinium Medicum*, (London, 1812).

³ Irvine Loudon, *Medical Care and the General Practitioner 1750-1850*, (Oxford, 1986), p.51.

⁴ *Ibid.*, p.38.

1800, but that a significant number were attending any local opportunities for development.

5.1 Hospitals and Dispensary Education and Training

In 1740, the new London Infirmary (later London Hospital) took in students with “Mr Harrison, Surgeon to the Infirmary, desiring to enter Mr Godfrey Webb as a pupil of Surgery within the said Infirmary for the space of one Year”.⁵ Post-apprenticeship attendance at hospitals was already an accepted way of completing training by 1750, when John Prosser of Monmouth announced that he was going “to see the Practice of the most eminent hospitals for some Time” for the “further benefit and satisfaction” of his patients.⁶ In 1754, Joseph Warner, surgeon to Guy’s Hospital, prefaced his *Cases in Surgery with Remarks* by noting that:

“a hospital is not only an instrument of relief to the distressed who are helped there, but also a means of helping others by furnishing such principles and practice as may improve the art of surgery”.⁷

It was not until 1783 that William Blizard at the London Hospital proposed a full range of medical lectures to accompany the experience of walking the wards. However, not all contemporary commentators viewed this development with confidence. James McKatrick Addair, writing in 1772, stated that:

“it was an egregious blunder for a man who had finished his apprenticeship to become a surgeon’s pupil because when he acquired his own practice he would deal with twenty medical cases to every one surgical”.⁸

By 1827, John Abernethy (1764-1831) was convinced that:

“unquestionably hospitals are the best schools of medical instruction ...the medical men have by degrees converted the hospitals of this country into

⁵ Archibald E. Clark-Kennedy, *The London, Vol. 1, 1740-1840*, (London, 1962), p.47. The Infirmary started taking dressing pupils shortly after foundation, and the first pupil for Physick started in 1743.

⁶ *Gloucester Journal*, 29 October 1751, quoted in Joseph F. Kett, “Provincial medical practice in England 1730-1815”, *Journal of the History of Medicine*, 29, (1964), 1, pp.17-29.

⁷ Hector S. Cameron, *Mr Guy’s Hospital 1726-1948*, (London, 1954), p.178.

⁸ James Makatrick Adair, *Commentaries on the Practice of Physic*, (London, 1772), p.27.

schools of medical instruction... the practical knowledge of our profession is much more readily obtained in hospitals than it can be elsewhere".⁹

The charitable hospitals did not pay salaries, but "such posts were eagerly sought after, bringing as they did not only patients but pupils".¹⁰ Senior doctors supplemented their incomes by lecturing to a melange of fee-paying apprentices, who gained clinical experience by 'walking the wards'. From 1769, Guy's Hospital allowed surgeons to take pupils or 'dressers', including "such as had served a considerable time to a surgeon in the country and for bettering their judgement in the art came to London to see the practice of the hospital".¹¹ This was not a replacement for apprenticeship but an adjunct to it.

Thus, by 1800 medical education in London was already a thriving business and by 1830 an apprentice to a surgeon at a London teaching hospital would pay about £500-600 per annum, as would a dresser, whereas a pupil paid £26 5s. The value of demonstrations was readily appreciated; Stephen Pollard's lithotomy in 1827 was:

"more than a surgical operation ... it was - like all operations performed in the operating theatres of the major London teaching hospitals - a means whereby (sometimes over a hundred) paying students could observe surgical techniques".¹²

Some modern historians have questioned whether systematised hospital training in metropolitan areas was underway. William McMenemey argues that circa 1815 the rank and file of the profession (that is, surgeons and apothecaries) were trained and worked in relative isolation.¹³ In contrast, Mary Fissell concludes from her work on Bristol that apprenticeship in the city waned, whilst the hospital, now effectively ruled by the surgeons, assumed a

⁹ John Abernethy, *The Dissector*, October 1827, quoted in Ruth Richardson, *Death, Dissection, and the Destitute*, (London, 1987), pp.25-6. John Abernethy was a pupil of John Hunter and Assistant Surgeon to St. Bartholomew's Hospital.

¹⁰ Frederick Noel Lawrence Poynter, "Medical education in England since 1600", *University of California School of Medicine*, (1968-70), pp.231-240.

¹¹ Rosemary O'Day, *The Professions in Early Modern England, 1450-1800: Servants of the Commonweal*, (Harlow, 2000), p.233.

¹² Richardson, *Death, Dissection*, p.47.

¹³ William H. McMenemey, "Medical education and the medical reform movement in Britain", in Frederick Noel Lawrence Poynter (ed.), *The Evolution of Medical Education in Britain*, (London, 1966), pp.135-154.

new educational function in the 1780s and 90s. However, her evidence on hospital pupillage and apprenticeship rests almost entirely on the account of a single surgeon, Richard Smith, working largely from memory and hearsay.¹⁴ Susan Lawrence similarly maintains that:

“the most striking characteristic of these years is the increase in the number following both the physicians and the surgeons on their rounds, or mixing their apothecary’s studies with one or the other experience”.¹⁵

This view seemingly strengthened Irvine Loudon’s view that walking the wards of a voluntary hospital, and afterwards sitting the examination for MRCS or LSA, was common practice.¹⁶ Joan Lane similarly believes that a further period of medical instruction after apprenticeship might include a year or more at London or provincial hospitals, walking the wards and attending courses.¹⁷ London undoubtedly catered especially for those unable to afford the time or expense of a university degree, or who saw the metropolitan experience as a more rapid way to achieve successful practice. However, Suffolk evidence is that young men from the provinces seeking to enhance their professional status by a stay in the metropolis were few and far between and that therefore the advantages were not likely to be well worth the expense.

Thus, most historians over the last thirty years have tended to assume that post-apprenticeship medical education was shaped by developments in London and a few major cities. Evidence from counties like Suffolk, which had far less secondary and specialist facilities available throughout the period, challenge that assumption, as its practitioners had only limited access to the more formal facilities of higher education.

Significantly for the argument here is that although there were thirty or more provincial hospitals by 1800, few were providing medical education beyond

¹⁴ Mary Fissell, *Patients, Power and the Poor in Eighteenth Century Bristol*, (Cambridge, 1991).

¹⁵ Susan Lawrence, *Science and Medicine in the London Hospitals 1750-1815*. Unpublished PhD, University of Toronto, 1985, p.57.

¹⁶ Irvine Loudon, “Medical education and medical reform”, in Vivian Nutton & Roy Porter, *The History of Medical Education in Britain*, (Amsterdam, 1995), pp.229-249.

¹⁷ Joan Lane, *A Social History of Medicine: Health, Healing and Disease in England 1750-1950*, (London, 2001), p.49.

the odd pupil. Carl Pfeiffer, while recognising the great increase in medical schools, licensing bodies and societies during the early decades of the nineteenth century, reflects on the enormous variation in training found between city centres of medical importance, and sparsely inhabited rural regions.¹⁸ The value of provincial hospitals to the population, where they existed and whether with teaching attached or not, has been more recently acknowledged, whereby:

“not only did hospitals avoid increasing mortality within their own wards, but... some may have also made a partial, though positive contribution towards improving health standards and reducing mortality rates in their own patient catchment area”.¹⁹

Initially their medical staffs were appointed by governors who ostensibly selected “from the ranks of local practitioners showing especial ability”.²⁰ Bristol Infirmary was a microcosm of London, and Manchester Infirmary admitted students in 1780 in exchange for fees. The building of a small hospital in Exeter was supported in 1741 by the dean of the local cathedral. None of these initially became teaching hospitals, not least because certificates from provincial hospitals were not accepted by the RCP until 1839, although the Society of Apothecaries had recognised them for the purposes of their own license before that. Consequently, O’Day suggests that the role played by hospitals in the actual training of doctors was debatable.²¹

Table 5.1 lists the facilities for medical education in England up to 1830, with both Norfolk and Suffolk noticeably lacking any.

¹⁸ Carl J. Pfeiffer, *The Art and Practice of Western Medicine in the Early Nineteenth Century*, (Jefferson, 1974), p.12.

¹⁹ Steven Cherry, “The role of a provincial hospital - the Norfolk and Norwich”, *Population Studies*, 26, (1972), 2, pp.291-306.

²⁰ A. Batty Shaw, “The Norwich school of lithotomy”, *Medical History*, 6, (1970), pp.221-259.

²¹ O’Day, *The Professions*, p.227.

Table 5.1: Facilities for Medical Education in England and Wales up to 1830**A: LONDON****1: Voluntary Hospitals**

	Established	Informal Teaching
St. Barts	1123	1734
St. Thomas	1207	1695
Westminster	1719	1827
Guy's	1721	1769
St. George's	1734	1752
London	1740	1741
Middlesex	1745	1757
Charing Cross	1822	
University College	1828	
Royal Free	1828	
St. Mary's	1851	

2: Private Anatomy Schools

	Established
Great Windmill Street	1746
Brookes' School	1786
Carpue's School	1800
Webb Street School	1819
Aldersgate Street School	1825
Dermott's School	1825
Grosvenor Place School	1830

B. PROVINCES**1: Provincial Medical Schools**

	Established	Clinical Facilities
Exeter	1823	Devon & Exeter Hospital
Manchester Royal School	1824	Manchester Royal Infirmary
Queen's College, Birmingham	1825	Queen's Hospital Birmingham
Sheffield	1828	Royal Infirmary

2: Bridge Street Manchester, Private School of Anatomy 1814.**C. UNIVERSITIES**

Oxford - Clinical facilities available at Radcliffe Infirmary from 1770.

Cambridge - Clinical facilities available at Addenbrooke's Hospital from 1720.

Source: Martin J. Muncaster, *The Medical Profession in Norfolk 1815-1922*. Unpublished PhD, University of East Anglia, 1976, Appendix 1.

The Norfolk and Norwich Hospital was the nearest facility approaching a teaching hospital for Suffolk practitioners, certainly in the northern part of East Anglia. Its rules of 1772 insisted that assistant surgeons had “been under the instruction of a regular surgeon for at least twelve months and ...likewise attended some public hospital for at least twelve months”.²² John Green Crosse (1790-1880), who had offered private anatomy classes in Norwich from 1818 and was elected Assistant Surgeon at the hospital in 1823, campaigned for its acceptance as a teaching hospital by the College of Surgeons at a time when no provincial hospital was so recognised. However, until 1826 Suffolk practitioners interested in hospital training looked outside the county, generally to London and there is no evidence that any went to Norwich (apart from Crosse), or to Cambridge, for their hospital experience. Of the total of over 950 doctors active in Suffolk between 1750 and 1830, there is formal data on post-apprenticeship training, including their dates or length of stay, for 103 (or eleven per cent), as listed in Appendix G and Table 5.2.

Table 5.2: Distribution Over Hospitals and Dispensaries of Those Suffolk Practitioners Whose Choice is Recorded

Hospital	Numbers	Dispensary	Numbers
Guy's	14	Surrey	18
The Borough Group of Hospitals	7	Ipswich General,	12
Middlesex	6	London	6
St. Bartholomew's	4	City, South London	4 each
London	4	Marylebone, St. George's and St. James'	3 each
St. Thomas'	3	Bloomsbury, Chelsea & Brompton, Pembrokeshire	1 each
Central Infirmary, St. George's, Royal Infirmary Edinburgh	2 each		
Addenbrooke's, Great Windmill, Norfolk & Norwich, Royal Naval Hospital	1 each		

Only thirteen were active pre-1815, from which one might conclude that, even in the countryside, the requirement for hospital experience prior to

²² *Rules and Orders for the Government of the Norfolk and Norwich Hospital 1772*, Rule 21 quoted in Cherry, “provincial hospital”.

being licensed as an apothecary or surgeon began to be more closely observed quite quickly after 1815. However, such a conclusion is unsafe, as nothing is known of the great majority who may have continued in the old way or simply ignored the new requirements, even if they were directly aware of them.

The county's only serious contender as a provincial hospital appeared late in the period under review, when the Suffolk General Hospital opened in 1826 in Bury St. Edmunds. The reasons for this belated provision are unclear, though evidently the combination of features essential for a successful foundation were lacking until then - patronage, enthusiasm and drive from well-respected practitioners, sufficient critical mass of potential patients, and more basic concerns such as a suitable site. Possibly county divisions had an effect: there were rivalries between Bury St. Edmunds and Ipswich, and indeed west and east Suffolk more generally, even to the extent of having two bishoprics. Although the need for a hospital was recognised long before the 1820s, arguments over its location contributed significantly to its delayed arrival.²³

Beyond that local rivalry, details of the founding and organisation of the hospital offer insight into ways in which provincial hospitals related to the local medical community and the county more widely, and into the limited nature of the facilities it offered for Suffolk practitioners. The importance of patrons and the value put upon association with their causes can be discerned from the outset.²⁴ The hospital was built on a site north of Chevington Lane, formerly an ordinance depot. A committee of twelve for the county and seven for the town was formed on 5 January 1826 and the Anniversary meeting, held in the Shire Hall in October 1826 with the Duke of Grafton in the Chair,

²³ J.W.E. Cory, *A Short History of the Suffolk General Hospital*, (Bury St. Edmunds, 1973), p.3.

²⁴ His Grace the Duke of Grafton, Lord Lieutenant of the County was President, and amongst the Vice Presidents were the Duke of Norfolk, the Duke of Rutland, the Earl of Euston, the Earl of Bristol, and the Lord Bishop of the Diocese (Ely). The others were Earl Howe, Lord Hervey, the Rt Hon Lord Walsingham, the Lord Calthorpe, Lord Bayning, plus Sir Thos Cullum, Sir H.E. Bunbury, Sir William Parker, Sir James Afflick, Sir William Rowley MP, Sir Edward Kerrison, T.S. Gooch MP, The Aldermen of Bury St. Edmunds, Alexander Adair, Richard Benyon de Beauvoir and J. Fitzgerald.

decided that the foundation needed £1,200 a year to finance its running costs.²⁵

Locally elected honorary surgeons included John Stevens Creed (1756-1829) and John Mullis (1759-1842), long-standing practitioners of Bury St. Edmunds but not known to have had apprentices, hospital experience or qualifications. However, younger appointees such as Charles Case Smith (1802-1873) and John Dalton Jnr. (1803-1859) had both apprenticeship and hospital experience, and came from dynastic medical families. Smith was apprenticed to his father from 1818-1823, then spending six months at Guy's Hospital before being appointed almost immediately on his return to Bury St. Edmunds. Similarly, Dalton had spent nine months at St. George's and St. James' Dispensary after being apprenticed to his father. James Mornement (1802-1827), the First House Surgeon and Secretary, had been apprenticed to Robert Camell {1776-1827} and Frederick Morris {1820-1828} at Bungay and had spent six months at St. Bartholomew's Hospital in London in 1825.²⁶ Therefore, these three were likely to have understood and valued the potential of teaching facilities in the new hospital. The precise duties of the surgeons were not detailed, although Dalton invited local surgeons to witness an operation on John Causton in April 1826, and such educational and professional sharing opportunities may have been offered by others. Dalton was also thanked by the Committee for the "beautiful preparation" of the skeleton of William Corder that was used for teaching purposes.²⁷

The House Apothecary responsible for the daily clinical duties was ordered to report all great operations to the Committee weekly, and a Matron and nursing staff were appointed. Admissions rose rapidly from an initial 116 in 1826 to 162 the next year and 203 in 1828. A further seven beds were added

²⁵ After the institution had been paid for and furnished from the original subscription, the hospital fund was left with £578.1.8 in hand and a subscription list of £894.10.6 for the year. By 1829, the Committee was putting money (£800) into 'Lunatic' Bonds and £2384.2 into 4% Consols.

²⁶ Referred to in the hospital reports as 'House Apothecary.'

²⁷ A young woman, Maria Marten, was shot dead by her lover, William Corder at the Red Barn, a local landmark, in Polstead, Suffolk in 1827. Corder was tracked down in London, where he had married and started a new life. After a well-publicised trial, he was found guilty of murder and hanged in Bury St. Edmunds in 1828; a huge crowd witnessed Corder's execution. The story provoked numerous articles in the newspapers, and songs and plays. The village where the crime had taken place

in 1830, raising the total to 50. However, the hospital had teething troubles with staff, with William Braithewaite the porter, Mary Catton the nurse and Mary Spink the cook all before the Matron for drunkenness in March 1826. Braithewaite was dismissed, but the nurse and cook showed due contrition and so were allowed to stay.²⁸

Mornement found his tasks as House Apothecary onerous, and resigned on 1 March 1827 because of ill-health. Two local surgeons covered for him temporarily but his replacement, George Catton {1827-1829}, also resigned due to ill-health less than eighteen months after his appointment, in September 1828.²⁹ Francis Charles Pyman (1805-1838) was then appointed in October 1828, at a lower salary than Catton but with an assistant, Nath Warren, who was paid £20 per annum.³⁰

Although eighteenth century hospitals became informal places of medical education, in Suffolk no word of teaching appears until an apprentice, the son of L.W. Barker, was indentured in 1829 for a premium of £250 to the General Hospital surgeons for three years and seven months, having already served one year and five months with a practitioner who had died.

As noted earlier, there are pre-1815 examples of Suffolk students attending out-county (mainly London) hospitals for teaching purposes. For example, Ipswich surgeon William Henry Williams {1790-1839} began his medical education at Bristol Royal Infirmary in 1790, and that October entered the

became a tourist attraction and the barn was stripped by souvenir hunters. The plays and ballads remained popular throughout the next century and continue to be performed today.

²⁸ Cory, *Suffolk General Hospital*, pp.12-13. James Mornement, the House Apothecary, wrote requesting the Committee to make enquiries into certain allegations affecting his character. Mrs Goodchild (Matron) made a statement in which Nurse Catton and others were involved. Mornement denied the charges, no facts were produced and the Committee took no action. But it appears that the Matron relieved the nurse of her duties, and shortly after herself resigned. The Committee decided to brew its own beer and bought brewing utensils at a sale of Revd W Turner. The porter, Dyer, was allowed to brew the beer for which he would be paid 2s and allowed to have the yeast. He did not carry out the arrangement and was instead paid half a guinea each time he brewed, though he had to supply the malt.

²⁹ The dismissed nurse had the same name as the overworked apothecary. Possibly the two facts were linked, though there is no direct evidence on this. The minutes of the Board meetings show that Mornement's mother stayed in the hospital to look after him for several weeks, and indeed she tendered his resignation to the Board.

Borough Hospitals as a pupil to a Mr J.P. Noble. William Henchman Crowfoot (1780-1848), surgeon of Framlingham and Beccles, attended the Borough Hospitals in 1799 under Cline and Astley Cooper, the latter becoming a lifelong friend. As already noted, John Green Crosse was a student of Great Windmill Street School of Anatomy from 1811 and on 8 April 1813 entered St. George's Hospital as a student for one year. He followed his master, Thomas Bayly (1750-1834), who was admitted as a pupil to St. Bartholomew's Hospital in 1772.

Examples of those attending after 1815 include Wangford surgeon Thomas E Clarke (1792-1818), who spent six months at Guy's Hospital in 1818, and Walton Kent (1803-1862), surgeon of Walsham le Willows, who attended the Surrey Dispensary for nine months in 1824. Joshua Smith (1792-1818), surgeon of Bury St. Edmunds, went to the Borough Hospitals in 1815 for six months and then spent another six months at Edinburgh Royal Infirmary. Unfortunately, he caught typhus as soon as he began to practice with his father in Bury St. Edmunds and died aged 26.

A number of schools of anatomy and surgery were founded in the provinces between 1800 and 1830, but these need to be distinguished from schools of medicine that gave comprehensive teaching to cover the curriculum laid down by the Court of Examiners of Society of Apothecaries. The only provincial medical schools opened before 1830 were in Exeter (1823), Manchester (1824), Birmingham (1825) and Sheffield (1828). Gloucester, Norwich and Bath were said to have had schools of anatomy, but not medical schools. Further research might confirm whether the pattern of hospital training post-apprenticeship in practice demonstrated in Suffolk was replicated elsewhere, but the county is unlikely to have been a singular exception.

Dispensaries existed to treat the sick poor from the end of the seventeenth century, but these had no teaching facilities, and all of these were disbanded

³⁰ *Ipswich Journal*, January 1833. All the House Apothecaries held MRCS and LSA. Pyman was formerly assistant to Newmarket surgeon R.J. Peck (1789-1848): he resigned in 1833 to take up an appointment in the India Service.

by the middle of the eighteenth century.³¹ Dr George Armstrong founded a dispensary in Red Lion Square, Holborn in 1769 administering largely to children, which stayed open until his death in 1789.³² John Coakley Lettsom was a Quaker who was regarded as the founder of the dispensary movement and believed that “the poor... have a just claim on the protection of the rich”.³³ He had found that the closed social and medical world of London prevented him from securing a post at one of the London hospitals, so with some Quaker colleagues he founded the Medical Society of London and the Aldersgate Street Dispensary was established in 1770.³⁴ He intended the dispensary to be used for teaching purposes from the outset and proposed that students should accompany a physician or surgeon on his dispensary rounds, while “...young gentlemen of genius might pay ten pounds per annum for the privilege of attending the practice of the dispensary and hearing a lecture a day”.³⁵

Thus, there were several drivers to the dispensary movement - providing for the sick poor in a way that hospitals did not, and offering additional opportunities for doctors including the possibilities around instruction. For doctors seeking further education, the dispensaries tended to be less crowded, competition for places was less, and the fees were lower than at the hospitals. The charges for attendance at St. George's and St. James' were six guineas for fifteen months, and for surgical practice two guineas more.³⁶ Dispensaries gave an unrivalled opportunity to study disease, as natural history and medical cases predominated, whereas in hospital surgical cases (particularly accidents) were most common. A wider range of conditions might be seen at a dispensary, invaluable for the 'jack of all trades' practitioner in the countryside and providing “an opportunity of watching a disease from the

³¹ Bronwyn Croxson, “The public and private faces of eighteenth century London dispensary charity”, *Medical History*, 41, (1997), 2, pp.127-149. Croxson cites “the Medical Society and Dispensary for the private and immediate use of the subscribers, their families and friends”.

³² Hilary Marland, *The Doncaster Dispensary 1792-1867*, (Doncaster, c.1989), p.1.

³³ John Coakley Lettsom, *Medical Memoirs of the London Dispensary*, (London, 1874), Introduction, p.3.

³⁴ Lindsay Granshaw, “The rise of the modern hospital in Britain”, in Andrew Wear (ed.), *Medicine in Society: Historical Essays*, (Cambridge, 1992), pp.197-218.

³⁵ Zachery Cope, “The influence of the free dispensaries upon medical education in Britain”, *Medical History*, 13, (1969), pp.29-36. Thomas Lettsom, *Of the Improvement of Medicine in London on the Basis of Public Good*, (London, 1775), p.51.

moment of commencement”.³⁷ Moreover, as patients were largely treated as out-patients, often in their own homes, the number who could be attended was not restricted by the availability of hospital beds.³⁸ John Reid, physician to the Finsbury Dispensary, felt that:

“Dispensary practice must appear to afford opportunities for medical improvement incomparably superior not only to those which are enjoyed by physicians in general, but even by those who professionally officiate at Hospitals”.³⁹

As the work of the dispensaries became recognised, the movement spread from London to other major cities, such as Bristol in 1775, Liverpool in 1778 and Birmingham in 1793. Unlike hospitals, they were often set up in small towns as well, because they needed much less capital and the subscriptions could be low enough to attract a wider range of patrons: Loudon cites Kendal (1783), Horncastle (1789) and Wigan (1798) as examples. The Norwich Dispensary, established in 1804, treated roughly 700 patients annually by 1820, sufficient to alarm those medical practitioners anxious about its effect upon their market and status. As a charity based on subscriber recommendation, it competed with the new hospital that mobilised opposition to plans for in-patient beds in 1819.⁴⁰

Earlier dispensaries in Suffolk had little difficulty in attracting local doctors to work there voluntarily. John Denny (1774-1835) took over from John Morgan as Medical Officer at the Ipswich Dispensary (founded in 1808) from 1817 until 1824, when he became Governor. The dispensary hours were 8.00 am to 10.00 pm, and he was available overnight at his private house in the Cornhill, although there was no evidence of teaching at the dispensary.⁴¹ It was a

³⁶ Cope, “Influence of free dispensaries”, p.34.

³⁷ Ulrich Trohler, “The doctor as naturalist: the idea of clinical teaching and research 1770-1850”, in H. Beukers & J. Molls (eds.), *Clinical Teaching, Past and Present*, (Amsterdam, 1987-1988), pp.21-34.

³⁸ Robert Kilpatrick, “Living in the light: dispensaries, philanthropy, and medical reform in late eighteenth century London”, in Andrew Cunningham & Roger French (eds.), *The Medical Enlightenment of the Eighteenth Century*, (Cambridge, 1990), pp.254-281.

³⁹ John Reid, “Accounts of the diseases in London, from the 20th December to the 20th January, admitted under the care of the physicians of the Finsbury dispensary”, *Monthly Magazine*, 83, (1802), 3, pp.74-75.

⁴⁰ Cherry, “Provincial hospital”, pp.291-306.

⁴¹ *SMB*.

similar situation with the Bury St. Edmunds Dispensary.⁴² This had been set up in Angel Lane in 1789 “for the relief of the sick poor not in receipt of parish assistance”, using two rooms rented from the Guildhall Feoffment Trust for six pounds a year.⁴³ Many of its subscribers later supported the hospital founded on this site in 1826. Another early dispensary was also established in Halesworth in 1805 “for the Purpose of supplying the indigent sick, with Advice and Medicines gratis, and to extend the benefits of Inoculation”.⁴⁴ Beccles Dispensary was founded on 24 June 1824 by the Earl of Gosford, with three of the Crowfoot medical dynasty and R.I. Metcalf as surgeons attending freely, and the services of a Matron, Mrs Maria Carter, indicating that it had beds from the outset.⁴⁵ Between June 1826 and June 1827, 293 patients were admitted with 250 discharged cured, six relieved and the remaining still on the books. The General Dispensary at Lowestoft, established in 1822, had the services of two surgeons who “attended gratuitously”.⁴⁶ Southwold dispensary had been operational for some time, with Edward Charles Bird (1784-1843) the attending surgeon, as with the dispensary at Woodbridge, although there is no direct evidence concerning practitioners there.

Whether or not the Suffolk dispensaries offered formal teaching arrangements, they were attractive to local practitioners for post-apprenticeship experience. As seen in Table 5.1, twelve practitioners attended Ipswich Dispensary, nearly one fifth of the 66 individuals known to have had such training between 1750 and 1830. However, this remains well short of Loudon’s estimate that by the 1830s, one in every six apothecaries in

⁴² SMB - for example, Alexander Henry Bartlet was appointed assistant surgeon to the dispensary in 1824 in place of his father, and then became surgeon in 1825.

⁴³ Cory, *Suffolk General Hospital*, p.10.

⁴⁴ *Rules of Uggheshall and Sotherton Parish Bank*, Suffolk Papers, BL 1304 ml. Physician, Dr William Hamilton (active between 1800 and 1808 in Ipswich, Yoxford, Halesworth and Bury St. Edmunds, and a Mr Revans offered their services free as physician, and surgeon and apothecary in this institution. could have been one of two brothers in practice in Halesworth. Stebbing Revan (1770-1812) was listed as an Apothecary, but his brother John (1766-1800) as a surgeon and apothecary that would fit more with the Proposal. However, his dates show that he died in 1800, so this is a puzzle.

⁴⁵ Pam Hardman & Maureen Saunders, *The Book of Beccles and its Hospital: a Century of Caring*, (Tiverton, 2004), p.86 This Dispensary was in existence for 52 years, finally closing in 1873. The Crowfoot family had maintained their role as Medical Officers throughout the period.

⁴⁶ *Rules and Orders for the Government of the Ufford New Friendly Society*, Suffolk Papers, BL 10351i10 J. Messrs Ball and Worthington were listed in the “State of the Charity” document for August 1828.

Britain was being trained in a dispensary.⁴⁷ Although likely to be incomplete, Zachary Cope's list of provincial dispensaries offering clinical instruction for the LSA post-dated 1830 and contained none for East Anglia, leading to his conclusion that "the educational influence of the dispensaries from 1770-1815 was limited to London".⁴⁸ Cope's views pre-date Loudon's interpretation, but the evidence for Suffolk supports his contention.

Another possible source of instruction were the private anatomy schools. As doctors became less dependent on patients describing their symptoms and more reliant on their own diagnostic skills from physical signs, so anatomy and physiology became more important, relying increasingly on dissection.⁴⁹ Of these anatomy schools, the most famous was that founded by William Hunter in Great Windmill Street in London during 1767. The teaching reputation of these schools was high and there is evidence of local anatomy schools being set up by enthusiastic practitioners who had been to London and were keen to spread what they had learned. Schools of anatomy and surgery founded in the provinces between 1800 and 1830 included Gloucester, Norwich and Bath.⁵⁰

No Suffolk medical schools were founded during the period of 1750-1830, although the young James Paget (1809 -1892), then a Great Yarmouth surgeon, attended an informal class run by Mr Randall, another young surgeon, who had just settled in Acle, Norfolk. His classes at the Angel Inn were attended by 6-8 pupils of surgeons and Paget thought them "at least as good as could have been derived in a London school at the time".⁵¹ Others followed what they had learned in dissection. For example, Sir Thomas Gery Cullum (1741-1831) was heavily criticised in 1772 for dissecting the body said to be that of Thomas Beaufort, son of John of Gaunt, whose remains were discovered in a well-preserved state in a lead coffin by some workmen

⁴⁷ Irvine Loudon, "Origin and growth of the dispensary movement in England", *Bulletin of History of Medicine*, 55, (1981), pp.322-242.

⁴⁸ Cope, "Influence of free dispensaries", p.32.

⁴⁹ Jeanne M. Peterson, *The Medical Profession in Mid-Victorian London*, (London, 1978), p.15.

⁵⁰ S.T. Anning, "Provincial medical schools in the nineteenth century", in Frederick Noel Lawrence Poynter, *Evolution of Medical Education*, pp.121-134.

⁵¹ Stephen Paget (ed.), *Memoirs and Letters of Sir James Paget*, (London, 1901), p.22.

carrying out renovations on the Abbey Church in Bury St. Edmunds.⁵² Later, local surgeons George Creed and Charles Case Smith reportedly helped in the public dissection of the body of the murderer William Corder in August 1828 at Suffolk General Hospital, referred to above.

Local practitioners were clearly aware of the advantages of such training, or of persuading potential clients of their additional skills and experience. Thus John Rodbard (1724-1808) surgeon, apothecary and man midwife of Debenham and Ipswich, advertised in 1755 that he had attended hospitals and lectures in London, but offered no details.⁵³ In 1764, William Bevil {1757-1764} advertised in the same newspaper that he had:

“Taken the shop late of Mr Beck... where he will practise Surgery, Midwifery and Physick. William Bevil hath for one year past attended lectures of the best Professors in London and was a pupil in the Middlesex Hospital”.⁵⁴

Similarly in 1785 surgeon, apothecary and man midwife Robert Anderson (1760-1842) of Sudbury, advertised that:

“he had laid a in a stock of medicines, and had not only attended for three years the Professors of Physic, Surgery and Medicine at the University of Edinburgh, but had also walked the wards in a London hospital and was willing to attend poor women in labour *gratis*”.⁵⁵

George Crabbe (1754-1832) of Aldeburgh reported an informal experience of London hospitals: although “my Father at this time was much distress’d and could not send me to London for the usual improvements”, he was aware of the need to develop skills in an area of medicine that might benefit patients and provide an opportunity. Thus:

“After one year I left my little Business to the care of a neighbouring Surgeon and came to London where I attended the lectures of Messrs Orme and Lowder on midwifery and occasionally stole round the hospitals to

⁵² *Beaufort Papers*, PRO, SP 37/9 H 43 & 44 SK 180. He told the antiquary Michael Tyson that he had got the right hand of Beaufort in a glass of spirits.

⁵³ *Ipswich Journal*, May 1755.

⁵⁴ *Ipswich Journal*, March 1864.

⁵⁵ *Ipswich Journal*, December 1785.

observe those remarkable Cases which might indeed, but which probably never would occur to me again”.⁵⁶

Others also obtained the security of a practice and income before continuing their education in this way, and more probably went to London just to gain certificates of course attendance or to listen to the great men of the day.

The vast majority stayed for six or nine months, less than the one year prescribed in the 1815 Apothecaries Act, or the year-long walking of the wards required of surgeons. It was also considerably less than Irvine Loudon’s assertion that further medical instruction might have included one year or more at a provincial hospital as a surgeon’s pupil, followed by a further year in London attending lectures and ‘walking the wards’, plus private courses on various medical subjects.⁵⁷ Twelve months’ instruction was exceptional for Suffolk practitioners, particularly if they were going into partnership with fathers keen to have them working as soon as possible, or if they were already in practice, as with George Crabbe.

The rise of hospitals was closely correlated to social mobility, growing populations and migration that encouraged medical practitioners to settle in towns.⁵⁸ Tertius Lydgate observed, when told of the new hospital in Middlemarch:

“There are few things better worth the pains in a provincial town like this... A fine fever hospital in addition to the old infirmary might be the nucleus of a medical school here... and what could do more for medical education than the spread of such schools over the country?”.⁵⁹

Doctors themselves saw hospital positions as making themselves known to leading local lay people, and building up their private practice through links with the hospital and its well-off governors.⁶⁰ Even though hospitals did not

⁵⁶ Thomas C. Faulkner (ed.), with the assistance of Rhonda L. Blair, *Selected Letters and Journals of George Crabbe*, (Oxford, 1985). Crabbe to Edmund Burke June 1781. David Orme and Lowder were Scottish man midwives practising in London, who followed in the obstetrical tradition developed by Dr William Smellie.

⁵⁷ Loudon, “Medical education and medical reform”.

⁵⁸ Granshaw, “The rise of the modern hospital”, pp.197-218.

⁵⁹ George Eliot, *Middlemarch a Study of Provincial Life*, (first published Edinburgh and London, 1871), Penguin English Library, (1965), p.152.

⁶⁰ Lane, *A Social History*, p.82.

figure for most Suffolk doctors as a regular means of completing their education, those doctors with dispensary appointments probably took their apprentices along and exposed them to the opportunities afforded to extend their skill and knowledge. However, bearing in mind the small number of dispensaries and doctors associated with them, their impact upon practitioner development must have been rather restricted.

5.2 Higher And Further Education

“The number of uneducated persons, who exercise the profession of medicine and surgery in its various departments, is almost incredible to those who have not investigated the subject”.⁶¹

If limited numbers of Suffolk practitioners attended post-apprenticeship further education in hospitals or dispensaries, even fewer appeared to see the need for higher qualifications, most of which required access to London or other major cities. A review of the range of higher and further education opportunities shows that the accepted picture of medical practitioner development and training is less typical of Suffolk and needs revision, especially if further research in other counties adds to the strength of the view that enforcement and acceptance of the need and value of the metro-centric qualifications was much later in the countryside than current histories portray.

English university education in medicine was largely for physicians who, for the RCP and ‘Oxbridge’, were also members of the Church of England. Between 1751 and 1800, English universities graduated only 246 men in medicine (or about five per year).⁶² Far greater numbers emerged from Edinburgh and Glasgow, not least because Scotland acted as a refuge for English dissenters and medical education here was less expensive. Moreover, the Scottish institutions aimed to provide a complete range of medical courses, including surgery and midwifery, integrating these into the practical work of clinics while still offering a university degree, a facility not provided

⁶¹ Kerrison, *Inquiry*, p.37.

⁶² Alastair H.T. Robb-Smith, “Medical education at Oxford and Cambridge prior to 1850”, in Poynter, *The Evolution of Medical Education*, pp.19-52.

in the English system. From Suffolk, only Sir Thomas Gery Cullum was recorded as present in Cambridge, from where he attended lectures given in London by both John and William Hunter. As already noted, Robert Anderson went to Edinburgh, but it is unclear whether he took a formal course. Halesworth physician and surgeon Richard Langslow {1790-1812} practised in Ludlow, Shropshire:

“...till the year 1790; he at that time was desirous of taking a medical degree, and went back to Edinburgh, where he studied physic, and took his degree at Glasgow”.⁶³

With interest growing in formal medical education in the early eighteenth century, numerous Britons went abroad, many to study under Herman Boerhaave (1668-1728) at Leyden University, famous as a medical school since the sixteenth century. John Kett commented that:

“judging from the frequency with which students transferred among the continental universities, foreign study seems to have been regarded as a species of grand tour, involving considerable expense”.⁶⁴

Yet this was beyond the reach of most country doctors, and few provincial apothecaries could avail themselves of such opportunities, home or abroad. There is no direct evidence of any from Suffolk doing so before 1830, although Wickhambrook surgeon J. Dunthorn (1791-1856), who had obtained his MRCS in 1808, did much later achieve his MD at Erlangen in 1847, just two years before he retired from practice.

The difference between city and country, academic and practical medicine is demonstrated by the fact that only thirteen Suffolk MDs are recorded for the period 1750-1830, the majority being physicians, with very few surgeons noted. For example, Robert Anderson obtained his MD from Aberdeen in 1809, after he had been in practice for at least twelve years. Similarly with William Whincopp (1768-1832) of Woodbridge and William Salmon {1821} of Wickham Market. Whincopp was the author of *A Case of Hydrothorax*, published in Woodbridge in 1822 and, as he achieved his MD at King's College Aberdeen in

⁶³ Richard Langslow, *The Case of Master Day*, (Bungay, 1801), p.48.

⁶⁴ Kett, “Provincial medical practice”, pp.24-25.

1821, it may be assumed that this was his thesis. No more was heard of him subsequently until his death announced in 1832.⁶⁵ Salmon also had an MD from Aberdeen in 1809 and conceivably he and Whincopp worked together, as their practices were not far apart, until Salmon left Suffolk in 1822, and let his Wickham Market house. As a Norfolk comparison, Michael Muncaster found only five practitioners there who obtained their MDs between 1817 and 1827, though their specialisms are not known.⁶⁶

With the medical profession generally, particularly London practitioners, more conscious of standards and the need for regulation to protect against undesirables impinging on the areas proscribed for doctors, the value of higher qualifications became increasingly important as a demonstration of competence and indeed a license to practise. However, in 1800, membership of the College of Surgeons still remained a qualification that required no examination, but only certificates in one course of anatomy and one on surgery. This changed in 1813 when the College required a year's attendance on the surgical practice in a hospital. Then the 1815 Apothecaries Act authorised the granting of the LSA for medical practice in England and between 1815-1834 the Society granted over 6,000 licenses.⁶⁷

For surgeons, the LSA was arguably of limited practical value, since it included only the most basic surgical training - two courses of lectures on anatomy and physiology and no dissection.⁶⁸ But in isolated areas like Suffolk, with a scarcity of hospitals and difficulties of transport and communication, this was frequently the best and most practical qualification to be obtained, and therefore the most frequently held. John Constable, referring to his local surgeon friend William Travis (1786-1873), gave an interesting lay slant on the relationship between membership of the College of Surgeons and apprenticeship. He wrote that "Travis brought a parcel from London where he had probably been studying to become a member of the College of Surgeons,

⁶⁵ Peter J. Wallis & R.V. Wallis (with Juanita Burnby and Thomas D. Whittet), *Eighteenth Century Medics - Subscriptions, Licences, Apprenticeships*, (Newcastle-upon-Tyne, 1985).

⁶⁶ Michael J. Muncaster, *Medical Services and the Medical Profession in Norfolk 1815-1911*. Unpublished thesis submitted to the University of East Anglia, (1976), p.58, Table VI.

⁶⁷ Peterson, *Medical Profession*, p.11.

⁶⁸ Muncaster, *Medical Services*, p.11.

unlike his father who probably learned his profession by apprenticeship”, an indication perhaps of the confusion around qualifications and practical learning.⁶⁹ Nor was the MRCS ideal if held in isolation from the LSA, since country practitioners prescribed and compounded their own prescriptions: a surgeon needed the apothecary’s license because he stood to be prosecuted if he supplied his own medicines without it. George Man Burrows had already noted in 1813 that “the majority [of doctors] were Licentiates of the Apothecaries’ Society, nine-tenths were Members of the College of Surgeons”.⁷⁰ Barely two decades after 1815, it was recognised by a Norwich practitioner that most of his colleagues (even in rural areas) possessed both qualifications, a view supported by Michael Muncaster’s later survey of Norfolk doctors.⁷¹

In the light of this, it is not surprising that in Suffolk between 1750 and 1830, where any qualification was held, most frequently both were obtained and Appendix H sets out all known qualifications by title. No FRCS awards were listed during the period and there was only a smattering of further degrees and collegiate licensing noted above.⁷² As the latter were largely derived or conferred for time served or monies paid, their paucity did not imply a lesser quality among practitioners. The limited data available suggest a post-1815 increase in licenses, but precludes any confident generalisations.

A very different picture emerges concerning local and socially-based educational activities. Membership of scientific and similar societies gave a medical man status and a reputation for learning so, although the levels of formal qualifications were not high in Suffolk, there were many societies and clubs whose role in affirming, maintaining or developing the education and

⁶⁹ Ronald B. Beckett (ed.), *John Constable’s Correspondence: The Family at East Bergholt 1807-1837*, (London, 1962), p.25. Letter 19 June 1808.

⁷⁰ Quoted in Vieda Skultans, *Madness and Morals - Ideas in Insanity in the Nineteenth Century*, (London, 1975), p.139. George Man Burrows was the owner of a private asylum in Chelsea from 1814 and of the Retreat in Clapham from 1823-43. He wrote extensively, for example, his *Commentaries on Insanity*, (London, 1828) and advocated the physical restraint of the insane.

⁷¹ Joseph Yelloly, *Observations on the Relief of the Sick Poor Addressed in a Letter to the Rt. Hon. Lord John Russell*, (London, 1837), p.40.

⁷² Robert Anderson 1809 Aberdeen MD, Crowfoot MRCS, 1801 and FRCS 1843, Cuthbert MRCS c.1800, Frances MRCS 1820, LSA 1821, Freeman 1818 LSA,/MRCS, Norford ex-licentiate RCP, practised as physician and called himself Dr Travis Cambridge 1816, MRCS 1808, Williams 1798 MD and FRCP.

skills of otherwise isolated practitioners was crucial. Medical associations ranged from student fraternities and dining clubs to serious study groups, combining conviviality, mutual assistance, and the exchange of professional knowledge and skills. Arguably such associations and forums provided a significant stimulus and means of keeping up-to-date, and partly explain why Suffolk medical care appears to have been of a higher standard than would perhaps be expected from the evidence of their limited formal training.⁷³

Some societies drew membership from single strands of the profession, such as the Suffolk Society of Surgeons founded in 1789 that subsequently had a regular membership. Similarly, there were the Royal College of Physicians' 'College Club' and the Apothecaries' Society 'Friendly Medical Society'.⁷⁴ Provincial hospital physicians and surgeons, together with general practitioners, formed their own organisations that provided a forum for professional discussion, social intercourse and medico-political activity. Provincial practitioners particularly tended to ignore corporate distinctions in their local organisations, since London leadership was both geographically and functionally remote. For many rural practitioners, these societies represented the only way of learning about new techniques and developments from London and abroad, and provided medical books and journals to enable them to keep up-to-date.

Specific local provincial societies also flourished from the late eighteenth century. For example, the Huntingdonshire Medical Society was formed in 1792 and the Plymouth Society in 1792, and there were at least forty such associations. As Clark puts it "The ambition... was not just to promote new information and practices but also to regulate the qualifications and activity of members".⁷⁵ In September 1796, Lincolnshire surgeon Matthew Flinders wrote in his diary:

"Drs Wilson and Crane and six of us surgeons and apothecaries have established a Monthly Meeting at the Red Cow Donnington during the

⁷³ Chapter 6 discusses the range of professional services delivered in Suffolk.

⁷⁴ Peter Clark, *British Clubs and Societies 1580-1800 - the Origins of the Associational World*, (Oxford, 2000), p.10.

⁷⁵ Clark, *British Clubs*, p.115.

summer to discuss Medical Subjects and raise a small fund for the purchase of New Medical Books”.⁷⁶

The most important of them proved to be the Provincial Medical and Surgical Association, founded in 1832 by Charles Hastings (1794-1866) in Worcester, since this expanded as a professional body or quasi-trade union for all British doctors, becoming the British Medical Association.⁷⁷

Although Sir D’Arcy Power’s history of British medical societies focused on the professional representational organisations and excluded benevolent societies and reading clubs, he conceded that the former frequently derived from the latter:

“The little book clubs brought neighbouring practitioners in contact with each other and from them the local medical society sometimes came into existence”.⁷⁸

Such bodies indicated the acute awareness of practitioners of the need to support and exchange information, particularly scientific and political, and reflected the remarkable growth in publishing, bookselling and book consumption in the late eighteenth century.

Most book clubs were initially based in cities: for example, Edinburgh, Glasgow, Aberdeen and London (Guy’s, Medical Society, Hunterian, Harveian, Middlesex Hospital). Early provincial examples in England included the Bristol Medical Reading Society founded in 1807, and Lancaster Medical Book Club in 1823. Usually a rota was formed, with a journal or book circulated to each member for a specified time enforced by fines, with an annual dinner and raffle, the winner keeping the book.⁷⁹ Provincial doctors scattered over a sparsely inhabited district might also club together to share the cost of subscribing to a medical journal or to buy books.

⁷⁶ Juanita Burnby, “An examined and free apothecary”, in Vivian Nutton & Roy Porter (eds.), *Medical Education*, pp.16-36.

⁷⁷ Peterson, *Medical Profession*, p.31.

⁷⁸ Sir D’Arcy Power (ed.), *British Medical Societies*, (London, 1939), Preface, p.viii.

⁷⁹ Power, *British Medical Societies*, Preface, p.viii.

All these types of organisations proliferated in Suffolk by 1830, and Table 5.3 summarises the data extant on the membership of the main ones. Since this information is largely based on office-holders, the general membership is likely to have been considerably larger, albeit fluctuating, as subscriptions were often cancelled when a practitioner fell upon difficult times.

**Table 5.3: Numbers of Known Members by Decades
of Suffolk Medical Societies and Book Clubs**

	1770-1780	1781-1790	1791-1800	1801-1810	1811-1820	1821-1830
Colchester Medical Society (1774)	5	3	3	1	2	2
Suffolk Benevolent Medical Society (1780)		34	8	25	19	15
Suffolk Society of Surgeons (1789)		10	4	2	7	6
Suffolk Medical Book Society, Founded 1824						26

Source: Data derived from *SMB*.

An early record in the *Ipswich Journal* noted that Francis David Mudd Snr. {1794-1835} attended a Suffolk Medical Book Club in Bury St. Edmunds at the Angel Hotel on Tuesday 6 July 1813.⁸⁰ This suggests an earlier association in the county than has been conventionally assumed. The Suffolk Medical Book Society started in Ipswich in 1824, running a small medical library of texts and journals in the back room of an Ipswich bookshop. Subscribing members and apprentices had the right to visit, borrow books or have them sent by post. Even though membership was confined to those living within twelve miles of Ipswich, at least 58 surgeon and apothecaries were members of this society, rather more than were identified for the successor club that was founded in 1829.⁸¹ Its Presidents and Vice Presidents included the surgeons William Cutting (1816-1850) from Holbrook and Charles Hammond (1819-1876) from Ipswich. A rival club was founded (or revived) in Bury St. Edmunds in 1833,

⁸⁰ *Ipswich Journal*, 6 July 1813.

⁸¹ Information extracted from the individual records in *SMB*.

with notables from among the local practitioners all subscribing two guineas.⁸² The Bury and Suffolk Medical Society and Book Club featured a system whereby “books be proposed at quarterly or Annual Meeting and the majority of members present determine their admission or rejection”.⁸³

That some practitioners kept up with modern medical thinking may be seen from the example of John Syer (1745-1823), who in 1823 was offering medical books for sale, including Abernethy’s *Surgical Observations* and older books on midwifery by Deventer, Chapman and Burton.⁸⁴ The Bury and Suffolk Book Club was offering books for sale in 1837 that included those by Addison on poisons and Higginbotham on nitrate silver.⁸⁵ The main focus for West Suffolk practitioners at least lay just outside the county with the Colchester Medical Society, founded in 1774 by Robert N. Newell, a local surgeon and apothecary and a friend of John Coakley Lettsom (1744-1815) who was elected to the Society a few years after its foundation.⁸⁶

Many practitioners were serial joiners and, if they belonged and rose through the ranks of one society, they tended to do so with others. George Vaux of Ipswich {1809-1830} was President of the Suffolk Society of Surgeons in 1826 and similarly of the Suffolk Medical Book Society three years later. Samuel Webber of Hopton {1800-1822} had an extensive record of office holding across four societies being, amongst other things, Vice President of the Suffolk Benevolent Medical Society in 1807, Vice President of the Suffolk Society of Surgeons in 1826 and 1829, and President of the Suffolk Medical Book Society in 1828. Clearly, being an office holder in these societies carried

⁸² George Creed, Rowland Dalton and George Le Neve were of the number together with 15 others from Hartest, Bury St. Edmunds, Barrow, Mildenhall and other towns in the environs of Bury St. Edmunds.

⁸³ *Probart Papers*, “Rules of the Bury and Suffolk Medical Society and Book Club”, SRO (Bury St. Edmunds), 2753/4/31.

⁸⁴ *Ipswich Journal*, 1823. John Abernethy, *Surgical Observations on the Constitutional Origin and Treatment of Local Diseases; and on Aneurisms; on Diseases Resembling Syphilis; and on the Diseases of the Urethra*, (London, 1809); Hendrik van Deventer, *The Art of Midwifery Improv’d*, (London, 1728); Edmund Chapman, *An Essay on the Improvement of Midwifery; Chiefly with Regard to the Operation*, (London, 1733); John Burton, *Midwifery*, (London, 1751). Thomas Addison, *An Essay on the Operation of Poisonous Agents Upon the Human Body*, (London, 1829).

⁸⁵ *Probart Papers*. Thomas Addison, *Poisonous Agents*; John Higginbotham, *An Essay on the use of Nitrate of Silver in the Cure of Inflammation*, (London, 1829).

⁸⁶ Clark, *British Clubs*, p.115. Lettsom had founded the Medical Society of London in 1773 as a forum for physicians, surgeons, apothecaries and accoucheurs to meet for the exchange of medical intelligence.

some caché judging by the many practitioners who held several posts. Yet it is interesting that few of the ‘notable’ practitioners, such as George Stebbing (1745-1825) or John Page (1730-1794), appear on these lists. Perhaps their reputations were such that they did not need to ‘network’ with others. They may have had sufficient contacts with London colleagues to acquire up-to-date knowledge and information that way; or they may simply have been too busy. Further research on other comparable counties might reveal more extensive evidence of the real impact of these societies upon the reputation and practice of country practitioners.

There were also benevolent societies that often preceded local medical societies and, like medical Book Clubs, these can be confused with medical societies proper.⁸⁷ The early ones, such as that founded in Surrey in 1812, held scientific and clinical meetings for 50 years. The first two provincial benevolent societies were Essex and Hertfordshire, and the Norfolk and Norwich, both founded in 1786. These also suggest the furthering of professional and clinical expertise of geographically widespread practitioners, as in Suffolk. The Suffolk Medical Benevolent Society, founded a year later, began with 34 known members, including Henry Seekamp of Ipswich (1771-1819), Robert Abbott of Needham Market (1750-1830) and William Hardy Travis of East Bergholt. Membership appeared to drop over the turn of the century, recovering to 25 by 1810, then declining to fifteen by 1830.⁸⁸

Although the numbers identified as directly involved in such societies were relatively small, there was likely to have been a much wider membership, and it is clear that they played an important role in compensating to some extent for the lack of more structured further education. Although Clark questions the wider national impact of associational activity in scientific and medical fields, the many active societies in Suffolk helped to bring together the three main arms of the medical community and boosted the circulation of knowledge, including technical advances in surgical and other cases.⁸⁹

⁸⁷ The Lincoln Benevolent Society and the Lincoln Medical Benevolent Society are confused, the former founded in 1802, but the latter not until 1862.

⁸⁸ Suffolk Medical Benevolent Society, *Minutes*, SRO (Ipswich), GC 617/1/1.

⁸⁹ Clark, *British Clubs and Societies*, p.440.

It is also important to include the considerable body of scientific publications and interests that emanated from Suffolk, and as a provincial county it was probably not alone in this respect. Medical men were increasingly identifying science as the agent for understanding and ordering the world. A surprising range of Suffolk medical practitioners gained status and reputation for expertise as authors on medical and other topics, often based largely on their local experiences and stimulated by a desire to share their knowledge and potential advances in medicine with others.⁹⁰ For example, John Mason Good (1764-1827) published an “Essay on medical technology” in the *Transactions of the Medical Society of London* in 1808, based on his work as a surgeon in Sudbury, and received the Fothergillian medal for it.⁹¹ John Lynn {1766-1780} wrote *The History of Fatal Inversion of Uterus* in 1767.⁹² Sir Thomas Cullum described a case of encysted tumour in *Medical Inquiries and Observations* in 1776. Similarly, Thomas Reeve Jnr. (1767-1832) of Gislingham published in July 1798 *Eysipelatous sore throat... to which is subjoined An Account of a Case of Hemiplegia*. Thomas Gibbons produced a fascinating volume of case notes sharing his experiences of treating with mercury, stating that “My only motive is because I think they will be of use to mankind”.⁹³ Ipswich surgeon William Mann Hamilton (1789-1855) wrote *Mercury in obstinate vomiting* in 1813, followed by his *Account of the rise, progress and treatment of fever in the neighbourhood of Ipswich* in 1817.⁹⁴

John Clubbe (1741-1811) wrote several pamphlets on the common conditions treated by medical practitioners - *A treatise on the inflammation of the breasts of lying in women* (London, 1779), *The venereal poison* (1782), and an essay on virulent gonorrhoea (1786). Sudbury surgeon David Bates (1791-1858) was also well-known in the medical world as the author of *Treatise on*

⁹⁰ Christopher Lawrence, *Medicine in the Making of Modern Britain 1700-1920*, (London, 1994), p.34.

⁹¹ Olinthus Gregory, *Memoirs of the Life, Writings and Character, Professional and Religious of the Late John Mason Good*, (London, 1828). Good’s textbooks included *A Study of Medicine* in 4 Volumes (1822) and *The History of Medicine so far as it Relates to the Profession of the Apothecary* (1795).

⁹² Others included William Goodwyn, Edmund Goodwyn, John Clubbe, Sir Thomas Gery Cullum and William Crowfoot.

⁹³ Thomas Gibbons, *Medical Case Notes and Remarks*, (Ipswich, 1789).

⁹⁴ Both were published in the *London Medical and Physical Journal*, the first in Vol. 33 pp.100-103, and second Vol. 37, pp.451-4.

inflammation. Edmund Goodwyn (1756-1829), surgeon and apothecary of Woodbridge, was the author of *Dissertio Medica de Morte Submersarium* and *Connexion of Life with Respiration*.⁹⁵ James Bedingfield wrote *The Enemy of Empiricism* and *The Compendium of Medical Practice*, published in London in 1816. John Green Crosse, a Suffolk son, engaged in public scientific discourse with the *Royal Society Journal*, and George Cowell (1805-1848), surgeon of Ipswich, lectured at least twice to the Ipswich Mechanics Institute, once on the circulation of blood and secondly on the head.⁹⁶

‘Enlightened’ pursuits, such as botany and antiquarianism, also stored up social capital and strengthened a doctor’s professional authority. Thomas Gelfand maintains that the medical profession of the eighteenth century was made up of various groups “whose training and practice were determined less by guild regulations and more by free-market forces”.⁹⁷ Consequently, related scientific interests were common, and several attained national notice for their work. Like Erasmus Darwin and John Keats, in Suffolk George Crabbe was a keen naturalist and herbalist, and Edward Acton of Grundisburgh (1806-1860) was an avid collector, a conchologist, fossilist, antiquarian and numismatist, with much of his collection now in the British Museum. Sir James Paget used the opportunities he gained in his apprenticeship to study botany and zoology. For the former he was guided by Mr Palgrave, nephew of Mr Dawson Turner, who represented Great Yarmouth “in what might justly be called the Norfolk School of Botanists”. They were followers of Linnaeus (1707-1778), who had just published his contributions to taxonomy,⁹⁸ and for Paget this was a lifetime interest.⁹⁹ Sir Thomas Gery Cullum was a famous botanist, writing *Florae anglicae specimen imperfectum et meditum* in 1774. Henry W.R. Davey (1798-1870), surgeon of Beccles, gave lectures on

⁹⁵ The former was published in Edinburgh in 1786, and the latter in London in 1788, according to the *DNB*.

⁹⁶ *Ipswich Journal*, September 1836.

⁹⁷ Thomas Gelfand, “The history of the medical profession” in William F. Bynum and Roy Porter, *Companion Encyclopaedia of the History of Medicine*, Vol 2, (London, 1997), pp.1119-1150.

⁹⁸ Linnaeus established what became known as the Linnaean taxonomy, the system of scientific classification now widely used in the biological sciences, starting with three Kingdoms, divided into Classes that in turn are divided into Orders. These are divided into Genus that in turn are divided into species. He is credited with having established the idea of a hierarchical structure of classification based upon observable characteristics.

⁹⁹ Paget, *Paget*, p.25.

geology.¹⁰⁰ Abel Clarke published an account of his ill-fated voyage in *Narrative of a Journey in the Interior of China 1816-1817*.¹⁰¹

Overall therefore, Suffolk doctors were neither as interested in or dependent upon further education at hospitals or dispensaries as their metropolitan counterparts who were more within the reach of the licensing bodies that were demanding more defined standards after 1815. The significance of hospital training was less for Suffolk and other rural counties, since teaching hospitals were almost entirely dominated by the London institutions and one or two in major metropolitan areas in northern and western England. Ruth Richardson concludes that:

“the intimate relationship between charitable hospital treatment and training, medical patronage, and the lucrative market of private practice was predicated upon the availability of a relatively passive pool of humanity upon which surgeons could learn and develop their craft”.¹⁰²

In Suffolk, although the latter was present, the former elements of this delicate balance were not noticeable until the mid-nineteenth century, for the reasons speculated upon above.

The move towards hospital-based medicine at the beginning of the nineteenth century had profound implications for the doctor-patient relationship because of the differing status of doctor and patient in the hospital setting. As Jewson puts it, “Under hospital medicine, medical authority derived from the practitioner’s status within an institutional structure. Patients had no role in constructing authority of this kind”.¹⁰³ As the rapid growth in medical education facilities in hospitals, private medical schools and dispensaries between 1750 and 1830 in major towns, particularly in London, was not reflected in Suffolk, this change in relationship must have been much slower there. The old eighteenth century patronage models, with the patient as the chief arbiter of the priorities inherent in a clinical encounter and as judge of

¹⁰⁰ *The Dix family papers of Smallburgh*, NRO (Norwich) Accn. 24.7.70.

¹⁰¹ Abel Clarke, *Narrative of a Journey in the Interior of China and a Voyage to and from that Country in the Years 1816-1817*, (London, 1818).

¹⁰² Richardson, *Death, Dissection*, p.48.

¹⁰³ Nicholas Jewson, “Medical knowledge and the patronage system in the eighteenth century”, *Sociology*, 13, (1974), pp.369-385.

the requisite qualities of a practitioner, continued long after 1800.¹⁰⁴ Moreover, it seems likely that in the provinces and particularly in the rural areas many, if not most, practitioners put up their plates with no further formal education, before and after this became a legal requirement in 1815. In Suffolk, there is more evidence of practitioners following further training opportunities after 1815, but the numbers remained small, suggesting that enforcement of the 1815 Act in this respect was not a concern for those so far from the nation's hub.

The societies and clubs across the county, together with a relatively high level of respected publications and nationally recognised expertise both within medicine and across the wider scientific field, thus may have helped to ensure that the standard of care was not lower in rural areas like Suffolk than in the well-endowed metropolitan areas. Despite the lack of facilities and little take-up of the higher education and training opportunities offered by London and the metropolitan areas, medical and scientific curiosity existed in Suffolk, together with a recognition by medical professionals that sharing developments and experiences was an essential way of keeping abreast of clinical developments. All this suggested a lively medical community, notwithstanding the lack of the more orthodox and developing facilities for teaching and research or formally educated and externally verified practitioners with recognisable qualifications. Moreover, as the next chapter demonstrates, the somewhat 'home-grown' nature of the further and higher education available in Suffolk did not demonstrably reduce the range of services provided or the regard in which they were held. Medical care in the county was not necessarily less skilled or comprehensive than in London, and in some respects was arguably safer, less 'heroic' and freer from hospital-borne infection.

¹⁰⁴ Stephen Jacyna, "Medicine in transformation 1800-1849", in William F. Bynum *et al.* (eds.), *The Western Medical Tradition 1800-2000*, (Cambridge, 2006).

CHAPTER 6: WHAT SORT OF MEDICINE **- TREATMENT OR PREVENTION?**

“I have consulted eminent men in the metropolis, and I am painfully aware of the backwardness under which medical treatment labours in our provincial districts”.¹

6.1 Treatment

Surgery at the time of the Anatomy Act of 1832 bore a greater resemblance to that of the seventeenth century than to surgery today. Its scope was limited, amputation of fingers and legs being frequent, together with the setting of fractures and dislocations, lithotomy, the suturing of wounds and the tapping of fluids. However nationally, particularly led by London and Continental practitioners, there had been some notable and rapid developments in treatments towards the latter part of the period. For example, in 1805 Friedrich Sertuner isolated morphine; amalgam for dental fillings was introduced; in 1808, interscapular-thoracic amputation was performed for the first time by Ralph Cuming; in 1812, appendicitis was described by James Parkinson; and in 1820 iodine was used in the treatment of goitre.²

Yet mortality rates did not fall dramatically, nor was any new technical apparatus developed (bar possibly the microscope) that gave hope for actual cures. The predominant reasons for the relatively narrow range of procedures and the lack of impact that new developments had on mortality, according to Ruth Richardson, were the ignorance of the causes of sepsis and other hospital-spread infections, plus the inability of the surgeons to anaesthetise their patients.³ Anaesthesia was not discovered until 1840 and before that operations had to be completed very quickly; the nature of infection was not understood, so ‘cold surgery’ such as that of cancer or any orthopaedic work or work on the brain, chest or abdomen were out of the question in most

¹ George Eliot, *Middlemarch or Scenes from a Provincial Life*, (first published Edinburgh and London, 1871), (Penguin English Library, 1965), Ch. 13, p.153.

² See Carl Pfeiffer, *The Art and Practice of Western Medicine in the Early Nineteenth Century*, (Jefferson, NY, 1985), Table 3, p.15. This gives a complete list of landmarks in biology and medicine, 1780-1825.

³ Ruth Richardson, *Death, Dissection and the Destitute*, (London, 1987), p.41.

cases.⁴ The importance of speed was illustrated by Aldeburgh surgeon and apothecary George Crabbe (1754-1832), whose son wrote of him “Ready sharpness of mind and mechanical cleverness of hand were the first essentials of a surgeon and he wanted them both”.⁵ He had “an innate lack of manual dexterity which made it hard for him to be swift in bleeding, bandaging or bone-setting”.⁶

In spite of Crabbe’s lack of surgical skills, East Anglia appears to have been something of a centre for surgery from the beginning of the eighteenth century until towards the end of the period under review. John Green Crosse (1790-1850) and John Yelloly (1774-1842) in Norwich were nationally recognised as experts on vesical calculus, and the Norfolk and Norwich Hospital was at the time the most celebrated institution for the removal of bladder stones.⁷ William Cheselden’s (1658-1752) new technique for lithotomy, derived from his knowledge of anatomy gained on the dissection table, was already a well-known procedure.⁸ It was a clear illustration of how speed was crucial in surgery - he was said to be able to carry out the procedure in under a minute, as opposed to taking up to an hour previously.⁹

Success rates in the provinces were high and the procedure popular, and many Suffolk surgeons performed lithotomies with success.¹⁰ These were often reported in the local press, an indication that such events had some news value. James D’Oyley {1768-1787}, surgeon and apothecary of Hadleigh,

⁴ Archibald E. Clark-Kennedy, *The London Vol. 1 1740-1840*, (London, 1962), pp.7-9.

⁵ Rev. George Jnr. Crabbe, *The Poetical Works of George Crabbe with his Letters and Journals and his Life*, (London, 1834), p.7.

⁶ Simon Dewes, “Life of Crabbe”, *East Anglian Magazine*, 24, (1973), pp.40-43.

⁷ John Yelloly was Northumbrian by origin, trained in Edinburgh and was physician to the London Hospital before he became physician to the Norfolk and Norwich Hospital in 1820, a post he held until 1832.

⁸ A. Batty Shaw, “The Norfolk school of lithotomy”, *Medical History*, 6, (1970), 3, pp.221-259.

⁹ Cheselden was trained at St. Thomas’ Hospital and in turn trained John Hunter. Prior to 1727, stones were removed using instruments inserted through the urethra, which was enlarged by surgical incision. Cheselden’s quick method, adopted from the French surgeon Jacques de Beaulieu, involved cutting through the perineum (the area between the anus and the urethral opening). Since surgical anaesthesia was not developed until the nineteenth century, Cheselden’s patients, with little more than rum to ease their pain, appreciated the speed of his procedures. His average time for performing a lateral lithotomy is estimated between 30 and 90 seconds. Cheselden’s innovation remained in use for more than 200 years until it was replaced by a procedure that mechanically crushed the stones.

¹⁰ Batty Shaw, “The Norfolk school of lithotomy”, pp.221-259.

extracted a stone from a six year old child, Thomas Sage, in October 1768, and from a John Barnes in November 1769, the latter not surviving. Bungay surgeon and apothecary Wolfram Lewis (1728-1823) was paid two and a half guineas by the Wenham Overseers on 25 Jan 1768 for cutting Daniel Chambers for the stone, and in 1799 Thomas Harsant (1764-1852), surgeon of Wickham Market, performed a lithotomy on James Dorkins of Little Bealings. He removed a two ounce stone and the patient was reported as “fair to making a recovery”.¹¹ Robert Carew King (1781-1842), surgeon of Saxmundham, was a well-known lithotomist who performed two successful operations in 1822.¹² Framlingham surgeon William Jeaffreson (1790-1865) almost certainly knew the work of the Norwich pioneers and became an expert lithotomist before he moved to other surgical techniques in the 1830s, gaining a reputation as a surgical pioneer. However, when he and Robert Carew King were invited to send their surgical instruments to London, these were criticised as the tools of a pork butcher, an indication of the scant regard held by the London surgeons for their country cousins, rather than any indication of the inadequacy of their equipment.¹³

Because of the problems of pain control, bleeding and infection, it is likely that surgeons and patients in the provinces took a conservative line on invasive techniques. Heroic surgery was for the few, mainly in London hospitals, or conducted on the poor or terminally ill. Country surgeons, even if they had attended lectures and walked the wards, might have been expected to limit themselves to straightforward procedures, summed up by John Steggall (1789-1881): “limbs had to be set, teeth drawn, pills made and of course swallowed, and many to be cured of various complaints”.¹⁴

¹¹ *Ipswich Journal*, December 1799. Another surgeon, Rayner Bellman of Earl Soham, performed a lithotomy on a boy of seven years in February 1800 and removed two stones.

¹² *Ipswich Journal*, November 1822.

¹³ Personal communication from Dr D. Ryder Richardson (1893-1973) of Saxmundham to David van Zwanenberg.

¹⁴ Richard Cobbold (ed.), *John H. Steggall - A Real History of a Suffolk Man Narrated by Himself*, (London, 1857), p.189. This view though may be treated with some scepticism as he gave up surgery that he practised while he was a curate at Great Ashfield, when a patient sued him for the loss of his leg.

However, there is evidence suggesting a wide range of more advanced surgical activity reported in Suffolk and therefore much went unreported. Accidents were frequent and placed major calls upon a doctor's skills. Practitioners working in rural and provincial areas did not have the benefit of such specialist back-up or hospital support as was available in larger towns and metropolitan areas. On the other hand, they had the great advantage of operating in simple surroundings in the patient's home, with infection less likely than in large metropolitan hospitals, where the incidence of sepsis and cross-infection was high and the odds on successful operations were low.¹⁵

For example, John Garneys (1727-1798) of Yoxford on 18 January 1768 attended "Mary Westhorp, a bastard child at Huntingfield, afflicted with a head scald application being made to admit [to the poor house] the said child which is rejected".¹⁶ In the same year, Wrentham surgeon Benjamin Primrose (1741-1817) was reported removing two halfpennies from a child who had swallowed them, devising an instrument specially made for the purpose.¹⁷

Frequent accidents meant that bone-setting was common, and in Suffolk it appears that surgeons were acquiring these skills, not least by copying, as Sir James Paget (1809-1892) put it, "what was good and useful in unorthodox practice".¹⁸ Using centuries-old semi-secret family skills, bone-setters worked amicably alongside orthodox practitioners. Indeed, reputable practitioners commonly referred fractures, dislocations and orthopaedic problems requiring mechanical ingenuity to a recognised bone-setter, not least because the surgeon's fees were much higher.¹⁹

There are many examples of such practice. William Goodwin (1746-1815), surgeon of Earl Soham, published an account of a patient with multiple fractures in the *Ipswich Journal* of 1785. John Green Crosse was inspired by his childhood experience of breaking a bone to become a doctor. He was

¹⁵ John A. Shepherd, "William Jeaffreson (1790-1865): Surgical pioneer", *British Medical Journal*, 2, (1965), pp.1119-1120.

¹⁶ Blything Hundred, *Minute Book*, 1786, SRO (Ipswich), ADA 1/AB3/2.

¹⁷ *Ipswich Journal*, July 1768.

¹⁸ Stephen Paget, *Memoirs and Letters of James Paget*, (London, 1901), p.35.

¹⁹ David Le Vay, "British bone setters", *History of Medicine*, 3, (1971), 2, pp.13-15.

treated in 1805 by Thomas Bayly (1750-1834), a Stowmarket surgeon, who later became his master and father-in-law. Benjamin Lane Clayton {1781-1819} was attending a wedding in Thurston in March 1815 when a Nurse Byford from Ixworth fell over a grave and fractured both bones in her leg. He and George Chinery {1769-1815} set the limb in the church and she did well.²⁰ Similarly, the Long Melford surgeons, Robert Cream (1783-1853) and Robert Jones (1800-1855), attended Mr and Mrs Musgrove in 1833 who had been thrown from their chaise to reduce their several fractures.²¹

Not all significant operations were successful. William Salmon (1721-1793), surgeon of Wickham Market, attended a patient with multiple spontaneous fractures in November 1785 and returned to perform a *post mortem* on the same patient in December a year later. In August 1792 in Framlingham, a Mr Hayward crushed both his legs and required immediate amputation. William Spalding (1723-1807) performed it and the patient reportedly did well.²² Henry Wilkin {1802-1851}, surgeon at Walton, extracted 15 pieces of bone from the face of a boy severely injured by gunshot wound.²³ Bungay surgeon Lancelot Davie (1783-1816) operated on the case of a Miss Loffy of Metfield in Suffolk who was severely deformed as a result of a distorted spine and a subsequent accident. This operation was cited by Sir Astley Cooper {1768-1841}:

“Mr Davie conceived that he should be able to prevent the gradual destruction which the altered position of the clavicle threatened, by removing the sternal extremity of the bone... few would have thought of this mode of relief; - very few would have dared to perform the operation - and a still smaller number would have had sufficient knowledge to accomplish it”.²⁴

Trepanning was also a treatment successfully carried out in the countryside.²⁵ Sir Thomas Gery Cullum (1741-1831) in 1769 trepanned a boy of eight, and

²⁰ *Bury Post*, March 1815.

²¹ *Ipswich Journal*, August 1833.

²² *Ipswich Journal*, August 1792.

²³ *Ipswich Journal*, May 1827.

²⁴ Sir Astley Cooper, *Treatise on Dislocations and Fractures of the Joints*, (London, 1822), pp.370-1.

²⁵ Trepanning, or making a burr hole, is a medical intervention in which a hole is drilled or scraped into the human skull, exposing the *dura mater* in order to treat health problems related to intracranial diseases.

items offered for sale at the death of Ellis Pett {1774}, surgeon and man midwife of Walsham le Willows, included trepanning instruments, amputating and dissecting instruments, and his midwifery kit. Aldeburgh surgeon Burnham Raymond (1740-1822) assisted Richard Langslow {1790-1812}, physician at Halesworth, to trepan a frontal fracture of the skull in 1799.²⁶

During this period, resuscitation from drowning was also increasingly dealt with successfully by medical practitioners, especially along the coast, seen as part of a medical campaign “to snatch people back from the jaws of death”.²⁷ The whole issue of resuscitation was one that caused considerable stir, because of the theological problems raised by apparently bringing the dead back to life, giving rise to questions as to what happened to the soul. This may partly explain the publicity that attended any such event, and the founding of the Royal Humane Society (RHS) in 1774 to promote the saving of lives of people who were in a state of suspended animation as a result of asphyxia. The commonest cause was immersion in water, but suffocation and strangulation caused the same effect.²⁸

There were a number of such incidents reported in Suffolk, particularly involving children, including those involving William Fairclough {1790}, surgeon and man midwife of Nayland in 1778, and surgeon and apothecary Samuel Denny {1801-1811} of Woodbridge and Bacton in July 1804, both of whom received a medal from the RHS.²⁹ Examples of practitioners resuscitating adults abounded, such as Boxford surgeon Nathaniel Salter (1770-1829) in 1799 and John Kinnell (1772-1843), surgeon, apothecary and druggist of Framlingham who, in April 1805, resuscitated an apparently drowned woman. She had shown no sign of life for more than an hour, but recovered after Kinnell had applied the method recommended by the RHS for an hour and a quarter.³⁰ William Henchman Crowfoot (1780-1848) was

²⁶ Richard Langslow, *The Case of Master Day of Yoxford*, SRO (Ipswich), Local Pamphlet No. XIX, 1801.

²⁷ Roy Porter, “Death and doctors in Georgian England”, in Ralph Houlbrooke (ed.), *Death, Ritual and Bereavement*, (London, 1989), pp.77-94.

²⁸ Shirley Roberts, *James Parkinson 1755-1824 From Apothecary to GP*, (London, 1997). The Society advocated respiration by mouth-to-mouth, warming the body, administering stimulants and bleeding. Parkinson was involved in several near drownings and received the RHS Silver Medal.

²⁹ *Ipswich Journal*, February 1778 & July 1804.

³⁰ *Ipswich Journal*, April 1805.

involved in another spectacular example. Soon after he had joined his uncle's practice in Beccles in 1805, he was on his way home from seeing a patient. He was passing Kessingland when he saw a soldier apparently dead on a cart, one of the victims of a wrecked transport. Crowfoot stripped the man, drying him and wrapping him in warm blankets, and as a result of his action, the soldier revived and Crowfoot was awarded RHS's silver medal.³¹

Besides dealing with the results of accidents, Edward Shorter maintains that being a doctor before 1900 meant spending the bulk of one's time on fever, and being a medical man before 1870 meant bloodletting, largely focusing on symptoms rather than underlying causes.

“Traditional medical therapeutics amounted to making patients anaemic through bloodletting, depleting them of fluids and valuable electrolytes via the stools, and poisoning them with compounds of such heavy metals as mercury and lead”.³²

Certainly bleeding remained an option for treatment that was still popular with patients in Suffolk, albeit it was less fashionable in town than it had been in John Evelyn's day.³³ The Blything Hundred Board of Overseers, on 13 April 1767, directed Richard Smith {1751-1788} their surgeon “to procure one dozen bleeding porringers and a yard of red cloth”.³⁴ Richard Langslow started his treatment of master Day of Yoxford by bleeding him.³⁵ William Travis (1761-1835), surgeon of East Bergholt, bled Mrs Constable “which somewhat reliev'd her - but she continued very ill throughout the day, growing weaker”.³⁶

³¹ Robert Malster, “The foundation of the Suffolk humane society”, *The Suffolk Review*, New Series, 48, (2007), pp.2-6. In August 1807 a Southwold practitioner, Dr Ellis, was commended by the second anniversary meeting of the Suffolk Humane Society for trying to save the life of a drowned man, and another surgeon John Morgan (1754-1817) of Ipswich was similarly honoured by the Ipswich Humane Society (of which he was Secretary in 1808) after the resuscitation of John Rogers in November 1809. Dr Bucke of Aldeburgh, in March 1823, restored a George Sayers to life after he had been rescued from the sea.

³² Edward Shorter, “Primary care”, in Roy Porter (ed.), *Cambridge History of Medicine*, (Cambridge, 2006), pp.103-135.

³³ Esmond S. de Beer (ed.), *John Evelyn's Diary*, (Oxford, 1955), 29 September 1684 - “Regularly I was let blood about 8 ounces for the dizziness of my head”.

³⁴ Blything Hundred, *Minute Book*, 1764-9, SRO (Lowestoft), 124/G11/1.

³⁵ Langslow, *Master Day*.

³⁶ Ronald B. Beckett (ed.), *John Constable's Correspondence: The Family at East Bergholt 1807-1837*, (London, 1962), p.117. Abram Constable to brother John, 10 March 1815.

Some practitioners in Suffolk acquired specialist skills and consequent reputations. For example, Nathaniel Bucke Snr. (1717-1786) at one point had eight people in his care who had had dog bites, according to the *Ipswich Journal* in March 1764 and, in 1785, he published his *Practical Observations on Canine Madness*. This common condition was the subject of at least ten books and treatises between 1760 and 1830, including that by George Lipscomb.³⁷

Neither craniology nor phrenology was studied before 1830, but eye treatments as a specialism fell within a practitioner's province. Oculists were frequently called on by parish overseers, with the most common concerns being cataracts and general inflammations of the eye.³⁸ Fear of loss of sight and disfigurement, with the devastating effect that could have on people's lives, led sufferers to pursue treatments with determination and persistence, often turning to an apothecary for a topical treatment or to folklore and other cures. Multiple consultations would often include itinerant oculists using the emerging provincial newspapers to publicise themselves.³⁹ Desperate patients could be gullible victims, but also could be exacting and vociferous, and itinerants could move on quickly when trouble loomed.⁴⁰ A number are listed in Suffolk, including Christian Krebs who advertised in the *Ipswich Journal* in April 1790 that "he has arrived at Ipswich from the Continent... to operate on eyes etc.". In May 1790 he moved to Hadleigh and was reported to have operated on the eyes of two people in Ipswich, who could now see. Dr Lamert, who was travelling through the county in 1810, 1811 and 1824, appeared in Ipswich in 1812. In March 1829 he advertised in the *Ipswich Journal*, giving a long list of his successful cures.⁴¹

Both Suffolk surgeons and physicians were involved in regular oculist work, although they were not part of the leading edge of new treatments being pioneered in London. Smallpox was a major cause of blindness,

³⁷ George Lipscomb, *Cautions and Reflections on Canine Madness with the Method of Preventing Hydrophobia in Persons that have been Bitten*, (London, 1807).

³⁸ Helen Corlett, "No small uncertainty; eye treatments in eighteenth century England and France", *Medical History*, 42, (1998), 2, pp.217-234.

³⁹ The Bury St. Edmunds and Ipswich journals of this period carried innumerable advertisements every week for oculist treatments.

⁴⁰ Corlett, "Eye treatments", p.221.

⁴¹ *Ipswich Journal*, March 1829.

notwithstanding the development of inoculation and vaccination referred to later although, as Corlett puts it, whether this was simply a reflection of irreversible eye damage, or a lack of knowledge or expertise in new surgery is not clear.⁴²

Nor is there clear evidence of greater success rates in the centres of development like London than in places like Suffolk, where there is some evidence of expertise. In May 1764, Samuel J. Thomas {1705-1713}, a surgeon of Lavenham, was called on to certify that Chevalier Taylor (1703-1772) had restored Dr Richard Child's sight, after Dr van Sarn from Bury St. Edmunds wrote to the local paper querying the claim.⁴³ Taylor was an itinerant oculist, son of an apothecary and surgeon in Norwich and, in 1722, he became an apothecary's assistant in London, where he also studied surgery under William Cheselden at St. Thomas' Hospital and developed a special interest in eye diseases. He practised for some time in Norwich as a surgeon and oculist, but encountered opposition and, in 1727, he began travelling around Britain as an itinerant eye-doctor. He claimed three MD degrees from Basel, Liège and Cologne. Taylor returned to London in November 1735 and was appointed oculist to George II in the following year. In January 1742 he advertised himself as "Oculist to His Majesty, Fellow of the Imperial Academy" in the *Ipswich Journal* and was a shameless self-advertiser.⁴⁴ However, he was by no means a charlatan, and his entry in the *DNB* claims he possessed considerable skill as an operator, kept up with the discoveries of the day, made original contributions to the treatment of squint, and was expert at couching for cataract.⁴⁵ He visited towns in East Anglia and had letters of support from Dr Messenger Monsey (1694-1788), physician of Bury St. Edmunds, and Dr Misael Malfalgueyrat (1705-1789), physician and man midwife of Bury St. Edmunds, as well as the one from Dr Thomas.⁴⁶ A physician and oculist, a Dr Uytrecht

⁴² Corlett, "Eye treatments", p.233.

⁴³ *Ipswich Journal*, May 1764. Richard Child was a third generation physician in Lavenham, who claimed that Taylor had restored his sight when he was over 80 years old and had been blind for five years.

⁴⁴ John Taylor, *History of the Travels and Adventures of the Chevalier John Taylor*, Vol. 2, (London, 1761), p.100. He described himself as "the most public man under the sun, being personally known not only in every Town in Europe, but in every part of the globe".

⁴⁵ Roy Porter, *Health for Sale - Quackery in England 160-1850*, (Manchester, 1989), pp.68-69.

⁴⁶ Frances Collingwood, "John Taylor - the gentleman quack", *East Anglian Magazine*, 10, (1950-51), pp.239-244.

practised originally in 1768 in Woodbridge with his partner, another Saxon Dr Goerslennen, and then moved to Bury St. Edmunds, then Sudbury and finally Ipswich in 1786. Richard Reeve (1739-1807), surgeon of Gislegham and Botesdale, operated successfully on the eyes of Susan Ribbons in August 1790 and, in September 1790, further cures at Hadleigh by him were reported.⁴⁷

Teeth as well as eyes fell within the country surgeon's purview. William Gibson (1733-1796), surgeon of Westleton, Wangford and Carlton Colville, received a public apology in the *Ipswich Journal* in April 1760 from a patient who had claimed he had extracted the wrong number of teeth. Mr Isdael advertised in Ipswich in 1760 as a:

"Surgeon and operator for the teeth from London. Makes false teeth, scales, cleans, fastens and stops up all hollow teeth. Extracts useless teeth and stumps without much pain. Will be at Greyhound, Bury St Edmunds on Monday next".⁴⁸

In the *Bury Post*, Mr Moor, a surgeon from Oxford, claimed to carry out the techniques of implanting and creating artificial teeth:

"...without the inconvenience of drawing the stumps, engrafting human teeth in the old stumps so as not to be distinguished from those which Nature first has formed, even if the gums have disappeared he will supply them with artificial ones".⁴⁹

But there were also quite obvious quacks, such as S. Crawcour (1748-1816), a 'Senior Dentist' advertising in the *Ipswich Journal* in October 1800 that he would be at "Mr Graves, hairdresser, St Clements... In common life we every day observe the irreparable damage that beauty sustains by the loss of a tooth".

Besides these invasive treatments, pills and potions were a staple of treatment. Mary Fissell remarks that "stereotypically we imagine country people making country remedies, whilst their city counterparts make use of

⁴⁷ *Ipswich Journal*, August 1790

⁴⁸ *Ipswich Journal*, March 1760.

⁴⁹ *Bury Post*, 13 March 1783.

druggists, chemists and the apparatus of commercial medicine”.⁵⁰ However, this urban/rural divide can be exaggerated as both town and country practice became increasingly commercialised; medicaments were a significant part of the treatments on offer and many practitioners had their favourite recipes, in both metropolitan areas and the provinces. Most of the drug treatments were herbal and folklore remedies, little different from the pills and potions sold by ‘quacks’, and some critics of quacks seemingly adopted the very measures they castigated in others. For example, leading ‘regulars’ such as Dr Richard Mead (1673-1754) and Sir Hans Sloane (1660-1753), both physicians and collectors of London, put their names to cures such as rabies powder and enlarged their fame.⁵¹ In Suffolk too, Stradbroke surgeon William Chapell {1787-1791} claimed that he “...treats fistulas and piles. Also cures cancers, King’s Evil and scorbutic cases. The method of curing fistulas has been a secret in the family for 80 years”.⁵² Local physicians, surgeons and apothecaries usually applied the standard concoctions of the day. Thus Dr Langslow, treating for master Day’s rheumatism, offered “small doses of calomel and Dr James’s powder, assisted by saline mixtures”, followed three days later by “the Gum Guaicum in a decoction of Bark”.⁵³ Samuel Denny, in January 1811, wrote to Mr Fenn testifying that his embrocation had cured Mrs Denny.⁵⁴

Medications were clearly a good source of income for Suffolk practitioners and the efficacy of these patent remedies was often extended to cover a multitude of conditions. Potion ‘inventors’ were not necessarily (or indeed usually) recommending to their medical colleagues, but rather advertised directly to the public. A common way of gaining greater credibility was to quote authenticated occurrences of cure. John Kent {1811} advertised his cure for scrofula and cancer, citing Mary Revell of Redingfield who had cancer of the lip; Thomas Mayhew {1813}, cured of a scrofulous complaint of the leg

⁵⁰ Mary Fissell, *Patients, Power and the Poor in the Eighteenth Century Bristol*, (Cambridge, 1991), p.40.

⁵¹ John Cordy Jeaffreson, *A Book of Doctors*, (London, 1860), p.116. Sir Hans Sloane sold an eye salve and Richard Mean a powder for the bite of a mad dog.

⁵² *Ipswich Journal*, throughout 1790.

⁵³ Langslow, *Master Day*, p.16.

⁵⁴ *Ipswich Post*, January 1811.

with 41 wounds; and Robert Colthorp {1813}, cured of cancer of the lip.⁵⁵ Surgeon C. Wilson (1779-1848) of Yoxford initially advertised medicinal water for gout and rheumatism, a mixture sold continually by his second wife who lived until 1891. Indeed, a bottle of ‘Wilson’s Gout’ was still kept in the medical surgery in Yoxford in 1975.⁵⁶ He also compiled a book that was essentially an extended advertisement of letters from satisfied clients.⁵⁷ Another surgeon, Robert Freeman (1776-1845) of Saxmundham, wrote to him in 12 June 1814 for some of his tincture for himself and his brother, so Wilson could justifiably claim support from fellow practitioners.

Throughout the period reviewed, the *Bury Post* and *Ipswich Journal* carried advertisements from surgeons for pills and potions, extravagant in claim, and extensive in newsprint. For example, Leake’s “justly famous Pill, called the PILL SALUTARIA” was said to cure not only venereal disease but also scurvy and rheumatism.⁵⁸ The *Bury Post* in 1782 regularly carried advertisements such as:

“Maredants Drops - Mr Norton surgeon of Golden Square London, inventor and proprietor of them refers those afflicted with the Scurvy and any other complaint arising from that cause, to the following people who have been cured of them viz the son of William Barber of Brockholes near Preston in Lancashire, after being deemed incurable, by taking them the humour, though inveterate was totally eradicated, and his health which was bad, restored, and this was sworn 20th April 1781 before Bartholomew Davis, Mayor”.⁵⁹

Others were more direct in their approach: for example, Edward Sparham {1712-1765} advertised in April 1765, “Female pills to be had with full directions”.⁶⁰ Henry Seekamp (1745-1819), apothecary, chemist and druggist of Ipswich, advertised in 1776 that he prepared various medicines including lozenges for heartburn. James Cockle (1782-1853) of Great Oakley, Essex,

⁵⁵ *Ipswich Journal*, January 1813, and after “at the Griffin Inn Ipswich on Friday, Stanton on Tuesday and the Half Moon Bury the first Wednesday of the month”.

⁵⁶ According to David van Zwanenberg, *Suffolk Medical Biographies*, unpublished but edited into the Internet by Eric Cockayne (2004).

⁵⁷ Charles Wilson, “*Observations on Gout and Rheumatism, Including an Account of a Speedy, Safe and Effectual Remedy for those Diseases with Numerous Cases and Communications*, (Ipswich, 1st edn. 1815, 2nd edn. 1817, 3rd edn. 1823).

⁵⁸ *Bury Post*, 10 October 1783.

⁵⁹ *Bury Post*, Thursday 18 July 1782.

⁶⁰ *Ipswich Journal*, April 1765.

surgeon brother of George and John, both surgeons at Woodbridge, ‘invented’ Cockle’s Antibilious pills that were frequently advertised in the *Ipswich Journal*. Practitioner Wallis of Lowestoft advertised in the *Ipswich Journal* as “Proprietor of Caledonian Drops - cure for the evil, leprosy and scurvy - now visiting Ipswich” in 1806, before selling the recipe to Mr J. King of Sudbury in 1809.

Much of the advertising from empirics was aimed more at the ill-informed masses, but irregulars also had clients from the ‘beau monde’, and a quack or mountebank might claim royal privilege to practise. Theodore von Myersbach {1730-1798}, described in the *DNB* as an ‘uroscopist’, practised in London with clients including David Garrick, the Duke and Duchess of Richmond, Lord Archer and other members of the propertied and professional classes.⁶¹ William Reade the oculist was knighted,⁶² and Richard Smith of Ipswich advertised himself in 1730 as “His Majesty’s Oculist who is lately come into these parts and keeps several stages, has performed many and remarkable cures in couching of the eyes and other distempers”.⁶³ Claims for royal patronage and profound achievements might tempt the gullible, but irregulars were probably a typical part of middle class healthcare.

Firmer evidence about irregulars and professional attitudes towards them comes from the survey by Dr Edward Harrison of Lincolnshire in 1806 on regular and irregular practitioners in different parts of Britain. The reply from rural Lancashire showed that graduate physicians made up two per cent of all healers; nine per cent were surgeons and apothecaries; sixteen per cent were druggists; irregulars and midwives made up 73 per cent of all practitioners. Northumberland reported “five empirics to every regular but nearly all of them part-timers”. In Nottingham, “78 persons exercise medicine for gain... of who not one in four has previously been educated for the profession”. Cambridgeshire practitioners included “a failed grocer turned bone-setter and

⁶¹ Roy Porter, “‘I think ye both quacks’: the controversy between Dr Theodor Myersbach and Dr John Coakley Lettsom”, in William Bynum & Roy Porter (eds.), *Medical Fringe and Medical Orthodoxy 1730-1860*, (London, 1987), pp.56-78.

⁶² William Reade was a favourite of Queen Anne, who had weak eyes and turned to their collyriums. Reade began life as a tailor and was illiterate but rose to be a royal ‘sworn oculist’, together with Roger Grant a cobbler and Anabaptist preacher.

man-midwife” and urine-casters - “generally very rich”. However, “Regular quacks... Who live entirely by quacking can hardly be expected to thrive in as poor a country as Scotland, and we have none of them here”.⁶⁴

The limited evidence from Suffolk suggests diverse views concerning irregulars, with George Crabbe appearing to see all doctors as quacks. The role of druggists and others, or their relationships with regular practitioners, is unclear, although they were listed in many small towns such as Aldeburgh alongside the apothecary and surgeon. In Bury St. Edmunds, a Dr Snell advertised as a “Druggist and Practitioner in Physic, sells drugs listed”, and he is cited as a physician and druggist, although it seems more likely he was an irregular bidding for respectability.⁶⁵ Harrison’s replies from Suffolk suggest their prevalence and likely impact on healthcare: “The chemists and druggists are of late become numerous... five in the principal towns and in every town one or more”; “twelve quacks to every regular practitioner”; with still more “private quacks” including “clergymen and their wives who treated their flock for one pound each”. One Suffolk physician noted that:

“the apothecaries in this neighbourhood inveigh against the druggists, decrying their medicines; partly perhaps by having their emoluments lessened by the number of prescriptions which these compound for the poor often at less than half the apothecaries’ price”.⁶⁶

However, one well-known and respectable druggist, Henry Seekamp of Ipswich, gave up his drug business in 1812 and continued as an apothecary only. Evidently the drug side of his business did not restrict his success or status: he was a Steward of the Suffolk Benevolent Medical Society, a Senior Portman, Assistant Justice, and one the Chief Magistrates of the town, suggesting that the alleged antipathy to druggists has been overstated.

The sale of patent medicines was not just in the hands of regulars, druggists and other quacks. The *Ipswich Journal* in 1779 listed 21 concessionaires of

⁶³ *Ipswich Journal*, 17 June 1730.

⁶⁴ Edward Harrison, *Remarks on the Ineffective State of the Practice of Physic*, (London, 1806), pp.1-2, 38-39.

⁶⁵ *Ipswich Journal*, 23 September 1783.

⁶⁶ Irvine Loudon, “The vile race of quacks with which this country is infested”, in Bynum & Porter, *Medical Fringe*, pp.106-128, (Appendix, p.123).

Bailey's Ointment for the Cure of the Itch, of which sixteen were printers or booksellers, three were 'shopkeepers', one was a Chandler, and one was a draper. Clearly the patent medicine trade in this part of Suffolk was mainly in the hands of booksellers, who were the printers for numerous patent medicines of the day.⁶⁷

There were also hobbyists - clergymen, farmers, midwives, itinerants who shaded off into regulars.⁶⁸ The Catholic Church tried to stop priests from engaging in medicine for gain, and Protestants were stopped by the Reformation from healing by means of sacraments as the age of miracles passed. Nevertheless, Christianity remained a powerful force to be appealed to when ill, or using naturalistic medicine. The Revd. Benjamin Rogers of Carlton in Bedfordshire kept a journal of his own and his parishioners' ailments, and provided medical treatments directly.⁶⁹ Ralph Josselin, a vicar of rural Essex, read orthodox medical books and made up pills and potions for himself and his family, little different from regular medicine.⁷⁰ In Suffolk, clergymen who were, or continued to be, practitioners included George Crabbe and the Revd. Pyke of Wickhambrook (1777-1827), listed on his tombstone as having a medical degree. In Hull, there was evidence that two masters of the grammar school may have supplemented their stipends with some medical work.⁷¹ James Clegg (1679-1755), a Presbyterian Minister in Chapel-en-le-Frith in Derbyshire, practised physic regularly and when challenged bought an MD from Aberdeen to regularise his second career.⁷² This was an illustration of the association of religion with medicine that continued until well into the nineteenth century. Ian Mortimer's analysis of the medicalisation of dying in provincial southern England showed that:

⁶⁷ *Ipswich Journal*, 28 August 1779, quoted in Joseph F. Kett, "Provincial medical practice in England 1730-1815", *Journal of History of Medicine*, 29, (1864), 1, pp.17-29.

⁶⁸ Loudon, "Vile race of quacks", p.13.

⁶⁹ C.D. Linnell (ed.), *The Diary of Benjamin Rogers, Rector of Carlton 1720-71*, (Luton, 1950), pp.21, 23, 88.

⁷⁰ Roy Porter, "The patient in England c1660-1800", in Andrew Wear (ed.), *Medicine in Society: Historical Essays*, (Cambridge, 1992), pp.91-118.

⁷¹ James A.R. Bickford & Margaret E. Bickford, *The Medical Profession in Hull 1400-1900*, (Kingston upon Hull, 1983), Introduction, p.v.

⁷² Loudon, "Vile race of quacks", p.107.

“after 1690, when the majority of people tended to choose a medical strategy to cope with fatal illness and injury, the religious framework to medical cure had ceased to dominate attitudes to treatment in the face of death”.⁷³

It is clear that there was an extensive range of pills and potions on offer in the countryside, particularly in areas near towns where both druggist and apothecary would carry a large variety. Moreover, the Suffolk evidence suggests that a wide range of treatments and skills was spread around the county, not just in the larger towns of Ipswich, Bury St. Edmunds, Sudbury and Woodbridge. Suffolk practitioners carried out a wide range of interventions, some quite heroic. As in country areas until quite recently, the demands placed on the skills of the local practitioner could be very wide in the face of little specialist assistance available, with the need to learn and seek support from each other. The range of pills and potions seems to have been little different from that on offer in any part of the country and therefore, apart from the upper and wealthy classes who could afford to pay for leading edge practitioners, it appears that the country cousins of average Londoners were no worse off in terms of the general medical skills available to them.

6.2 Preventative Medicine

“Inoculation was the diabolical invention of Satan, who smote boils, from the sole of his foot to the crown of his head, the upright and patient Job”.⁷⁴

A very extensive example of how rural medicine was far from primitive and old-fashioned was in the field of preventative medicine, specifically smallpox inoculation. On the contrary, rural medicine was innovative and experimental. Preventative medicine at this time was barely understood while, according to Carl Pfeiffer, “active therapy was the hallmark of medical practice at the turn of the nineteenth century - bloodletting, purging, dousing”.⁷⁵ In the early nineteenth century, physicians had no real knowledge of the concept of

⁷³ Ian Mortimer, “The triumph of the doctors: medical assistance to the dying c.1570-1720”, *Transactions of the Royal Historical Society*, 15, (2005), pp.97-116.

⁷⁴ Rev. Mr. Nassey, *A Sermon Against the Dangerous and Sinful Practice of Inoculation*, 8 July 1722, quoted in Maisie May, “Inoculating the urban poor in the late eighteenth century”, *British Journal for the History of Science*, 30, (1997), 3, pp.291-306.

contagion, so Pfeiffer is only right insofar as neither an active nor preventative approach was based on an understanding of the true aetiology of disease. Both treatments were based on false premises. Nevertheless, the importance of smallpox and the part it played in a Suffolk general practitioner's practice in the eighteenth century may not be fully understood. As this section shows, a significant part of the scope of medical practice and indeed a practitioner's income came from dealing with this disease. More research into such activity in other parts of country, as well as London, is needed to establish whether this was peculiar to Suffolk because of its particular central role in the development and use of inoculation, or true more generally in the UK.

The role of practitioners in containing smallpox from a community-wide attack is important in the history of healthcare, especially for the role of the country doctor and the development of the general medical practitioner. Smallpox had been known since classical times, though neither the virus nor its airborne transmission was understood. It was highly infective and its effects on individual patients and communities could be devastating. Some 80 per cent of smallpox deaths in London during 1769-1774 were children under the age of five.⁷⁶ In Suffolk, the evidence is considerable. In Bury St. Edmunds:

“sometimes between 1738 and 1743... the small pox was so severe at St Edmundsbury, that the assizes were twice if not three times, held at Ipswich... During the term, it was said, that the town had been deprived of a sixth part of its inhabitants: there were no markets, and the town was avoided as the seat of death and terror”.⁷⁷

The presence of smallpox frequently led to the cancellation of the highly prized annual fairs in Suffolk:

“There will be no fair kept at Bildeston this year on Ash Wednesday as usual, on account of the Small-Pox being in several adjacent parishes”.⁷⁸

⁷⁵ Pfeiffer, *Western Medicine*, p.10.

⁷⁶ *Ibid.*, p.78.

⁷⁷ *Gentleman's Magazine*, 1796, No. 66, quoted in May, “Inoculating the poor”, p.112.

⁷⁸ *Ipswich Journal*, February 1759.

In the seventeenth and well into the eighteenth century, the medical treatment of smallpox was largely fever-based, comprising isolation of patient, rest in bed in a hot, ill-ventilated room, frequent blood-letting and over-drugging. Thomas Sydenham (1624-1689) was a prime mover and rejected the belief that the disease was contagious and believed in the 'cooling' method - no fire in the bedroom, windows open, bedclothes "no higher than the waist", and small beer. Few doctors adopted this approach, even though Sydenham's patients did well - medical rivals said it was in fact because the physician was doing nothing. In rural areas and for those unable to afford a physician, the treatment for many years had been a simple, rough and ready inoculation by using the crusts of smallpox victims, a process employed by many within the family, the village wise woman or indeed the blacksmith.⁷⁹

The first formal steps towards 'professional' inoculation in Britain were taken in 1713 when Dr Emmanuel Timoni, a Greek physician in Constantinople, gave an account of the Chinese method of inserting smallpox crusts into the nostrils of patients, whereby the disease was communicated through the respiratory tract. Lady Mary Wortley-Montagu, wife of the British ambassador to Constantinople, had her son inoculated by this method in 1717. James Moore believed that "she actually effected a complete revolution in the practice of Small Pox all over Europe".⁸⁰ As a result of this success, six condemned criminals in Newgate were offered freedom if they consented to be part of the experiment. The test was also successful and as a result the King, Queen Caroline, the Princess of Wales and her two daughters were inoculated. By 1746, a hospital for inoculation had been set up in London and the process was deemed by the College of Physicians "to be highly salutary to the human race".⁸¹

If the patient was lucky, the inoculation gave a mild attack of smallpox using 'matter' or pus from a sufferer who had a light form of the disease, thus

⁷⁹ Sir Arthur Salusbury MacNalty, "The prevention of smallpox: from Edward Jenner to Monckton Copeman", (Inaugural Monckton Copeman Lecture delivered at Apothecaries Hall on 30 March 1867), *Medical History*, 12, (1968), 1, pp.1-19.

⁸⁰ James Carrick Moore, *The History of Smallpox*, (London, 1815), p.228.

conferring immunity, although also risking death and/or the patient becoming a carrier of the disease. By the late 1740s, public confidence was beginning to increase and the epidemic of 1752 was a stimulus to what John Raymond Smith calls the “age of inoculation”.⁸² Maisie May states that:

“it is possible to trace the development of inoculation from a folk lore practice carried out within the home with the aim of protecting individuals, to large-scale general inoculations of an entire community, which aimed to eradicate the disease altogether”.⁸³

Yet opposition was great and there was evidence of a very slow uptake, apart from the rich and gentry. After the founding of the London Smallpox Hospital, private inoculation houses had sprung up, supporting the recommended strict and expensive regime, involving highly paid physicians. Thomas Ruston, in 1767, published an essay explaining the nature of the disease and describing the various methods of preparation from America which he had used with success he claimed. In it, he suggested:

“tea, coffee, or weak chocolate, with dry toast; rice-milk, milk gruel, skimmed milk and such like for breakfast. For dinner, rice pudding, apple pudding, apple pye, plumb or plain pudding, with vinegar sauce... Supper in general had better be omitted”.⁸⁴

Many physicians and surgeons joined the bandwagon, writing tracts and essays on the subject, both supporting it and abusing it.⁸⁵ As James Moore put it, “The press now groaned with works in favour of inoculation, and with various plans of treatment”.⁸⁶ “What had been a simple, empirically-based folk practice of lightly scratching the skin with infected matter became a highly complex, risky and expensive procedure in the hands of British physicians”.⁸⁷ The latter were gradually deemed unnecessary, with William Buchan even

⁸¹ Ibid., p.232.

⁸² John Raymond Smith, *The Speckled Monster - Smallpox in England 1670-1970 with Particular Reference to Essex*, (Chelmsford, 1987), p.39.

⁸³ May, “Inoculating the urban poor”, pp.291-306.

⁸⁴ Thomas Ruston, *An Essay on Inoculation for the Smallpox*, (London, 1767), p.49.

⁸⁵ For example, Giles Watts, *A Vindication of the New Method of Inoculating Smallpox Against the Arguments and Objections of Dr Langton and Mr Bromfield*, (London, 1767), p.vii. “The author had many times ocular demonstration, not only that the distemper was extremely light on Mr Sutton’s patients but that it was also the true genuine smallpox”; Hostis Monopoliarum, *The General Method of Inoculation, as it is Practised with Great Success, in the Counties of Kent and Sussex, Discovered in the Meanest Capacity, in a Letter to a Friend, by a Lover of Mankind*, (London, 1767).

⁸⁶ Moore, *Smallpox*, p.253.

recommending that clergy could attend patients as part of their duties on the grounds that “common mechanics have often to my knowledge performed the operation with as good a success as physicians”.⁸⁸

Ironically, inoculation was practised more extensively and across more social classes in rural areas and small towns than in large towns and cities, partly because of the relative lack of provision for charitable inoculation in the latter, but also because of the nature of epidemics in towns and the countryside. In the early 1750s, John Haygarth contrasted lack of consciousness in towns of the impact on mortality of inoculation, because of the dispersed nature of the outbreaks, with that in small towns and villages where “especially in remote situations, the younger generation grow up to have a consciousness of the danger before they are attacked by the dreadful disease”.⁸⁹

Suffolk doctors were in the vanguard of this development of population medicine. The earliest reference to inoculation in Suffolk comes from 1724, when Dr William Beeston (1687-1732) inoculated three people and provoked a violent reaction.⁹⁰ The *Ipswich Journal* of 1 November 1729 reported:

“The beginning of Oct last, Mr Robert Warner, a young man, student of Pembroke Hall has lately received the small pox by inoculation under the care and direction of Dr Beeston; he has had the distemper through all its stages, no way different from the natural sort, of the favourable large distinct kind and is perfectly recovered, without having occasion for any sort of medicines since the operation was performed”.⁹¹

Twenty years later, in May 1752, the *Ipswich Journal* reported that John Rodbard (1724-1808), a young apprentice of Woodbridge surgeon James Lynn (1700-1775), inoculated himself and his patients. What is not clear is how Rodbard heard of the procedure, as Lynn himself was not inoculated until some time later; but after he had moved to Debenham to practise there, he was invited by Robert Sutton (1707-1788) to inoculate his eldest son, another

⁸⁷ May, “Inoculating the urban poor”, p.293.

⁸⁸ William Buchan, *Domestic Medicine or the Family Physician*, (Edinburgh, 1769), p.220.

⁸⁹ John Haygarth, *Sketch of a Plan to Exterminate the Casual Small Pox from Great Britain and to Introduce General Inoculation* (1793), (London, 1793), p.186.

⁹⁰ William Beeston was the son of Revd. Edmund Beeston, rector of Sproughton, near Ipswich.

Robert. Robert Jnr. contracted a severe case of smallpox that stimulated his father to look at ways of improving the technique of inoculation.⁹² He became a specialist inoculator as did many of his contemporaries, and his sons, in particular Daniel (1735-1819), developed inoculation into a successful commercial enterprise.

In April 1757, Daniel Sutton advertised in the *Ipswich Journal* that he had:

“hired a large commodious House for the Reception of Persons who are disposed to be INOCULATED by Him for the SMALLPOX on the following terms, viz Gentlemen and Ladies will be prepared, inoculated, boarded and nursed, and allowed Tea, Wine, Fish and Fowl at Seven Guineas each for one months; Farmers at Five pounds, to be allowed Tea, Veal, Mutton, Lamb etc; And for the benefit of the meaner Sort, he will take them at Three Guineas a Month, if they are not fit to be discharged sooner; and those that can board and nurse themselves, he will inoculate them for Half a Guinea”.⁹³

The Sutton expansion continued into 1763, with houses established at Toftmonks near Beccles, Yelverton Hall and Ashfield near Stowmarket. All initially were under the control of Robert Sutton. By 1768, there were 47 ‘authorised ‘ partnerships in England, Ireland, Wales, Holland, France (Paris), Jamaica and Virginia, and eight of the partners were members of the Sutton family.⁹⁴

Robert Sutton introduced a method of arm-to-arm inoculation that reduced risk as it did not require an incision and, although it required a special regime both before and after the operation, was less invasive than the more orthodox methods. Benjamin Chandler described the method as “the taking of the infective humour in a crude state [from a previous inoculation] before it has been, if I may be allowed the expression, variolated by the succeeding fever”.⁹⁵ A description of the process was given by Bamber Gascoyne MP, whose son (another Bamber) was inoculated by Daniel Sutton in 1766:

⁹¹ *Ipswich Journal*, 1 November 1729.

⁹² David van Zwanenberg, “The Suttons and the business of inoculation”, *Medical History*, 22, (1978), pp.71-82.

⁹³ *Ipswich Journal*, 16 April 1757. Repeated 14 and 21 May.

⁹⁴ Smith, *Speckled Monster*, p.84.

⁹⁵ Benjamin Chandler, *An Essay Towards an Investigation of the Successful and most General Method of Inoculation*, (London, 1767), quoted by Charles Craighton, *A History of Epidemics in Britain*, Vol. 2, (Cambridge, 1894), p.499.

“Mrs Wallis was the infected person, she had about seven pustules with large white heads on them. The doctor thrust a lancet into one of them which he immediately applied to the arm of Bamber and put so small a part of the point under the skin that he was not sensible of the points touching him. Then he put on his cloathes without plaister, rag or any covering whatever”.⁹⁶

A number of the Sutton family were engaged in the business. Daniel’s brother Thomas also advertised in October 1777 and March 1778 that “he had engaged two houses at Braiseworth near Eye for the reception of patients for inoculation - applications to Thomas Sutton where they will receive their medicines and printed directions”.⁹⁷ Robert Jnr. opened an inoculating house near Bury St. Edmunds, as patients were not allowed in the town and the poor were inoculated *gratis*. Neither Robert Jnr. (1732-1797) nor Daniel were medically qualified, but they combined inoculation with Sydenham’s cooling treatment. Daniel quarrelled with his father over the modifications in the procedure that Robert Snr. considered dangerous, and Daniel moved to Essex where he “set up as an empirical inoculator... with puffing handbills and boasting advertisements”.⁹⁸ According to Robert Houlton, Daniel inoculated 1,629 persons in 1764, 4,347 in 1765 and 7,816 in 1766 that, together with inoculations by his assistants, added up to some 20,000 persons “fairly from inoculation, by him or his assistants or from its effects”.⁹⁹ He had agents in sixteen towns and villages in Suffolk, south Norfolk and North East Essex, including Lynn in Woodbridge. The latter was advertising in May 1761 for a “journeyman who had had the Smallpox”,¹⁰⁰ presumably because he was treating so many.

The Suttonian method was very popular and was widely copied, especially in East Anglia. It usually involved all three branches of the profession both delivering it and then maintaining the patient afterwards. Papers and manuals were produced, such as that by George Lipsomb, a London surgeon,

⁹⁶ Strutt papers: letters of B. Gascoyne MP to John Strutt of Terling Place. Typescript copy in Essex Record Office, Chelmsford.

⁹⁷ *Ipswich Journal*, October 1777 and March 1778.

⁹⁸ Moore, *Smallpox*, p.268.

⁹⁹ Robert Houlton, *The Practice of Inoculation Justified, A Sermon Preached at Ingatestone, Essex, October 12 1766 in Defence of Inoculation*, (Chelmsford, 1766).

¹⁰⁰ *Ipswich Journal*, May 1761.

advocating Sutton's approach often with a personal recommendation.¹⁰¹ Inoculation had become a lucrative part of practice in the Suffolk countryside as the towns, particularly in the beginning when it was only for those who could pay for it. Advertisements appeared regularly in the *Ipswich Journal* from 1760 onwards. Some were for surgeons simply providing inoculation at their surgery. Thus, William Gibson {1753-1764} advertised in August 1760 that he took people from Claydon for inoculation, and later that he continued on the "same moderate terms as for some years past". Meanwhile, from 1761, "the Infirmary of W. Gibson Surgeon at Claydon will be ready... same moderate terms", - the implication being that he was now taking in patients. Isaac Hunt {1767-1773}, in April 1773, advertised that he "continues to inoculate at his house in Bury St. Edmunds but others travelled, establishing specific days and venues, often in market towns, for inoculation". Edward Beck (1732-1780) announced in November 1763 that he:

"continues to practise inoculation on reasonable terms. House at Crowfield for inoculation. Now attending for inoculation - Mondays - The Crown at Coddendam; Thursdays - The Queens Head Stowmarket; Saturdays - The Bear and Crown, Ipswich".¹⁰²

Many doctors followed the Sutton example and took houses specially appointed for reception of those who wished to be inoculated. For example, Joseph Walford {1766-1774}, surgeon and man midwife of Woodbridge and Bredfield, fitted up a house at Dalling Hoo for inoculation in May 1766. It could accommodate 40 patients, the terms being five guineas for ladies and gentlemen and three guineas for their servants. In 1768, he was presumably doing well as he decided to sell up at Woodbridge and move to Bredfield to be nearer to the inoculation house. He was still inoculating in July 1774.¹⁰³

¹⁰¹ George Lipscomb, *A Manual of Inoculation for the Use of the Faculty and Private Families*, (London, 1806).

¹⁰² *Ipswich Journal*, November 1763. Ipswich apothecary Robert Goodwin {1757-1782} became a partner with Miles Rudland {1761-1789} and Robert Goodwin {1765-1782} in December 1766 for inoculation, but in April 1767 he parted from Rudland and became an itinerant inoculator in Suffolk, known to have inoculated at Manningtree in 1772 and Freston Tower in 1772-3. D.R., "Freston tower", *East Anglian Magazine*, 1, (1956) 12, pp.654-655. Miles Rudland went into partnership with Robert Ashley {1751-1774} of Ipswich and John Garneys (1727-1798) of Yoxford to fit up Sibton Red House for inoculation, although the partnership was dissolved within a year. (*Ipswich Journal*, April and June 1967).

¹⁰³ Other examples include John Gravenor (1701-1778) apothecary of Ipswich, who advertised in 1761 that he had a convenient house for inoculation; John Rodbard (1724-1808) surgeon, apothecary and man midwife of Debenham and Ipswich set up a house for inoculation in March 1767; Robert Wilson

Wickham Market surgeon Samuel Salmon {1753-1793} advertised in 1767 that he had “fitted House at Pettistree for inoculation” and reported in November 1772 and November 1775 that “inoculation continued at Pettistree with great success”.¹⁰⁴

The popularity of inoculation with practitioners was not surprising, as the financial rewards could be enormous. Indeed, some of the objection to this new form of inoculation was that “Mr Sutton in the last three years of his practice has made forty or fifty thousand pounds”, a claim disputed, though Giles Watts went on to say “But suppose Mr Sutton has gained by his practice twice, or even ten times as much in the time specified, would this circumstance be any proof of the inutility of inoculation?”.¹⁰⁵ Certainly, Daniel Sutton netted 2,000 guineas in 1764 and £6,300 the following year.¹⁰⁶ The Suttons charged between three and seven guineas for inpatients, although Robert offered to inoculate people in their homes at a guinea per person. He also advertised in 1766 that he would inoculate the poor at a charge of five shillings and three pence, providing there were not less than 100 patients.

The popularity of inoculation and the perceived efficacy put pressure on the finances of the overseers of the House of Industry. Mass inoculation was usually implemented by parish authorities, financed through the poor rates, and was aimed to control the rise of an epidemic or avoid the introduction of smallpox from neighbouring settlements. As a result of epidemics, communities became burdened with the cost both of damage to trade and that of caring for the sick and the poor. There was widespread adoption of general inoculation in rural areas, where there was fear of the disaster it could bring to entire generations of a community. Isolated communities with

(1750-1833), surgeon of Peasenhall in March 1784 fitted up a house for inoculation and terms of two or three guineas; William Hailstone (1760-1806), surgeon of Wangford/Southwold advertised in 1788 “Inoculation House, late of Mr Smith now ready to receive patients”; Thomas Penrice (d. 1786), surgeon of Harleston in September 1763 altered a house at St. Margaret South Elmham for the reception of patients for inoculation, and in April 1769 opened another house near Harleston for inoculation; William John Sandiver (active 1726-1784), surgeon of Newmarket, set up a house of inoculation near Mildenhall in September 1762 and another near Tuddenham in February 1768 when he moved there.

¹⁰⁴ *Ipswich Journal*, March 1767, November 1772 & September 1775.

¹⁰⁵ Watts, *A Vindication*, p.3.

¹⁰⁶ Smith, *Speckled Monster*, pp.72-75.

long periods without the disease were at great risk, because children reached adulthood without exposure to the virus.¹⁰⁷ To try to reduce the risk, many towns in Suffolk, as with the rest of the country, banned travellers from entering until treatment was complete, and practitioners were asked to agree not to treat strangers or people coming from outside.

The first general inoculation took place in 1756 in Wootton-under-Edge in Gloucestershire, where a total of 300 people were inoculated at two shillings per head.¹⁰⁸ General inoculations began to be carried out in Suffolk, a great many by Daniel Sutton himself. Authorised by parish authorities and financed through the poor rates, it was implemented in smaller parishes of under 3,000 inhabitants where the incidence of the disease could be monitored effectively and isolation measures more rigorously enforced. Robert Goodwin {1757-1782}, for instance, agreed in 1757 along with several other practitioners in Ipswich, not to treat non-residents.¹⁰⁹ It became commonplace in villages and market towns all over the country, with all kinds of practitioners involved, including lay people. Joan Lane quotes some in Warwickshire receiving two shillings and sixpence per patient.¹¹⁰ Doctors began to change from being treaters to preventors of smallpox. Vestries preferred to pay as needed for general or specific inoculation and such contracts could be very lucrative for the doctors, particularly when they had contracts to provide Poor Law medicine on a basis that excluded the cost of inoculation.¹¹¹

There are many extant records of Poor Law payments in Suffolk for inoculation, including John Assey (1742-1798) who inoculated 350 paupers in 1757 as surgeon to the poor of Beccles.¹¹² Richard Smith {1751-1788}, the appointed surgeon to the Blything Hundred Poorhouse, was directed in April 1767 to inoculate all children and willing adults at seven shillings and sixpence

¹⁰⁷ May, "Inoculating the urban poor", p.294.

¹⁰⁸ Peter Razzell, *"The Conquest of Smallpox: the Impact of Inoculation on Smallpox Mortality in Eighteenth Century Britain"*, (Sussex, 1977), p.46.

¹⁰⁹ *Ipswich Journal*, April 1757.

¹¹⁰ Joan Lane, "The provincial practitioner and his services to the poor 1750-1800", *Society for the Social History of Medicine Bulletin*, 28, (1981), pp.353-371.

¹¹¹ See Chapter 7 for a discussion of Poor Law contracts.

¹¹² Edwin Alvis Goodwyn, *Beccles and Bungay: Georgian Miscellany*, (Beccles, 1969), p.40.

for each person inoculated, over and above his annual fee of £36 15s.¹¹³ When his reappointment came up in August 1768, his fee was increased to £42 *per annum* but with inoculations included. The numbers involved are not recorded, but he inoculated 200 of the poor at Halesworth in the same year. Samuel Salmon inoculated the paupers at Melton House of Industry (“145 without loss”) in August 1769.¹¹⁴ Nacton House of Industry paid £40 in 1771 for the inoculation of its inmates, which was the equivalent of the cost of all other services from the local surgeon.¹¹⁵ In Nayland, there were records of payments for “inoculating five boys at Musgraves £1.1.0” on 10 June 1775 and in 1779 “Pd Mr Day for the Small Pox £15.15.0.”¹¹⁶ The Assington *Parish Records* of 1796 state “paid Inoculation Bill £4.13.0.”. Occasionally local philanthropists paid, as in Bury St. Edmunds where General William Hervey in 1803 paid nearly £50 to Mr Smith to vaccinate 200 men, women and children of Horrenger and Chevington.¹¹⁷

When the disease cleared, towns were quick to make the fact widely known, and the development of provincial newspapers could give press notice.¹¹⁸ Local worthies were charged with reporting the state of smallpox infection in their parish and not surprisingly local doctors combined to make declarations, thus giving more confidence to the populace. For example, Robert Drury {1750} and Richard Parsons Snr. (1680-1758), surgeons of Hadleigh, both certified there was no smallpox in the town in 1750, and Sudbury surgeons P. Anderson and John Clarke reported only mild fever in February 1788, in 1790 no smallpox in Sudbury and in February 1794 that there was smallpox only in the pest house.

Although they may have combined to report, there were sometimes conflicts in the reporting of smallpox by local practitioners. In Beccles, John Amyas

¹¹³ Blything Hundred, *Minute Book*, 1767.

¹¹⁴ *Ipswich Journal*, August 1769.

¹¹⁵ David Warsop, “Social aspects of Nacton workhouse in its early years”, *The Suffolk Review*, 4, (1973), 2, pp.25-40.

¹¹⁶ Assington, *Parish Accounts*, 1775, SRO (Bury St. Edmunds), FL 521/7/1-2.

¹¹⁷ Lilian J. Redstone, *Our East Anglian Heritage*, (London, 1939), p.123.

¹¹⁸ For example *Ipswich Journal*, 6 January 1750, “That the smallpox is not in Dedham Street and is only in two families at Prince’s Green, and nowhere else in the town, excepting the pest house (where only one or two have it) as far as we know and believe”.

(1706-1780) with Tyrell Carter {1748-1799}, John Clarke {1723-1763} and Ralph Keable {1740-1764} reported in both February 1748 and June 1763 that smallpox was present in the town, but the following year it had gone. Their colleague in the town, Robert Thomas Le Grice or Le Grys {1719-1764}, had signed a declaration in 1748 that there were only three cases of smallpox in the town, but in 1763 he reported smallpox specifically in six houses, the posthouse and the workhouse. On the other hand, James Craddock (1723-1787), surgeon of Stowmarket and George Richardson {1743-1764} in July 1762 reported that Needham Market was entirely free of smallpox, but by December of that year William Palgrave {1762-3} and Brice Pyman {1743-1776}, both surgeons of the town, were reporting three persons with the disease. Clearly, a level of personal interest may have contributed to the differences, but also the lack of precision over data, diagnosis and effectiveness, and completion of treatment will have been contributory factors.

There are varying views about the effectiveness of inoculation and its impact upon both demography and public health medicine generally. At the time the Revd. Howlett reported on the impact of Daniel Sutton's mass inoculation at Maidstone:

“Upon casting an eye over the annual lists of burials, we see that, before the modern improved method of inoculation was introduced, every five or six years the average number was almost doubled... that at such intervals nearly the smallpox used to repeat its periodical visits... whereas in the fifteen or sixteen years that have elapsed since that general inoculation it has occasioned the deaths of only about 60. Ample and satisfactory evidence of the vast benefits the town has received from that salutary intervention”.¹¹⁹

However, James Moore claimed that Daniel Sutton's use of 'quackery' devices and exorbitant claims did him a disservice, as his plan of treatment was greatly superior to that of any former practitioner. “And if he had followed the correct rules of open professional conduct, his name would have been recorded with honourable distinction”.¹²⁰

¹¹⁹ Rev. John Howlett *Observations on the Increased Population of Maidstone*, (Maidstone, 1782), p.8.

¹²⁰ Moore, *History*, p.270.

There was also outright opposition to inoculation from the outset, since clergy and parishioners considered it ‘unnatural and impious’. The medical profession felt that it protected the individual but filled the country with contagion, so that the relative mortality was lessened but absolute mortality increased. There was increasing concern by the end of the eighteenth century that inoculation was bringing people from outside towns to be inoculated or treated, and in fact spreading the risk rather than reducing it. The knowledge that infection could spread from patients undergoing inoculation to the non-immune populations was almost universal in the second half of the eighteenth century. Daniel Sutton denied this, but others who had adopted his system, such as Thomas Dinsdale of Hertford, continually issued warnings.

Town authorities tried to regulate inoculation and preclude practitioners from inoculating strangers, and restrained the activity to the houses designed for that purpose. Mid-century examples of local practitioners agreeing not to treat those from out of the parish or strangers included Bury St. Edmunds apothecary Robert Hawes (1705-1784) and Charles Febb (1705-1789), apothecary of Ipswich. Debenham and Ipswich surgeon Thomas Matthews {1763-1787} declared that “no person to be brought into the parish for inoculation” in January 1763 and, in the same year at Debenham, parishioners threatened to prosecute anyone performing inoculation there.¹²¹ Indeed, Daniel Sutton himself was put on trial at Chelmsford Assizes in July 1776 on the charge of bringing infected patients to the county town on market days and thereby being responsible for starting a major outbreak earlier in the year.¹²²

Yet these measures did not prevent further outbreaks in Beccles that June, when:

“Mr John Assey surgeon voluntarily inoculated (gratis) near 350 poor persons: for the relief of which the gentlemen and tradesmen of the Parish subscribed the sum of £28.13/0 which was later distributed by the churchwardens”.¹²³

¹²¹ *Ipswich Journal*, 18 June 1763.

¹²² Smith, *Speckled Monster*, p.45.

Five years later the scourge returned and this time a general inoculation was ordered, “Paid to Messrs Assey, Crowfoot, Purvis, Harber and Sayers towards the charge for inoculating the poor with the small-pox £15.10.0”.¹²⁴ In 1805, when there was another outbreak, the old method was discarded and Jenner’s new vaccination method was used.

Similarly, in Bury St. Edmunds, the Court of Guardians in 1783 applied to the doctors of the town (physicians, surgeons and apothecaries) “in order to put a stop to INOCULATION and the faculty came to the resolution not to inoculate any person after the 30th April”.¹²⁵ John Stevens Creed (1756-1829), surgeon of Bury St. Edmunds, made a joint statement with other physicians, surgeons and apothecaries that he would not inoculate any person after 30 April 1783 “to put an end to any further danger of infection with the smallpox”.¹²⁶

The development of vaccination at the end of the eighteenth century constituted one of the milestones in the advancement of preventative medicine. Jenner’s approach, differing from that of Sutton, consisted of inoculating into humans a formulation of one type (cowpox) that induced in the host immunity to one of a more dangerous character. His hypothesis that vaccination with cowpox ‘matter’ protected from smallpox became a major talking point in society of the day. Jane Austen described an instructive evening spent hearing Dr Jenner’s *Inquiry* read aloud.¹²⁷ His work had a mixed reception, although in the first quarter of the century vaccination was being systematically carried out in large towns. In smaller towns and the countryside, vaccination with cowpox appears to have been irregular, usually sparked by an alarm about a nearby outbreak.¹²⁸

There is little evidence of vaccination in Suffolk before 1815, perhaps an indication of their reluctance to give up their lucrative inoculation opposing

¹²³ Beccles, *Town Council Minute Book*, SRO (Lowestoft), FL 2541, June 1776.

¹²⁴ Beccles, *Town Council Minute Book*, SRO (Lowestoft), FL 2541, 1781.

¹²⁵ *Bury Post*, 15 May 1783.

¹²⁶ *Bury Court of Guardians*, SRO (Bury St. Edmunds), FL 541.

¹²⁷ Deirdre La Faye, *Letters of Jane Austen*, (London, 2003), p.212.

¹²⁸ Creighton, Charles, *A History of Epidemics in Britain*, (Cambridge, 1894), p.586.

Jenner through “a hereditary interest and pride in inoculation”.¹²⁹ Moreover, the poorer classes had only just recently taken to it, and a good deal of inoculation was done as in past times by people like farriers, blacksmiths, tradesmen and women. They saw their children continue to die:

“The many late failures of supposed cowpox to prevent smallpox have excited in some parts so much clamour among the lower orders of people that they insist upon being inoculated for the smallpox at some of the public institutions”.¹³⁰

However, some did change. Ipswich surgeons Jonathan Davie (1781-1858), John Denny (1774-1835), John Morgan (1754-1817) and Robert Fitch (1755-1823) advertised in November 1815 that they intended to inoculate with cowpox only. It then became common, as evidenced for example by Hugh Davis Hughes (1781-1839), surgeon of Saxmundam and Shottisham, who was presented in March 1817 with an Honorary Diploma by the London Vaccine Institute, having vaccinated 935 patients during past year. He received the Honorary Diploma from the Royal Jennerian and original Vaccine Institution for inoculating at least 10,000 patients. John Sutherland (1782-1852), surgeon of Southwold in 1819, had the Honorary Diploma of the National Vaccination Establishment conferred, and he was appointed Corresponding Vaccinator. The fear of smallpox was great, and as the ability of inoculation to prevent epidemics had been proved to be ineffective, so the practice of vaccination steadily progressed. When John Green Crosse sent out questionnaires to Norfolk and Suffolk practitioners on the state of the epidemic, of the 91 who replied, 38 had practised inoculation of smallpox, and the respondents also confirmed the use of tailors, shoemakers and women for inoculation in East Anglia.¹³¹ It remained popular, especially with the poorer classes who were very prejudiced against vaccination and during the first half of the nineteenth century, “virtually all of the population were protected by one injection or another, sometimes by both”.¹³²

¹²⁹ Creighton, *Epidemics*, p.587.

¹³⁰ Letter, October 1805, *Edinburgh Medical and Surgical Journal*, 1, p.507.

¹³¹ V. Mary Crosse, *A Surgeon in the Nineteenth Century - the Life and Times of John Green Crosse*, (London, 1968), p.149.

¹³² Peter Razzell, “Population change in eighteenth century England - a reinterpretation”, *Economic History Review*, 18, (1965), 2, pp.312-332.

It is clear from this review that the development of a cheap and apparently effective manner of treating smallpox was developed and used extensively in Suffolk prior to the introduction of vaccination. Inoculation had a major impact on medicine, the incomes of those who provided it and the cost of the poor rates in counties such as Suffolk. Historians have been equally divided over its efficacy and significance in the development of public health medicine. Peter Razzell claims that:

“inoculation against smallpox could theoretically explain the whole of the increase in population, and until other explanations are convincingly documented it is an explanation which must stand as the best one available”.¹³³

However, John Smith expresses caution, as “inoculation kept smallpox alive and treatment was expensive, drastic, and exhausting”.¹³⁴ There is evidence that the non-immune proportion of the population nationally declined during the middle years of the eighteenth century and, with children particularly affected, inoculation may have led to a marked reduction in the incidence and mortality of smallpox. Razzell maintains that the original decline in the prevalence of smallpox was due to inoculation, not just by the Suttons but to countless practitioners in small towns and villages.¹³⁵ This conclusion is supported by the returns from Suffolk doctors, and a number of towns and villages seemingly kept smallpox at bay. However, the effectiveness of inoculation is difficult to demonstrate precisely and returns made by town doctors were neither complete nor free from political or financial considerations. David van Zwanenberg can find “no evidence to show that inoculation caused the population to increase or that it conferred any other benefit on the population as a whole”.¹³⁶ He also claims that the Suttons, by their inoculating technique and by isolating patients or inoculating all members of a community at one time, avoided the pitfalls of causing severe smallpox in a patient and/or an epidemic. Other historians see improvements in living conditions, in diet and nutritional standards of food, plus increased

¹³³ Ibid., p.318.

¹³⁴ Smith, *Speckled Monster*, p.67.

¹³⁵ Peter Razzell, *Population and Disease: Transforming English Society, 1550-1850*, (London, 2007), p.177.

¹³⁶ van Zwanenberg, “Suttons”, p.81.

fertility as greater contributors to the rise in population. However, this review shows that the work of general practitioners in Suffolk constituted a major contribution to both to the development and extension of popular medicine and the concept of preventative care.¹³⁷ It also provides further evidence for the thesis that the care by provincial and rural practitioners was experimental and leading edge in many areas, including surgery and the treatment of population diseases. The third major area of patient care, that of midwifery together with the role of women in providing medical and medically related services, provides yet more underpinning for this view, as the next chapter shows.

¹³⁷ Thomas McKeown & R.G. Brown, "Reasons for the decline of mortality in England and Wales during the nineteenth century", *Population Studies*, 16, (1962), 2, pp.94-122.

CHAPTER 7: MIDWIFERY AND THE ROLE OF WOMEN IN MEDICINE

“So all, like her, may evil Fate defy,
If Dr Glib, with saving hand, be nigh”.¹

The third major element in a country practitioner’s scope of practice, besides the surgery and prescription of pills described in the last chapter, was dealing with childbirth. This chapter considers the changing relationship between female midwives and the man midwife, noting briefly the historiographical context of this development. The Suffolk evidence points to the conclusion that many country surgeons throughout the period carried out midwifery as part of their normal daily practice, offering services that could rival those available in London, thus adding to the credibility of the argument that provincial surgeons and apothecaries could be a link in the chain between local healers of the sixteenth and seventeenth centuries and the general practitioners of the later nineteenth century. The chapter also raises questions about the role of women as doctors’ wives and as practitioners in their own right, in line with the understanding that “gender is a subject for cultural inquiry and historical research”.² By delving more deeply into primary sources for Suffolk, it concludes that there was more direct female input than hitherto assumed by some historians, supporting further the argument, unless Suffolk is completely original, that conclusions about the practice of medicine in this period are too metro-centric to reflect the larger proportion of practice across the country.

7.1 Historiographical Context

Relatively little is known about childbirth history, since data is limited and largely from urban areas (predominantly London), but it was undoubtedly a high-risk business throughout the period. Before 1750, the rate of difficult births may have been similar to today’s two per cent, but maternal mortality

¹ George Crabbe, *The Parish Register 111*, ll.662-664, in *Complete Works*, edited by N. Dalrymple & A. Pollard, in 3 Volumes, (Oxford, 1988).

² Barbara Kanner, *Women in English Social History 1800-1914 - A Guide to Research*, (New York, 1990), p.xv.

was far higher, perhaps around one per cent of all births.³ The presence or otherwise of medical practitioners at childbirth was frequently determined by cost. In general terms, the expenses of birth might include the midwife's fee (male or female or both), the attendance of a nurse for a few days, a bottle of gin or brandy, and half a bushel of malt brewed or hops. All these were part of the traditional rituals around childbirth, particularly observed by the poor, and churching and swaddling still went on into the nineteenth century.⁴ For the poor and labouring classes, it was only when complications arose during labour that a medical practitioner might be asked to attend.

Modern commentaries have offered two main explanations for the rise of the distinct profession of man midwives - technology and fashion. The former was seen to be most important, as not least it coincided in the early eighteenth century with William Smellie (1697-1763) teaching the use of the forceps.⁵ Together with the vectis and the fillet, the forceps were developed with the aim of achieving the delivery of a live child in obstructed births by the head.⁶ Previously, such difficulty would have resulted in the death of the child, the mother or both, and the arrival of the doctor in such circumstances would have been greeted with despair. As Dr Michel wrote, "What can be more horrid than the burying of a living child within the entrails of a corpse!".⁷ Sophisticated forceps were being used in provincial towns by surgeons such as Nally Woods and John Drinkwater in Oxford and Brentford respectively, though rarely if at all in rural areas. However Edmund Chapman, who practised at Halstead, Essex, had used forceps since 1720, and later referred

³ Ralph Houlbrooke, *Death, Religion and the Family in England 1480-1750*, (Oxford, 1998), p.18.

⁴ Adrian Wilson, *The Making of Man Midwifery: Childbirth in England 1660-1770*, (Cambridge, Mass., 1995), p.26.

⁵ John Glaister, *Dr Smellie and His Contemporaries: A Contribution to the History of Midwifery in the Eighteenth Century*, (London, 1894), p.304. Smellie began his career in London by setting himself up as a teacher. Not surprisingly, he attracted a considerable amount of criticism from some of his peers, notably John Douglas and the midwife Elizabeth Nihell who condemned Smellie's use of forceps, his 'machine', and his dress at deliveries. She also claimed that he possessed "the delicate fist of a great-horse-godmother of a he-midwife".

⁶ The forceps consisted of two blades by which the foetal head could be grasped and traction exerted; the vectis was a single curved blade which could be used to alter the position of the head; the fillet comprised a rigid handle and a flexible strip that could be looped around the head before exerting traction.

⁷ Dr Michel, *Essay on the Causes Which Demand the Caesarean Operation*, (read before The Medical Society of South Carolina, 1820), quoted in Carl J. Pfeiffer, *The Art and Practice of Western Medicine in the Early Nineteenth Century*, (Jefferson, N.C., 1974), p.129.

to “a brother practitioner in the country” who had “used forceps for some years but seldom with success or advantage”.⁸

Modern commentators like Adrian Wilson argue that, together with this technology, women in particular began to recognise the benefit of a male practitioner who could deliver a child in obstructed delivery and that this was the most important factor in making of man midwifery.⁹ By law, only members of the Barbers and Surgeons’ Guilds could use surgical instruments, and few female midwives belonged to the Guilds. Thus, forceps contributed to the medicalisation of childbirth, a changing relationship of midwifery to the general health system for society, and growing rivalry between male doctors and female midwives. Wilson also maintains that man midwifery was probably more common before 1700 than previously supposed.¹⁰ Certainly Perceval Willoughby (1596-1685), an apprenticed London surgeon in 1619, enjoyed a substantial practice in Derby between 1620 and 1670. He strongly opposed midwives’ interventionist practices and wrote on midwifery, intending to instruct colleagues “how to help poor suffering women in distress”. He cites an example:

“Alice, the wife of Ralph Doxy was delivered by mee of a dead child. The arme came first and it was mortified by the midwives pullings. I slid up my hand, and, upon the child’s belly, I found the knees. I fetched down the feet, and quickly laid her at Snelton April 27 die Ois 1662”.¹¹

Contemporary views reflected the polarity in attitudes towards the involvement of men in what for many (particularly the upper and poorer classes) was essentially ‘women’s business’. William Foart Simmons reflected this in his 1783 *Medical Register* where “the rarest category of all... was that of man-midwife, with only two men so described (though two more physicians called themselves ‘*accoucheur*’), though this referred to full timers only”.¹² This was clearly an underestimate, particularly where midwifery was a part-

⁸ Ibid., p.28.

⁹ Wilson, *Man Midwifery*, p.192.

¹⁰ Jean Donnison, *Midwives and Medical Men: a History of Inter-professional Rivalries and Women’s Rights*, (London, 1977), pp.2, 192.

¹¹ Perceval Willoughby, (ed. Henry Blenkinsop), *Observations in Midwifery*, (London, 1868), pp.98-99, 105.

time adjunct to more mainstream care, perhaps because Foart Simmons was a physician who himself may have disapproved of man midwifery. The only men midwives listed as such by him would have had an exclusively female clientele and only handled difficult confinements referred to them by fellow physicians and surgeons. In spite of the growing numbers in London and increasing demand by the ladies of society, there remained a strong body of contemporary opinion that resisted the influx of man midwives in all except where surgical intervention was essential to save the life of the mother.

Many of the critics were female midwives such as Elizabeth Nihell, who maintained that even the worst of female midwives was better than the best of men.¹³ However Sarah Stone, in contrast to Nihell, occasionally felt compelled to call in a male assistant for a particularly difficult delivery.¹⁴ Margaret Stephens {1765-1795}, a midwife for 30 years in the late eighteenth century, had attended Queen Caroline in her confinements; her *Domestic Midwife* criticised those influenced by interests of fashion rather than those of competence, and the man midwives who refused to give women equal training.¹⁵ One of the most vindictive attacks was John Blunt's diatribe against man midwifery, which argued that women would be "unnecessarily handled by gentlemen of midwifery faculty".¹⁶

Roy and Dorothy Porter argue that polite and educated women seemed to have happily accepted the male accoucheur, overcoming in the name of medical progress what they saw as the false delicacy of hiding their 'privities'

¹² Joan Lane, "The medical practitioners of provincial England in 1783", *Medical History*, 28, (1984), pp.353-371.

¹³ Elizabeth Nihell, *Treatise on the Art of Midwifery*, (London, 1760), Preface, p.viii.

¹⁴ Pam Lieske, *Eighteenth Century British Midwifery*, (London, 2007), pp.xx-xxi. Sarah Stone was a midwife practising in London and Bridgewater in the early seventeenth century.

¹⁵ Margaret Stephens, *Domestic Midwife*, (London, 1795).

¹⁶ John Blunt, (pseudonym of S.W. Coves, Bookseller, No. 3 Piccadilly, 1793), *The Man Midwifery Dissected or the Obstetric Family Instructor for the Use of Married Couples*. The frontispiece showed a drawing of a half man and half woman holding the tools of trade, with forceps, blunt hook and Boring scissors hanging on wall. The inscription reads: "A Man Midwife, or a newly discovered animal, not known in Buffon's time; for a more full description of this Monster, see an ingenious book, lately published price 3/6 entitled Man midwifery Dissected, countering a variety of well authenticated cases elucidating this animal's Propensities to crudity and indecency sold by the publisher of this book who has presented the author with the above Frontispiece to his Book".

from doctors.¹⁷ Attractive though this sweeping statement is, it was unlikely to have been generalised, and certainly not in the more conservative countryside, where issues of propriety (especially from overseers of the Poor Law) and cost were more influential in the use of man midwives, as evidence from Suffolk will show. Adrian Wilson also maintains that the modesty argument came mainly from men not wanting their womenfolk to be exposed to other men's eyes. Certainly childbirth was a great leveller, for "in subordinating the lady to the midwife, it had ceaselessly reminded that lady that she was, for all her pretensions to rank and breeding, a woman like other women". The man midwife became attractive to the new wealthy and literate women of the mid-eighteenth century, because he offered proof of her superior social status, and by the 1780s the aristocracy had almost entirely abandoned female midwives. Exclusive fees implied exclusive technical abilities and "mentally therefore they detached themselves from the dangers of childbirth - a further separation from their less fortunate sisters".¹⁸ Amanda Vickery also argues that for the upper class ladies at least, a man midwife was "a useful ally to his patient in her battles with convention, duty and demanding relatives". She goes on to demonstrate that male practitioners were the first resort for the majority of genteel women who sometimes recorded their arrangements.¹⁹ Pam Lieske also contends that by the end of the eighteenth century man midwives or accoucheurs were the preferred attendants for many women, excepting the rural poor and those averse to male practitioners.²⁰

Variations in the developments in midwifery practice reflected factors such as education, location and social class. Wealthy urban and upper class county families were more accepting of man midwives than poorer rural women. The Revd. James Woodforde (1740-1803) noted the instance of Mrs Custance, the wife of a Norfolk squire, who gave birth in 1791 and was attended by a man

¹⁷ Dorothy Porter & Roy Porter, *Patients' Progress - Doctors and Doctoring in Eighteenth Century England*, (Oxford, 1989), p.54.

¹⁸ Wilson, *Man Midwifery*, p.191.

¹⁹ Amanda Vickery, *The Gentleman's Daughter: Women's Lives in Georgian England*, (London, 1998), pp.95, 101-2.

²⁰ Lieske, *British Midwifery*, p.xx.

midwife, “it having becoming popular in London earlier”.²¹ Many attending obstetricians would have been physicians from genteel families themselves, known socially to their patients. Ann Pellet pronounced herself “much pleased that [Mrs Scrimshaw] deigns to follow your prudence in choosing to be assisted by a Docr, rather than an ignorant old woman”.²²

There may be truth in this interpretation, but it is likely that the predominant determinant of the choice of attendant at childbirth for those who could afford to make such choices was that put forward by the Porters, namely the wish to have a safe delivery in a dangerous enterprise. Thus the method of identifying the practitioner used, regular or irregular, was the one thought to be most likely to achieve a successful outcome.

Irvine Loudon maintains that, outside London, obstetrics was poorly paid considering the time and the enormous physical and mental strain involved, quoting fees of one to two guineas for practitioners as far apart as Liverpool and Bristol. It was rare for anyone outside of London to sustain an income by man midwifery alone, the argument being that medicine and surgery tended to be much more profitable than midwifery, providing the practitioner could be fully employed in them.²³

There is an alternative explanation, however, namely the greater integration of midwifery into the practice of country surgeons. Irrespective of the specific income derived from obstetrics, there was an expectation amongst families that ‘their’ practitioner would provide a full service including attendance at childbirth, or they would turn to other competitors if this were not the case. However, the Suffolk evidence set out here shows that midwifery was very much a part of many surgeons’ and apothecaries’ professional lives, and they would indeed have had the necessary experience.

²¹ James Woodforde, *The Diary of a Country Parson (1759-1802)*, Vol. I 3, 1788-1792, (London, 1927), p.323.

²² Amanda Vicker, *The Gentleman’s Daughter*, pp.106 & 103, illustrated by the letters of Elizabeth Parker in 1750s, Bessy Ramsden in 1760s, and Eliza Whitaker in 1810s.

Irvine Loudon has argued that “the rapid adoption by the surgeon-apothecary of the role of the man-midwife could only have taken place if it was actively sought by women and their husbands”.²⁴ He argues that confidence in using instruments in difficult births gave practitioners great reputations locally, and consequently they were called upon for more normal ones. However, it is also likely that such confidence came from the fact that the obstetrical service was being provided as part of an ongoing relationship between patient and doctor, a situation more likely to pertain in rural and provincial communities than in the more cosmopolitan large towns, and demonstrating significantly the existence of a full family doctor service in Suffolk and potentially in other parts of the provinces.

Irvine Loudon also argues that because man midwifery in the eighteenth century was largely confined to emergency interventions, few practising it had extensive experience of normal midwifery. Doreen Evenden revives and extends Loudon’s model incorporating the goal of family doctoring, stating that:

“Young surgeons and apothecaries, struggling to become established, were enticed into midwifery as an untapped, pseudo-medical area of expansion, and by the prospect of acquiring the family of the new mother as prospective patients for general practice”.²⁵

Competition between medical men for a limited pool of patients may also therefore have helped to transform surgeons and apothecaries into general practitioners.²⁶ Irvine Loudon dates this process from the 1730s, accelerating through the 1750s, driven by family contacts and the lifelong wider client base that midwifery brought.²⁷ He sums up the situation thus:

²³ Steven Cherry, “Responses to sickness: medical and health care provision in modern Norwich”, in Carole Rawcliffe & Richard G. Wilson (eds.), *Norwich Since 1550*, (London, 2004), pp.271-294. There was certainly one in Norwich by 1783.

²⁴ Irvine Loudon, “The vile race of quacks with which this country is infected”, in William Bynum & Roy Porter (eds.), *Medical Fringe and Medical Orthodoxy*, (London, 1987), pp.106-128.

²⁵ Doreen Evenden, *The Midwives of the Seventeenth Century*, (Cambridge, 2000), p.176.

²⁶ Adrian Wilson, “Midwifery in the ‘medical marketplace’”, in Mark Jenner & Patrick Wallis (eds.), *Medicine in the Market Place of England and its Colonies, c.1450-c.1850*, (Basingstoke, 2007), pp.153-174.

²⁷ Irvine Loudon, *Medical Care and General Practitioner*, (Oxford, 1986), p.90 *passim*.

“Some practitioners undertook obstetrics because there was no one else in their area to do it; others used it as a means of becoming established, and gave it up as soon as they could; and some persisted with it from the enjoyment of exercising an acquired skill. Very few did it for altruistic reasons”.²⁸

He builds this conclusion largely on the single case of Richard Smith of Bristol: “I know of no surgeon who would not willingly have given up attending midwifery cases providing he could retain the family in other respects”.²⁹

Yet there were other provincial scenarios: some doctors offered midwifery services to prevent competitors from gaining advantage, or to enhance their reputations. Lucinda McCray Beier saw man midwifery as one aspect of the larger contest between licensed and unlicensed practitioners, arguing that female midwives were only licensed as to character, not skill, and the key was negative advertising against unwanted competition.³⁰ Anne Digby describes three possible motivations and attitudes: doctors disliked it and did almost none; they did it as a financial necessity, as part of a mixed practice; or were attracted to it for professional and human satisfaction.³¹ Joan Lane suggests the contention that the midwifery picture in London was completely different from that in the provinces. She identifies fifteen physicians in 1783 who were noted men-midwives in London, whereas in the provinces this sort of work was usually carried out by the local surgeon.³²

Historians have thus put forward a range of probably complementary reasons for the rise of man midwifery. The balance between these reasons, however, is more likely to be in favour of the importance of ‘family’ practice in the countryside and less with fashion. What is clear from the evidence set out here is that obstetric practice was widely accepted in Suffolk.

²⁸ Irvine Loudon, “The nature of provincial medical practice in 18th England”, *Medical History*, 29, (1985), 1, pp.1-32.

²⁹ Loudon, *Medical Care*, p.94.

³⁰ Lucinda McCray Beier, *Sufferers and Healers: The Experience of Illness in Seventeenth Century England*, (London, 1987), p.15.

³¹ Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911*, (Cambridge, 1994), p.202.

³² Joan Lane, *A Social History of Medicine: Health, Healing and Disease in England 1750-1950*, (London, 2001), p.125.

7.2 Training and Standards

Like most of medicine, the regulation of midwifery was confused and tortured. At the turn of the nineteenth century there were nineteen different licensing bodies for medicine, mostly concerned with the licensing of surgeons and apothecaries, and this changed only slowly. The medical colleges excluded midwifery from their curriculum, but the influence on potential clients of success in childbirth meant that the physicians had to take some notice of the new specialism. In an attempt to recognise, but also to restrict, the expertise of socially prominent men-midwives, the RCP instituted a Licence in *Ars Obstetrica*, but this was short-lived and terminated in 1804. The College of Surgeons, while reaffirming its promotion of the art and science of surgery, was persuaded by the Society of Apothecaries that from 1821 only men-midwives holding the LSA Diploma should be allowed to practise midwifery. Much of the impetus for change came from Edinburgh graduates who were practising as surgeons in England and were appalled by the divisive nature of education and licensing based on the London medical colleges. Even when the Obstetric Society was founded in 1825, largely from the London-based staff of the great hospitals and the lying-in hospitals, the RCS and the Society of Apothecaries declined to include midwifery in their examinations and, in spite of political lobbying, the Society withered away by 1834, having apparently achieved very little.³³

Arguably, the development of man midwifery as a profession and a major part of general practitioner services lay less in licensing than in specific education and training. William Smellie was instrumental in achieving improvements in standards and outcomes in eighteenth century London, and was acknowledged as the greatest practitioner and teacher of midwifery.³⁴ Teachers like Smellie and George Macaulay (1716-1766) were trained in medicine, anatomy, surgery and midwifery at the principal universities in Europe.³⁵ Smellie gave courses

³³ Ibid., pp.235-245.

³⁴ William Smellie, *A Treatise on the Theory and Practice of Midwifery*, (London, 1752), was the classic text of its day.

³⁵ William Smellie studied in Paris under Gregoire and obtained his MD from Glasgow University in 1745; George Macaulay obtained his MD from Padua University in 1738 after studying at Edinburgh University. George Macaulay moved to London in late 1750 or early 1751 and sought and won the position of man midwife to the British Lying-In Hospital for Married Women in Brownlow Street, the

of lectures on reproductive anatomy and abnormal midwifery to male pupils, advertising the times and places of his teaching sessions and training methods at the cost of three guineas for a full course. Most of his lectures dealt with all aspects of pregnancy and labour, both normal and abnormal, and the theory of natural and preternatural labour and delivery.

The availability of the vectis and the fillet, coupled with edicts forbidding women midwives to use instruments, increased the interest in and availability of private midwifery lectures for (mostly male) students. More formalised training facilities in London, particularly Middlesex lying-in wards in 1747 and City of London Lying-in Hospital 1750, provided would-be man midwives with a ready made population they could simultaneously assist and use as teaching material. The level of expertise in London hospitals offering teaching was very variable and the costs of acquiring greater qualifications and experience, as envisaged by the metropolitan-based Society of Apothecaries, were far too high for most provincial practitioners during the review period. As a result, there were variable sorts of ‘trained’ men midwives, besides many more with no training at all beyond their apprenticeship. However, Adrian Wilson has also described how male practitioners taught by Smellie and his successors then “swarmed through country and market towns from Devon to Yorkshire”.³⁶

Suffolk provides several examples of this. William Hunter (1718-1783), one of Smellie’s pupils, became chief surgeon and man midwife at the British Lying-In Hospital in 1749, and his pupils, Orme and Lowder, attracted Aldeburgh surgeon George Crabbe (1754-1832) to London in 1776 to pick up “a little surgical knowledge as cheap as he could”.³⁷ Crabbe sought advanced tuition in midwifery and observation of ward rounds, not least because he had received

first hospital in England exclusively devoted to obstetrics. Macaulay subscribed to the hospital on 21 March 1751, thereby joining its board of governors. In a fiercely contested election he won the post of man midwife on 11 July 1751 by packing the board, notably with women and particularly with his wife’s female Bathurst relatives. Macaulay’s contributions to his profession included, in 1752, the establishment at the British Lying-In Hospital of a midwifery course for women, thereby countering the eighteenth-century trend of hastily ill-educating man midwives to take over what was traditionally a female role.

³⁶ Wilson, *Male Midwifery*, p.2.

³⁷ Rev. George Jnr. Crabbe, *The Poetical Works of George Crabbe with his Letters and Journals and his Life*, (London, 1834), p.2.

scant training beyond watching his master.³⁸ Other Suffolk practitioners were known to have been attracted to London, including Thomas Wraight {1730-1758} a man midwife of Cavendish, who claimed to have been trained by Dr Smellie when trying to extend his practice.³⁹ Similarly, Thomas Ebden {1795}, a surgeon apothecary and man midwife of Thetford, attended lectures in midwifery and surgery in a London hospital under Mr Pott and Dr Hunter, but there is no evidence of his practice subsequently.⁴⁰ Richard Langslow, physician and surgeon in Halesworth {1790-1812}, was elected physician to the Lying-In Hospital in London, though it is unclear whether either he had any training himself or he taught others, and there is no record of his obstetric practice in Halesworth.⁴¹

Some merely had practical experience based on accompanying their masters to births, and much depended upon the experience and competence of masters, for example Edward Beck {1770-1807} and Robert Anderson (1760-1842), who both had numbers of apprentices.⁴² However, many gained experience at the expense of the lives and health of mothers and infants and, most disturbingly, also sometimes undertook to instruct others in their scant knowledge.⁴³ John Keats (1795-1821) is a good example of this *ad hoc* education - "There is no evidence that he took the early-morning midwifery course by D. Haighton; it was not necessary for him to do so in order to qualify, and he would have had plenty of obstetric experience while assisting Hammond (his master)".⁴⁴ There were also 'self-made' practitioners. For example a Rochdale man, Robert Stott, prosecuted for unregulated practice by the Society of Apothecaries in 1823, had gone straight from working fourteen hours a day in a woollen mill to practise as an apothecary and man midwife. The Society declared that for protection of the subordinate classes who could not afford the fees of regular practitioners, such 'empirical'

³⁸ Orme and Lowder were Scottish man midwives who had been pupils of Smellie and who had developed further the forcep.

³⁹ *Ipswich Journal*, February 1754.

⁴⁰ *Ipswich Journal*, April 1795.

⁴¹ David van Zwanenberg, *SMB*.

⁴² Anderson attended for three years Professors of Physic, Surgery and Midwifery at the University of Edinburgh - walked in a London Hospital, and at least two of his five known apprentices went on to hospital training and further degrees.

⁴³ Wilson, *Male Midwifery*, p.103.

practitioners should be subject to license by municipal authorities. There are no known examples of such extreme unregulated practice from Suffolk, but they probably existed.

7.3 The Suffolk Evidence

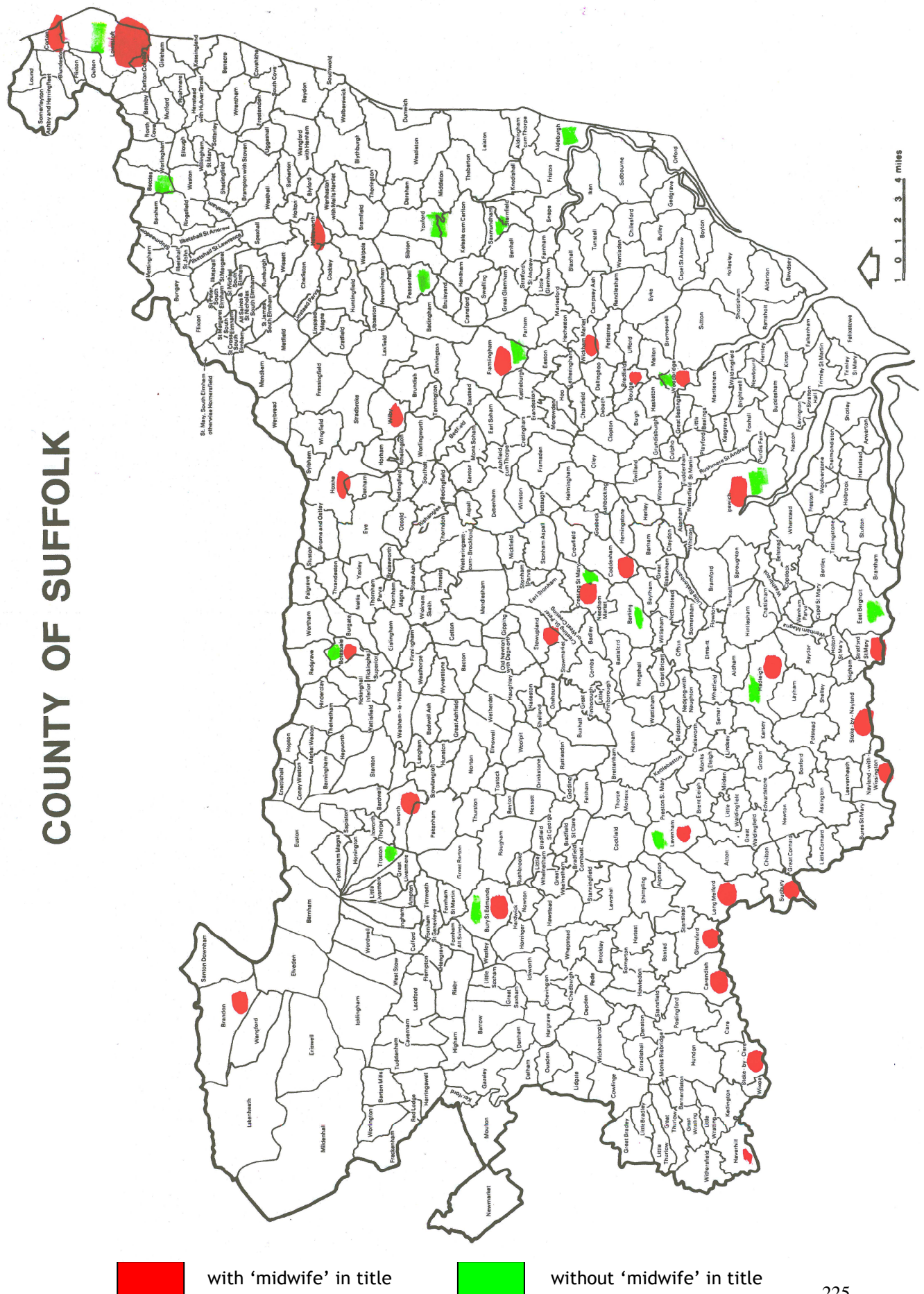
Since the reasons for the rise of man midwifery are complex, evidence from Suffolk offers a test of interpretation and additional illumination. Although there are limited county records of obstetric cases available, evidence from registers of birth (notably Quaker records), from practice histories, the press and anecdotes is more plentiful, as is information from adjacent counties, particularly Norfolk.⁴⁵ Provincial surgeons were keen to improve the services they already provided, but the difficulties for Suffolk practitioners caused by the distance from London, modes and costs of travel and the paucity of local facilities for training and development described in Chapter 5 applied also to midwifery. Compared to other counties, there were relatively few using the title ‘man midwife’ in Suffolk before about 1750, judging from evidence of attendance at childbirth.⁴⁶ Appendix I lists those practitioners known to have had ‘man midwife’ actually in their titles and Figure 7.1 shows their geographical spread. It also illustrates just how important it was that those practitioners who did not claim the title ‘man midwife’ were in fact competent at childbirth, and how dependent many towns and villages were on the holistic service provided by the latter.

⁴⁴ Robert Gittings, *A Life of John Keats*, (London, 1968), p.83.

⁴⁵ Michael J. Muncaster, *Medical Services and the Medical Profession in Norfolk 1815-1911*. Unpublished thesis submitted to the University of East Anglia, (1976), p.193. He cites five Norfolk practitioners whose records have survived, c.1800-1845 but similar records have not yet been found for Suffolk.

⁴⁶ The Suffolk evidence is underlined by that from Nottingham, when replies to Dr Edward Harrison published in the preface to *Medical and Chirurgical Review*, 13, (1804) show Nottingham had 11 midwives and 15 surgeon-apothecaries all practicing midwifery, while the county had another 25 surgeons and 123 midwives.

**Figure 7.1: Access to a Man Midwife Locally,
1750-1830, Throughout Suffolk**



Of those who did use the title, Thomas Wraight had been apprenticed to John Birch {1730-1782} in 1730 for seven years, at a premium of £48. By February 1754 he was seeking to extend his practice to Clare and Glemsford, and claimed to have been trained by William Smellie.⁴⁷ The frequency with which such a person as he would have attended both normal and difficult births provided experience that partly compensated for the lack of formal education and training available to those nearer the metropolis, potentially enhancing their confidence and skill.

Use of the title ‘man midwife’ carried some risks and was relatively rare because of the suspicion with which the lower classes viewed them, either because of the fees charged or the concept of a man being present during childbirth. Possibly surgeons found it advisable to omit the title, or perhaps use it only when attendance at a birth required it. Yet evidence shows that the majority were practising a combined role, often formally linking midwifery with other specialisms such as surgeon and apothecary throughout the period. Thus, John Green {1764-1773} of Glemsford and John Willson of Framlingham both styled themselves “surgeon, apothecary and man midwife”. William Prince (1744-1811) of Botesdale was a surgeon, pharmacist and man midwife active between 1780 and 1799. There is even a reference in *SMB* to a physician and man midwife, Misael Malfalqueyrat (1735-1789) of Bury St. Edmunds, whilst Dr Smith “Surgeon and accoucheur” in 1828, was apparently a travelling midwife. Such men appear throughout the period, the greatest numbers recorded at the end of the eighteenth century, and across the whole county. It is clear that many more practitioners were delivering babies and were involved with gynaecological matters than suggested by their titles.

The licensing of man midwives (or those with midwife in their title) appeared to have peaked in Suffolk in the mid-nineteenth century and, as Ipswich had the only lying-in hospital, the reasons for any rise in the use of man midwives probably reflected both practitioner interest in the subject and patient pressure. Because of greater success in live births, death in childbirth or neonatal deaths became less acceptable, and patients and their families may

⁴⁷ *Ipswich Journal*, February 1754.

have turned to perceived and known experts, with the aura of new healing and knowledge. Most men midwives would have been keen to oblige. John Garneys (1727-1798), surgeon of Yoxford, even announced in the *Ipswich Journal* in 1762 that there was no truth in the rumour that he intended to leave off midwifery. Thomas Keable (1742-1774), man midwife, surgeon and apothecary of Stoke-by-Nayland, was also renowned.⁴⁸ When he died his widow advertised:

“To be let - house and shop late in the occupation of Thomas Keable... deceased in Stoke by Nayland. No person of the above profession in the town. Enquire of Mrs Keable... wanted a gentleman who can be recommended, particularly in midwifery. Mr Keable was very happily situated and highly honoured with the ladies”.

Phillip Gretton (1757-1834), surgeon, advertised in April 1786, “Practitioner in surgery and midwifery informing friends that he now practises in East Bergholt”.⁴⁹ Misael Remon Malfalqueyrat {1735-1789}, physician and man midwife of Bury St. Edmunds, had an extensive midwifery practice and held an Episcopal license to practise surgery. The *Bury Post*, reporting his death on 20 November 1789 at the age of 87, said that “he carried on an extensive practice in midwifery with the greatest credit and success. He is supposed to have brought more children into the world than any person now living”.⁵⁰ In April 1773 he had successfully delivered triplets at Horningsheath and “as he had always promised to provide for the third child if he successfully delivered triplets, he was taking steps to achieve this”.⁵¹ Yoxford surgeon Robert Press Dalton (1765-1800) was sufficiently inundated (or uncertain of his own ability to meet the demand) to advertise for an “assistant instructed in midwifery”.⁵²

The *Quaker Register of Births for Suffolk* recorded medical practitioner attendance on a regular basis at apparently normal births, both those practitioners who declared themselves midwives and those who did not. It also reported a midwife and no doctors present in several instances. For example, Ann Dallinger, midwife, attended the birth of four of Robert and

⁴⁸ Charles Torlesse, *Some Account of Stoke by Nayland*, (London, 1877), p.14.

⁴⁹ *Ipswich Journal*, April 1786.

⁵⁰ *Bury Post*, November 1789.

⁵¹ *Ipswich Journal*, April 1773.

Mary Ransome's children, although the couple called in Ipswich surgeon George Stebbing (1749-1825) for the birth of the fifth.⁵³ It is likely that for the last there were complications, for mother or baby or both required medical intervention.

However, there were some recorded deliveries where medical support was definitely required. Thomas Debenham {1751-1755}, surgeon and man midwife of Debenham in June 1751, reported in detail a remarkable case of tubal or ectopic pregnancy where the child survived, and in December 1760 he explained in the *Ipswich Journal* his technique for treating a retained placenta.⁵⁴ Needham Market surgeon Edward Bigsby Beck (1760-1845), in June 1776, successfully delivered triplets. Similarly George Parsons (1734-1798), surgeon and apothecary of Hadleigh, delivered conjoined twins as part of triplets.⁵⁵ Framlingham surgeon William Spalding (1723-1807) attended a 'false' pregnancy at Framlingham Workhouse in July 1784.⁵⁶ Benjamin Clayton {1781-1819}, surgeon and apothecary of Norton, attended the delivery of a two-headed child monster in Langham, which died soon after birth.⁵⁷

On a remarkable number of occasions the Quaker registers show the same practitioner attended the same couple over and over again, suggesting a high level of satisfaction, though not necessarily success. Robert Anderson attended a Quaker birth on 21 May 1787 at Sudbury where John King, draper, and his wife Hannah, had a son John and two years later when they had a daughter, Hannah. Anderson attended them again on 3 September 1795 when they had a third child, also called Hannah presumably because the second child had died. Edward Beck's tally of Quaker births included those of John

⁵² *Ipswich Journal*, May 1800.

⁵³ Society of Friends (Quakers), *Register of Births, Marriages and Deaths*, SRO (Ipswich), J 424/1. On 20 July 1789, a son Robert was born with persons present being Prudence Ransome, Ann Dallinger (midwife) and Mary Head; on 8 November 1790, a daughter Prudence was born with present Ann Dallinger, Ann Atkinson and Willemena Patrick; on 2 August 1792, a daughter Patience was born with the witness named as Ann Dallinger, and again when a daughter Anna was born on 18 March 1796. SRO (Ipswich), microfilm reel J 424/1: PRO RG6 (book 1062), RG6 1053 (book 1063), RG6 1054 (book 1064).

⁵⁴ *Ipswich Journal*, December 1760.

⁵⁵ *Ipswich Journal*, July 1763.

⁵⁶ *Ipswich Journal*, July 1784.

and Sarah Parkisson, neighbours in the town, a son Samuel on 8 June 1785, and at Barking to William and Sarah Mayes, a daughter Sophia on 24 June 1796. Beck's popularity is evidenced by multiple attendances: he attended at Creeting a papermaker, Thomas Man's wife Lucy, when she gave birth to a son, Samuel Alexander, on 13 October 1806 and the following year, a daughter Lorna. Samuel Alexander, a merchant of Needham Market and his wife Elizabeth called in Beck to attend the birth on 18 January 1778 of their son, John Gurney. However, Robert Abbott another surgeon in Needham Market, attended the birth of their second son on 1 January 1781. Interestingly, an earlier birth in 3 April 1780 of a daughter Lucy to John and Mary Cock was witnessed by a Janamaria Beck, from which one might legitimately conclude that either Beck's wife or daughter was assisting him. Samuel Alexander had another son, William Henry, with a new wife, Ann, followed by a second son, both of which births Beck attended. At all these births, no indication is given that they were difficult or that a female midwife was in attendance.

Intervals between births were short and the number of births was large, although whether for insurance against early death or from lack of contraception is not clear. Tyrell Carter {1748-1779} attended draper Philip Pullen's wife Katherine at Beccles on four occasions between 1783 and 1791, although at least one if not two of the babies did not survive; the second birth registered no name and the third and fourth children were both christened Philip. Similarly, James Brookes (1759-1832), who was both surgeon and Medical Officer at Ipswich, attended merchant Dykes Alexander and his wife Hannah five times between 31 August 1787 and 1803, and John and Mary Head six times between 1786 and 1791. The latter showed a gap of barely nine months between several of the children, and not surprisingly at least one died in infancy.⁵⁸

⁵⁷ William Goodwyn, *Diaries at Earl Soham 1746-1816*, 2 March 1973, SRO (Ipswich), HD 3651-3. According to the diary of William Goodwin, the mother later toured the country with the body of the child in a glass of spirits.

⁵⁸ Dykes Alexander and wife Hannah - a daughter Catherine on 31 August 1787, a son Richard Dykes on 15 August 1788, a son Henry on 24 August 1789, a daughter Hannah on 4 May 1793, and a daughter Priscilla on 5 January 1803. John Head, grocer, and wife Mary - a daughter Mary Ann on 4 January 1786, a daughter Eliza on 1 January 1787, a son John on 21 October 1787, a son Jeremiah on 24 January 1789, a daughter Mary on 10 September 1790, and a son John on 19 October 1791.

Ipswich surgeon George Stebbing attended many Quaker births across a wide range of occupations, from woolcomber and cordwainer to draper and brewer, and also had a successful private practice amongst the merchants and middle classes locally. His name appeared frequently in the lists of births, with notable repeat business. Thus John Bentley, screw cutter and tanner, and his wife Mary had a daughter Priscilla on 11 January 1793, then eight years later John's new wife Phoebe produced a daughter, Martha on 12 December 1801; on 2 January 1803 a son, John; on 17 May 1804 a daughter, Phoebe; on 29 October 1805, a son who appears to have died, and on 4 February 1807 another unnamed son. On 3 January 1796, Stebbing attended Joshua Head, a brewer and his wife Isabella for an unknown child, followed on 26 February 1797 by Alfred, on 8 June 1798 by Barclay, on 10 or 28 March 1800 by John, on 28 September 1801 by Benjamin, on 16 April 1803 by Lucy Ann, on 16 February 1805 by Edward, and finally on 10th October 1806 by Henry.⁵⁹

George Crabbe was less lucky in his midwifery experiences, although on his return from London walking the wards after his funds had run out, he started off well in translating his observations into practice. He was called to a woman in childbirth and safely delivered her, and shortly afterwards he attended another safe birth but the mother died within the month which shattered his confidence.⁶⁰

If few provincial practitioners were able to specialise solely in man midwifery, this evidence of attendance at childbirth is sufficiently common in Suffolk to question any claim that they only attended complicated or difficult births, or

⁵⁹ Other births attended by George Stebbings included: Simon Harding, woolcomber, and wife Rose - a son John on 2 October 1777; Simon Man, yarnmaker, and wife Rose - a daughter Sarah on 9 January 1782; Stephen Ramplin, painter, and wife Ann - a son Richard on 6 June 1790, and a son Stephen on 1 November 1791; Christopher Choate, cordwainer, and Alice - a son Samuel on 6 September 1793, and a son Jonathan on 13 May 1800; Harris Peckover, draper, and wife Elizabeth - a daughter Caroline on 13 January 1794, a son Henry Beesley on 13 July 1795, and a son Charles on 19 November 1798; Robert Ransome, iron founder, and wife Mary - a son Richard on 11 June 1798; Edward Wakefield of Barham Wick and wife Susannah - a son John Harold on 2 June 1803; Thomas Wilson, grocer, and wife Hannah - a daughter Rachel on 15 October 1804; John Maw, tallow chandler and yarn maker, and wife Maria - a daughter Maria Ann on 24 August 1805, a daughter Catherine on 30 September 1806, a son Benjamin Jesup on 29 August 1808; Samuel Alexander Maw and wife Maria - a daughter Ellen Maria on 5 April 1808; John Bentley and wife Phoebe - a son Fuller on 29 October 1808.

failed to gain the wide expertise of normal births deemed essential nowadays for a successful obstetric practice. Local Suffolk practitioners, of whatever description, appear to have attended and intervened at childbirth throughout the period simply as part of their normal practice responsibilities, whether they called themselves ‘man midwife’ or had had training. Evidence in the registers of births, the local press and Quaker lists suggests that midwifery was part of the everyday practice of the local doctor and it seems reasonable to conclude that those who were listed as attending Quaker births attended at least as many non-Quaker families. This supports the argument of a generalised family practitioner operating in country areas with considerable success, and there is little to indicate that any lack of training and expertise between 1750-1830 produced greater infant or maternal mortality. Indeed, the factors that may have helped the rise of the specialist man midwife in London did not apply in a rural county like Suffolk, where the pressures of fashion, public expectations, attraction of money and the capacity to acquire skills in new techniques with new implements did not apply to anything like the same degree, leading to an all-round general practitioner.

7.4 Female Midwifery

Nor is the view that the rise of obstetrics was to the detriment of female midwives totally sustained nationally or by such evidence from Suffolk as has been found. Nineteenth century commentators like J.H. Aveling, undoubtedly reflecting the general denigration of female midwives underway by then, stated that “women too frequently began to practise midwifery more for the purpose of earning a livelihood than from any special aptitude they possessed for the art”.⁶¹ Yet his own work demonstrated a greater proportion of formal training and licensing for female midwives than previously assumed.⁶² By the end of the seventeenth century therefore, a number of female midwives were active, educated and articulate. A significant development (for London) was that for over ten years Smellie taught an unknown number of female students,

⁶⁰ Neville Blackburne, *The Restless Ocean - The Story of George Crabbe, the Aldeburgh Poet*, (Lavenham, 1972), p.55.

⁶¹ James Hobson Aveling, *English Midwives; Their History and Prospects*, (London, 1872), p.52.

⁶² *Ibid.*, p.98 ff.

albeit separately from male students and viewing their roles as distinct yet subordinate. He wrote that “she ought to avoid all reflections upon male practitioners, and when she finds herself diffculted, candidly have recourse to their assistance”.⁶³ Margaret Stephen trained under Smellie, and other females sought out formal midwifery training in London from receptive man midwives like John Leake (1729-1792).

Episcopal licensing reflected the continuing influence of the Church on midwifery, and suitable midwives “had to be recommended by matrons who had experience of her skill, and had to bring a certificate from the parish minister certifying as to her life and conversation, and that she was a member of the Church of England”.⁶⁴ The licensing process was also an attempt to ensure that babies were not stolen, that sick newborn babies could be baptised in emergency, and that stillborn babies were not sold unbaptised to other irregulars, including witches. Thus, the duties of the midwife also included establishing true parentage, preventing infanticide and ensuring baptism according to Anglican rites. Bastardy and infanticide were the concern of civil authorities as well as ecclesiastical ones, so the midwife’s respectability was of considerable importance to a well-organised parish.⁶⁵ The focus of the license therefore was on the good character of the midwife, not her skills.

Midwifery was an honourable profession, especially for widows and a number of individuals illustrate the high number of trained females. Elizabeth Francis, noted above as licensed for surgery, was also licensed in 1690 to practise obstetrics.⁶⁶ Jane Sharp practised from 1641 to 1671 and wrote *The Midwives Book*, which went through four editions before 1725. Far from being full of folklore and magic, it covered anatomy and delivery techniques and pointed out that “men ... are forced to borrow from us the very name they practise by

⁶³ Glaister, *Dr William Smellie*, p.205.

⁶⁴ Aveling, *English Midwives*, pp.89-90.

⁶⁵ David N. Harley, “Ignorant midwives - a persistent stereotype”, *The Society for the Social History of Medicine Bulletin*, 29, (1981), pp.6-9.

⁶⁶ Doreen Nagy Evenden, “Gender differences in the licensing and practising of female and male surgeons in early modern England”, *Medical History*, 42, (1998), pp.194-216.

and to call themselves men-midwives”.⁶⁷ Elizabeth Cellier practised as a midwife between 1668 and 1688 and was well-read, took notes and had apprentices.⁶⁸

Such developments plus the written tracts and publications from midwives themselves in the eighteenth century, demonstrate a greater scientific and practical status than previously thought. Sarah Stone published *A Complete Practice of Midwifery* in 1737, a casebook of forty or more complications of birth and how to deal with them, “interspersed with many necessary cautions and useful instructions, proper to be observed in the most dangerous and Critical exigencies”. Her purpose was to educate country midwives “whose ignorance has led to a fashion for men midwives”.⁶⁹ Martha Mears, writing in 1797, argued in *The Pupil of Nature* for a general upgrading of midwifery. From her survey of this literature, Amy Sellar concludes that “midwives could be highly educated, literate and accomplished in the art, which was reflected in the reluctance of many mothers to part with their traditional practitioner”.⁷⁰ For example, Carl Pfeiffer reports a female midwife, Sarah Roddry, at the Manchester Lying-In Hospital “having delivered over 5,000 babies, including 63 sets of twins, between 1817 and 1840, and never lost a mother!”.⁷¹ The story of Tristram Shandy’s entry into the world is well known, but it too reflects many aspects of the state of midwifery in the mid-eighteenth century, and supports Adrian Wilson’s rather more measured view of the role of women in the rise of man midwives noted above.⁷²

⁶⁷ Jane Sharp, *The Midwives Book or the Whole Art of Midwifery Discovered*, (London, 1671), p.12.

⁶⁸ Ruth K. McClure, *Coram’s Children: The London Foundling Hospital in the Eighteenth Century*, (London, 1981), p.9. Cellier proposed the establishment of a Royal Hospital to care for foundlings and also to train midwives. It was to be supported by the annual license fees that the practicing midwives would pay to the corporation, by the fees paid by the twelve subsidiary lying-in hospitals for poor women, by fees from doctors and surgeons for the privilege of attending the monthly lectures on midwifery, by one fifth of all voluntary charity from parishes and by gifts, legacies and Poor Law contributions. Nothing came of this scheme.

⁶⁹ Sarah Stone, *A Complete Practice of Midwifery*, (1737), reproduced in Lieske, *British Midwifery*, Vol. 4. p.xxiii.

⁷⁰ Amy Sellar, *Eighteenth and Nineteenth Century Midwives*. Unpublished PhD, University of East Anglia, 2001.

⁷¹ Pfeiffer, *Western Medicine*, p.121.

⁷² Lawrence Sterne, *The Life and Adventures of Tristram Shandy, Gentleman*, (first published Dublin, 1759), reprinted Clarendon Press, (Oxford, 1983). Tristram’s father wanted to send for a man midwife but his mother cried “by no mean”, and she sent for the village midwife, a “widow in great distress, forty seven years old, mother of three or four small children, decent in carriage, grave in deportment - a woman of few words...” She ‘watched’ with Mrs Shandy for several days before her confinement, mainly so that Mr Shandy would not need to ride to fetch the doctor immediately

However, there are few signs in Suffolk of a discourse involving highly educated female midwives, or that their impact on rural and country services changed significantly through the period, confirmed by the accounts of Poor Law overseers. Wissington *Overseers Accounts* show 2s 6d being paid to “Mrs Blomfield, midwife”,⁷³ and the burghers of Hepworth in 1799 paid “Frances Lows for Midwife 2s 6d”.⁷⁴ With plenty of work for such female practitioners, there was no need to press for professional status or qualification. At Boxford in Suffolk, where the midwife Fanny Rolls charged two shillings and six pence, and the doctor probably charged one guinea, the agreement between the overseers and the local surgeons was for midwifery to be included within general medical services, but only for them to attend in such difficult cases of midwifery as “where the women employed by this said parish shall not be competent to deliver (but not otherwise)”. Thus:

“Whereas Jane the wife of Robert Crocker is in a very weak condition and near her time of delivery and her case in that respect being thought very dangerous, therefore we the undersigned whose names are hereto subscribed hereby consent and agree that a man-midwife shall be allowed for attending but at the time only of such labour and delivery”.⁷⁵

Most midwives took office without formal instruction and the influence of London did not reach more remote parts of the countryside. In a county like Suffolk with such a stable population and lack of mobility between classes, it seems unlikely that ‘modern’ ideas and arguments would reach female midwives beyond the biggest towns. Penelope Corfield cites the example of Betsey Tomlinson, a Methodist lay preacher who was consulted as a midwife

labour began. The midwife’s training consisted of a few lessons given by someone in the parish that the parson’s wife had found and she had become “with the help of a little plain good sense and some years full employment in her business, in which she had all along trusted little to her own efforts and a great deal to those of Dame Nature, had acquired in her way no small degree of reputation in the world”. Because she was on hand, the doctor, Dr. Slop, was able to be wined and entertained by Mr Shandy and declined to enter the birthing room when requested to do so by the midwife. The midwife was confident that birth was head first, but Dr Slop was not convinced by a mere midwife’s findings, nor in alleviating the mother’s pains, reflecting the extant religious view that childbirth was supposed to hurt. He was determined to extract the child by forceps and used them to such ill effect that he broke the baby Tristram’s nose.

⁷³ Wissington, *Overseers Accounts*, 14 June 1760, SRO (Ipswich), FB 65/G6/1.

⁷⁴ Hepworth, *Parish Council Town Bills*, 1799, SRO (Ipswich), FL 582/5/32-85.

⁷⁵ Boxford, *Overseers’ Accounts*, SRO (Bury St. Edmunds), FB 77/G1/3/40.

as she toured the villages.⁷⁶ Many families relied on ‘the Sairey Gamps’, for many years the standard metaphor for midwife practice, presented as lacking in medical knowledge, incoherent, old, fat, rough, unkempt, drunk and generally unsavoury.⁷⁷

Although Hilary Marland argues that most local midwives continued to practice untouched by new knowledge or teaching, this caricature may not reflect them all.⁷⁸ Some were capable, skilled and experienced. Examples from Suffolk include a midwife being paid 10s for “laying Minters wife”, demonstrating both that it was common to be employed for general nursing duties and that the country rates were much below the metropolitan rate.⁷⁹ Midwifery was a regular part of a parish surgeon’s work but most pauper women were delivered by the local midwife, as reflected in the obituary notices and the respect accorded many of them.⁸⁰

Ipswich surgeon, George Stebbing, concerned about the lack of help available to poor women giving birth, arranged for his daughter, Rachel, to be trained as a midwife in London. He persuaded the ladies of Ipswich to establish a lying-in charity and became its surgeon (and treasurer), with his daughter acting as the first Governess or Matron until 1801. Subscribers to the Charity could secure for any poor woman the services of the midwife and surgeon during her delivery, and a set of baby linen - an early ‘Bounty’ set. This charity flourished for a century, Stebbing working for it until 1811.⁸¹ Rachel Stebbing herself had a large practice in midwifery and announced at her

⁷⁶ Penelope J. Corfield, *Power & the Professions in Britain 1700-1850*, (London, 1995), p.144.

⁷⁷ Charles Dickens, *Martin Chuzzlewit*, (first published, London, 1844), Reprinted Oxford 1984, p.246.

⁷⁸ Hilary Marland, “Stately, and dignified, kindly and god-fearing - midwives, age and status in the Netherlands in the eighteenth century”, in Hilary Marland & Margaret Pelling (eds.), *The Task of Healing: Medicine, Religion and Gender in England and the Netherlands 1450-1800*, (Rotterdam, 1996), pp.271-305.

⁷⁹ Assington, *Parish Accounts*, SRO (Bury St. Edmunds), FL 521/7/1, 6 January 1766.

⁸⁰ Lane, *A Social History*, pp.38-40. For example “On Sunday the 24th of May died Mrs Mary Hopkins, of Wilkton, in this County, widow; a person well-practised in the art of midwifery, and who, during the space of forty-five years last past, delivered upwards of 10,000 women, with the greatest success, and is therefore greatly lamented by all who knew her”. *Adams Weekly Courant*, 9 June 1767. “Died a few days ago at Horseley in Derbyshire a woman named Frances Barton, at the astonishing age of 107. She followed midwifery upwards of 80 years”. *The Newcastle Chronicle*, 23 January 1790.

⁸¹ David van Zwanenberg, “Interesting GPs of the Past: George Stebbing of Ipswich”, *British Medical Journal*, 283, (1981), pp.1517-18.

father's death that she would continue with his practice.⁸² She was sometimes called in by other doctors.

Jean Towler and Joan Bramall quote a remarkable contemporary account of sophisticated female midwifery in a small village remote from the nearest medical practitioner in Shrewsbury, which supports the contention that in many rural areas like Suffolk the midwife had to diagnose, prescribe and carry out the procedure:

“This [Richard] Clarke had several children by his first wife, all of which dyed while hee was a quaker and were buried by him in the oarchyard. When his second wife, Anne, was in travail of a child, the midwife told him that the child was dead in the womb, and unless it was drawn from the woman, shee would dye also; and thereupon Clarke made iron hooks in his lytle smith's forge, according to the midwife's direction, and therewith shee eased the woman of her burden and the woman recovered. But when she was with child agen, and the woman was in the same condition, hee would not suffer the midwife to do the like, soe the woman dyed”.⁸³

Female midwives are not included in lists of medical practitioners for Suffolk in the eighteenth century, although man midwives appear regularly from 1750-1830, as Appendix I shows. Nor did female midwives obtain Episcopal licenses in Suffolk in this period, but although they may have been eclipsed by men at the top end of the market, the suggestion that “the shift in the dominant location of medical services from the private domestic to the public market arena sounded the death knell for women's medical practice” may be overstated, as the next section shows.⁸⁴

7.5 Women in Other Healthcare Roles

“It is not for thee, O woman, to undergo the perils of the deep, to dig in the hollow mines of the earth, to trace the dark springs of science or to number the thick stars of the heaven”.⁸⁵

Suffolk data on women in other healthcare roles is limited, but changing approaches to the concepts of femininity and the social history of the feminist

⁸² *Ipswich Journal*, 6 June 1825.

⁸³ Roger Gough, *The History of Myddle*, (first published London, 1834), quoted in Jean Towler & Joan Bramall, *Midwives in History and Society*, (London, 1986), pp.172-3.

⁸⁴ Anne Witz, *Professions and Patriarchy*, (London, 1992), p.82.

movement have led to a revaluation of the broader contribution women made, both directly and indirectly, to medicine and healthcare. This means that such evidence as there is should be evaluated. Women have sometimes been presented as victims, unable to shape their own lives, and as homogeneous, not taking account of differences in the historical experiences depending on social class, location or other factors, as would happen with men.⁸⁶ They have also been added rather as tokens to subject areas without examining critically their specific role, so that men remain 'the norm' and a fundamentally male-centred narrative of history has been unchanged.⁸⁷

Some historians have continued to maintain that medicine was "an exclusively male occupation until the present century".⁸⁸ Penelope Corfield also sees women as playing "a conspicuously low-ranking role, clustered around the nurturing branches of the medical profession", though she also sees medicine "as a crucial battleground for female advancement".⁸⁹ Certainly there were clear gender divisions and, because women's access to education was so limited, few were likely to acquire the university education required of a physician, or break into the essentially masculine world of the surgeon.⁹⁰ However, if a wider view of healing is taken, then as Roy Porter observes, "it is highly probable that large numbers of female healers possessed valuable medical skills in traditional society". It is thus all the more important to record any evidence, however slight and problematic, that can shed any light on how women functioned within the provincial medical fields in Suffolk.

Mary Fissell's study of eighteenth century Bristol has revealed a surprisingly large role played by women in the delivery of patient care. She found midwives and family healers, barber-surgeons and apothecaries, those who

⁸⁵ *A Lady, The Whole Duty of Woman or a Guide to the Female Sex from the Age of 16-60*, (London, 1701), p.17.

⁸⁶ Alice Clark, *Working Life of Women in the Seventeenth Century*, (London, 1919), Ivy Pinchbeck, *Women Workers and the Industrial Revolution*, (London, 1930).

⁸⁷ Robert E. Shoemaker, *Gender in English Society, 1650-1850*, (London, 1998), p.2.

⁸⁸ Lane, *A Social History*, p.11.

⁸⁹ Corfield, *Power and Professions*, p.21.

⁹⁰ Evenden, *Gender Differences*, states that women in seventeenth century London were very rarely licensed because of the London medical monopolies. They had to provide much greater testimonial documents than men, which was a big barrier because of bias by gender and by extrapolation education. So mostly they were unlicensed and therefore unrecorded.

carried on their husband's business, bone-setters and so on. She quotes the example of Nanny Holland who inoculated against smallpox, set bones and helped women in childbirth.⁹¹ Margaret Pelling also refers to substantial numbers of female practitioners in Norwich, working very largely as general practitioners,⁹² although James and Margaret Bickford in their study of Hull practitioners find few instances prior to 1800.⁹³ Suffolk evidence shows a significant number of women contributing to healthcare, even if it is limited about those who were definably medical practitioners.

Occupational data on women and children was not collected in the eighteenth century, but industrialisation and growing prosperity for some impacted upon the lives and potential careers of women.⁹⁴ Peter Earle's work on the occupations of married couples in London in 1725 does not show any medical practitioners with working wives, although a number of gentlemen's and attorneys' wives were listed with defined occupations.⁹⁵ Of course, information on the vast majority of the wives of professional men is not available, as they were not supposed to have 'occupations' and the wives of most medical practitioners were referred to usually as 'the doctor's wife'. As seen in Chapter 3, the majority of medical practitioners came from professional families, and many looked for similar backgrounds when scrutinising potential marriage partners. Only limited information is available from Suffolk sources, which provide details of the parental backgrounds of just eighteen practitioners' wives (see Appendix K). However, this cohort shows medicine predominating in family backgrounds, and fourteen instances of marriage into another medical family.

Little has been written directly about doctors' wives, and literature of the day increasingly depicted women as supportive, sentimental, domestic and

⁹¹ Mary Fissell, *Patients, Power and the Poor in Eighteenth Century Bristol*, (Cambridge, 1991), pp.59 & 64-66, quoting from Roger Langdon, *The Life of Roger Langdon*, (London, n.d.).

⁹² Margaret Pelling, *The Common Lot: Sickness, Medical Occupations and the Urban Poor in Early Modern England*, (London, 1998), p.86.

⁹³ James A.R. Bickford & Margaret E. Bickford, *The Medical Profession in Hull 1400-1900*, (Kingston Upon Hull, 1983).

⁹⁴ M. Berg, "What difference did women's work make to the industrial revolution?", in Pamela Sharpe (ed.), *Women's Work. The English Experience 1650-1914*, (London, 1998), pp.149-171.

⁹⁵ Peter Earle, "The female market in the late seventeenth and early eighteenth centuries", Appendix A, pp.144-149 in Sharpe, *Women's Work*, pp.121-149.

maternal.⁹⁶ For some families, the prospect of a daughter marrying an up-and-coming professional would undoubtedly be attractive. George Eliot, writing in the mid-nineteenth century but about an earlier era, depicted an urban medical wife who married in order to become part of the gentry, rather than to work alongside her husband as helpmate and partner. Thus, Rosamund Vincy came from a family where “there had been much intermarrying with neighbours more or less decidedly genteel”.⁹⁷ She saw Tertius Lydgate, the young surgeon, as “possessing connections which offered vistas of that middle-class heaven, rank”. For her part, he was gaining a wife with “that feminine radiance, that distinctive womanhood which must be classed with flowers and music, that sort of beauty which by its very nature was virtuous, being moulded only for pure and delicate joys”.⁹⁸ This image of the largely decorative married woman was unlikely to suit the more robust partnership required for country practice, nor indeed in this case for the rural town of Middlemarch. However, Ivy Pinchbeck observed that:

“In some instances, wives and daughters of professional men appear to have so closely associated with their work that they were considered almost as partners, and after the death of their husband or father as the case may be, continued to practice (sic) independently”.⁹⁹

Many appear to have carried out multiple roles, from managing the finances to maintaining the interface between domestic and professional activities. The doctor’s wife looked after the pupils and apprentices and live-in assistants, as well as being the social hostess and in many cases hidden heart of the business. A considerable restriction in the roles of the doctor’s wife or business partner in the late eighteenth and early nineteenth century was that a married woman had no status in law and could not control property, make contracts, sue or be sued. Once widowed, however, a woman regained the legal status of a person, able to act for herself in civil transactions and to enter into another marriage of her own volition. This was reflected in the roles that doctors’ wives often took on after their husbands’ deaths, some

⁹⁶ Ibid., p.40.

⁹⁷ George Eliot, *Middlemarch - a Study of Provincial Life*, (first published London, 1871-2) (Penguin English Library, 1965), p.123.

⁹⁸ Ibid., p.193.

⁹⁹ Pinchbeck, *Women Workers*, p.302.

actually taking over the business side of the practice, and featuring in the public sphere.

Thus, Suffolk newspapers carried advertisements from women for a doctor to run the clinical side of the business as a replacement for their deceased husbands. Joseph Reynolds' {1773-1788} widow in Wangford required a replacement practitioner in 1796 and Elizabeth Whimper, widow of Thurston {1698-1776}, a surgeon in Woodbridge, engaged John Lynn {1766-1794} to take her husband's patients upon his death in 1794. In Grundisburgh, Edward Acton (1806-1860), surgeon, took on the practice of John Potter {1728-1830} on behalf of Mrs Potter, although it is unclear whether she retained her interest in it or merely sold the whole business.¹⁰⁰ Jesse Leeder's {1757-1762} wife was surprisingly listed jointly with him as 'master' to female apprentice, Ann Turner {1757}, of itself a rare occurrence.¹⁰¹ Mrs Leeder appears to have been not so much a medical practitioner as a business partner in the practice, for she advertised that she was giving up her millinery shop and that she intended to keep a boarding school.¹⁰²

At least one wife actually continued with elements of her husband's clinical practice, particularly in dispensing regular and irregular prescriptions. Yoxford surgeon Charles Wilson Snr. (1779-1848) produced medicinal water for gout and rheumatism, which he prescribed for his patients throughout his life. After his death, his second wife, Caroline, who lived until 1891, continued to sell his mixture, and a bottle of it remained in the surgery until at least 1975.¹⁰³ Similarly with Dorothy, the wife of Ipswich surgeon Richard Dowling {1753-1755} whose medication, 'Guttae Salutus', sold at 1s a bottle and was regularly advertised in the *Ipswich Journal* for purchase "at St Matthew's Parish where he is to be consulted in all cases of physic and surgery".¹⁰⁴ His widow continued to prepare and sell this tincture after his death. This is

¹⁰⁰ *Ipswich Journal*, 13 May 1830.

¹⁰¹ Peter J. Wallis & R.V. Wallis (with Juanita Burnby and Thomas D. Whittet), *Eighteenth Century Medics - Subscriptions, Licences, Apprenticeships*, (Newcastle, 1985). This may have been for reasons of propriety, as the apprentice was a woman.

¹⁰² *Ipswich Journal*, 11 December 1760.

¹⁰³ According to David van Zwanenberg in *SMB*.

¹⁰⁴ Various throughout 1750-1755.

similar to the example of Elizabeth Shackleton of Lancashire, another rural county, who inherited her husband's 'Cure for Hydrophobia' after his death in 1758 and continued to make it up to her own death in 1781.¹⁰⁵

The social and practical circle for aspiring doctors was small and likely to be dominated by their family contacts and their neighbouring fellow professionals. Norton surgeon Samuel Taylor met former Woodbridge surgeon Joseph Walford {1741-1774} through medical contacts, even though they lived quite some distance apart, and married his daughter in February 1785. According to a *Medical Quarterly Review* contributor in 1843, the easiest way to succeed modestly in the country was for an apprentice to marry the master's daughter and succeed to the practice.¹⁰⁶ A glance at Suffolk evidence from 1750 suggests that many had anticipated this advice. The advantages of marrying the master's daughter were obvious: the practitioner had a ready made livelihood; there were no setting-up expenses; he had less need of assistance from his parents; and he acquired an existing clientele with good prospects of ultimately taking over the family business. For the master too, such a marriage might be advantageous. He could gain a young partner trained in his ways who would keep the enterprise profitable when his own earning power failed, would protect his trade secrets and would not be a rival. The need for only a small dowry for the daughter would be an added benefit, though on the other hand there might be special arrangements or no capital sum at all for the goodwill that went with the sale of a practice.¹⁰⁷

Moreover, a wife from a medical household was a considerable asset to a practitioner, as she would probably have helped her mother with dispensing, keeping the accounts and handling patients. Thus, John Green Crosse (1790-1850) married the daughter of his master, Stowmarket surgeon Thomas Bayly (1775-1834) and Woodbridge physician George Lynn (1780-1854) married the daughter of his master, Robert Abbott (1750-1830), surgeon of Needham Market. Conversely, Henry Wilkin {1802-1851}, a Walton surgeon, married his apprentice's sister, and Samuel Haward {1792-1834}, surgeon of Halesworth

¹⁰⁵ Vickery, *The Gentleman's Daughter*, p.287.

¹⁰⁶ *Medical Quarterly Review*, 2, (1834), pp.391-393.

and Walpole, married the eldest daughter of his previous partner, John Walker {1760-1849}.

If not a daughter, at least a family that included several surgeons or had connections would have been an asset, as Rattlesden surgeon John Steggall (1789-1881) discovered. He married Sarah Weeding at Great Glemham in October 1815. She came from a family of surgeons, with her brother a leading Woodbridge surgeon and her sister was married to John Cockle {1794-1849}, surgeon at Woodbridge and Trimley.¹⁰⁸

In common with the general findings regarding practitioner antecedents,¹⁰⁹ there are also examples of medical men choosing a wife from a clerical or landowning family. Examples include Long Melford surgeon Robert Cream (1783-1853) who married Sophia, youngest daughter of the Reverend Temple Chevallier in 1812. Similarly Elizabeth Growse, the daughter of John Growse (1761-1840), a Bildeston surgeon, married the Reverend G. Webster in 1830. George Crabbe married Sarah Elmy, his childhood sweetheart, in 1783 and, although her father was a tanner who had gone bankrupt in 1759, her uncle James inherited land and married wealth.¹¹⁰

Although limited, evidence from Suffolk supports the view that some doctors' wives played an important or even essential role as a business and social partner, often running the business side of the practice, and were looked to by the community for proxy care when the doctor was not available. Occasionally, that might lead to the wife indeed continuing the business, or parts of it, after her husband's death, particularly the profitable potions side.

Some women even played a clinical role. In the sixteenth and seventeenth centuries, women of all classes played an important role as healers inside and

¹⁰⁷ Joan Lane, *Apprenticeship in England 1600-1914*, (London, 1996), pp.229-230.

¹⁰⁸ Pip Wright & Joy Wright, *The Amazing Story of John Heigham Steggall, "The Suffolk Gypsy"*, (Stowmarket, 2004), p.144.

¹⁰⁹ Discussed in Chapter 4.

¹¹⁰ Neil Powell, *George Crabbe: An English Life 1754-1832*, (London, 2004), p.22.

outside the home.¹¹¹ Wives and mothers were expected to provide medical care, and local communities often received unpaid medical services from clergy and medical wives, and via the aristocratic traditions of paternalism.¹¹² With the “culture of household medicine, the role of women in establishing their claims to expertise in this area was crucial”.¹¹³ For example, John Evelyn refers in his diary to the activities of his sister and mother: “Their recreation was in the distillorie, the knowledge of plants and their virtues for the comfort of the poor neighbours and the use of their family”.¹¹⁴ However, in the same year James Makattrick Adair regretted the passing of obligation:

“In those halcyon days when men of rank and fortune spent the greater part of their time at their country mansions, the mistress of the family commenced a Lady Bountiful... A revolution in the habits of life has now almost extinguished the race of the Lady Bountiful, and the poor are now generally resigned to the care of those humane and tender-hearted gentlemen, the parish officers”.¹¹⁵

Not only did the work of aristocratic care decline but as agriculture, craft work and commerce grew larger in scale, so domestic industries like cotton, lace making, stocking knitting and silk weaving, in which women had played a leading role and for which they had had levels of education and training, declined.

However, some women went further in delivering forms of medical care, and were recognised as having a medical occupation. Seven women’s names have been found in the records of the Archbishop of Canterbury, including Anne Hubbard {1615} of Toft Monks in Suffolk.¹¹⁶ Margaret Pelling argues that surgery was seen as the most masculine of the three elements of medical

¹¹¹ MS 3712 and MS 7931 (Wellcome Library) are examples of medical recipe books, probably written by Elizabeth Okeover (Adderley) of Staffordshire at the end of the seventeenth century. It contains gynaecological, obstetric and paediatric remedies and directions, as well as more general remedies, and while they appear to have been mainly for household use, one entry refers to giving a recipe for “sweet ointment [to] a woman of Burton who went on crutches two years together and useinge this a month was so well that she flung them away”.

¹¹² Shoemaker, *Gender in English Society*, p.179.

¹¹³ Robert Aspin, “Illustrations from the Wellcome Library: who was Elizabeth Okeover?”, *Medical History*, 44, (2000), pp.531-40.

¹¹⁴ Esmond .S. de Beer (ed.), *John Evelyn’s Diary*, 15 January 1786, (Oxford, 1955).

¹¹⁵ James Makattrick Adair, *Medical Cautions for the Consideration of Invalids*, (Bath, 1786), p.159.

¹¹⁶ The others were Eleanor Woodhouse of St. Leonards Shoreditch (1613), Elizabeth Wheatland of Winchester (1687), Elizabeth Francis of London (1690), Elizabeth Moore of Market Harborough, Leicestershire (1690), Mary Rose of Portsmouth (1696).

practice in the seventeenth and eighteenth centuries, so it may be assumed that few actually practised in the capital.¹¹⁷ However, some women were admitted to membership of the Company of Barber-Surgeons by apprenticeship and patrimony, though how many actually practised surgery is not clear.¹¹⁸

Why is there so little information on these and other female medical practitioners? Robert Shoemaker argues convincingly that records of women's activities were generally kept by men and reflected the biases of a male-dominated society.¹¹⁹ Whilst there are a number of autobiographies and case books of male practitioners, there are no equivalents from the female healers, and much has to be deduced from second or even third hand. Some women may have been practising little more than 'magic' or an extension of family remedies: middle and upper class women relied heavily on 'lay' remedies and swapped recommended remedies. Thus, Elizabeth Leathes of Norfolk in 1776 professed herself ignorant of medicine, but by 1783 had a medical reference book at home.¹²⁰ This was Dr William Buchan's *Domestic Medicine*, first published in Edinburgh in 1769, which popularised medicine and warned of the dangers of "physicians and quacks who rob ye of health and money", advocating enlightened self-care and educated auto-medication.¹²¹ The correspondence of Mrs Beatrice Lister of Gisburn Park and her daughter in Lancashire in the 1760s and 70s was often concerned with medicinal remedies.¹²² Moreover the concept of "every woman her own doctress" was derived from a tract based on the belief that "every woman of common abilities may be able to relieve herself by the method and remedies therein contained without any assistance".¹²³ Nevertheless, it was also advertised as a

¹¹⁷ Margaret Pelling, "Compromised by gender: the role of the male practitioner in early modern England", in Marland & Pelling (eds), *The Task of Healing*, pp.101-133.

¹¹⁸ Evenden, "Gender differences", pp.194-216.

¹¹⁹ Shoemaker, *Gender in English Society*, p.13.

¹²⁰ Rita Gallard, *Evidence from Correspondence of Elizabeth Leathes*, Research Progress Report, UEA, 2008.

¹²¹ John Mann of Moreton, *Recollections of my Early and Professional Life*, (London 1887), p.61. The use of Buchan's views is illustrated by Mann who "could always obtain [relief from heartburn] by taking a dose of magnesia in water. This recipe I met with in Buchan's 'Domestic medicine' then a very popular and useful work". However, Buchan was also clear that if the symptoms persisted or looked serious, the patient should go to a reputable practitioner.

¹²² Vickery, *Gentleman's Daughter*, p.155.

¹²³ John Ball, *The Female Physician or Every Woman Her Own Doctress*, (London, 1770), Preface, p.iv.

work of great “Utility to the young Physician, Surgeon and Apothecaries”, but not for midwives. Medical handbooks such as John Maubray’s *Female Physician* in 1724 or *The Ladies Dispensatory* of 1740 were designed similarly for women to help their families, as were conduct manuals, that stressed women’s domestic duties.¹²⁴

The relationship between the provision of food as a source of healing as well as sustenance was reflected in the success of ‘recipe’ books produced by upper class women (particularly those running large households) and being responsible therefore for the health and welfare of large numbers of both family and retainers. Manuscripts of the ‘recipe book’ of Elizabeth Okeover of Derbyshire in the late seventeenth century indicate that the whole family had an interest in medicine, but that Elizabeth stood out as a source of recipes, a lay practitioner and something of a medical authority within her own local circle.¹²⁵ Another example is Sarah Mapp, the daughter of a Wiltshire bone-setter, who had some success in the early 1730s, leading to a stage song being composed about her:

“What signifies learning or going to school
When a woman can do, without reason or rule,
What puts you to nonplus, and baffles your art.
For petticoat practice has now got the start”.¹²⁶

Although no distinct Suffolk examples of these remedy books and self-help manuals have been found, it is reasonable to suppose that these would have had a place in the libraries of the great houses and the domestic rooms of the middle classes.

A number of post-seventeenth century books on household management had sections on the treatment of illness and had prescriptions for cures. These included Timothy Roger’s *Character of a Good Woman* (1697), the definition of which included relieving “her poorer neighbours in sudden distress, when a

¹²⁴ Shoemaker, *Gender in English Society*, p.32.

¹²⁵ Aspin, “Okeover”, p.539.

¹²⁶ James Caulfield, *Portraits, Memoirs, and Characters of Remarkable Persons*, (London, 1819-20), Vol. 4, pp.77-85, quoted in Corfield, *Power and Professions*, p.145.

doctor is not [by]”.¹²⁷ Information on 56 London women practitioners between 1695 and 1725 suggests that the majority were in nursing and, of the eleven who were medical, eight were midwives, one cured cancers, one the pox, and one provided physic to the poor, the latter three engaged in alternative medicine.¹²⁸

All this supports to some degree the idea of ‘separate spheres’, which is in Ann Summers’ view “real enough by the early nineteenth century”.¹²⁹ She puts forward the view that there were different kinds of social ‘space’ for men and women, particularly where the womenfolk of increasingly prosperous tradesmen and farmers led lives of greater leisure. Ivy Pinchbeck suggested they were less likely to want or be allowed to gain higher education or pursue any sort of career.¹³⁰ Tim Hitchcock also describes the “heterosocial world” of domestic economy of the eighteenth century being replaced by the more “homosocial worlds” of home and work in the nineteenth.¹³¹ In terms of the professions, the articulation of higher standards of care, the increasing requirement of appropriate training and an emphasis on formal education meant that women were increasingly excluded. Indeed, better off families did not see professional occupations as at all appropriate for their daughters.

Summers argues that by 1830 women might be involved in the civil spheres (such as charity work and household management) but not the public spheres inhabited by the professions. She illustrates this change by citing several medical or quasi-medical families. Thus, the Taylors of Whitworth in Lancashire were irregulars (bone-setters and druggists) in medicine. Until the early nineteenth century daughters were actively involved in the family business, both in business and in clinical terms. However, after the 1815 Apothecaries Act, the focus changed to require qualifications such as LSA and MRCS. Daughters were excluded by reason both of educational attainment and

¹²⁷ Timothy Rogers, *The Character of a Good Woman: in a Funeral Discourse on Proverbs 3. 10*, (London, 1697), p.17.

¹²⁸ Earle, “The female market”, Table 5, p.10.

¹²⁹ Anne Summers, *Female Lives, Moral States: Women, Religion and Public Life in Britain, 1800-1930*, (Newbury, 2000), p.6.

¹³⁰ Pinchbeck, *Women Workers*, p.304.

¹³¹ Tim Hitchcock, “Redefining sex in eighteenth century England”, *History Workshop*, 41, (1996), pp.73-90.

social appropriateness. Similarly, the bone-setter Thomas of Anglesey and Liverpool included three sons and four daughters in the business in the late eighteenth century, but by the middle of the nineteenth century there were five sons medically qualified but no daughters following the family profession.¹³²

The increase in scientific knowledge was also associated with new interpretations of women's roles, involving the primary characteristic of women as 'natural' carers, with a more limited scope in the public sphere, together with a move away from the areas of midwifery and medicine.¹³³ More pointedly, Ehrenreich and English see "an active takeover by male professionals, resulting from their close service to the ruling class, both medically and politically".¹³⁴

However, A.L. Wyman suggests that there was more direct medical involvement by women than previously thought. Thus, in 1729 Mary Webb was indentured to Mrs Anne Saint, surgeonness, for seven years. Some eighteenth century overseers of the poor used women to treat both adults and children. Wyman quotes Mrs Walker in 1777 in Fulham being paid £2 2s 0d for "the cure of Cluver's leg" whereas, at the other end of the scale, the overseer at Foxton in Cambridgeshire "Paid Mary Green for doctoring Rutter's leg" a paltry 1s.¹³⁵ In terms of recognisable medical activity amongst women, the term 'surgeonness' was certainly in use in the eighteenth century, and though their skills and services varied, such women could thrive when medical help was scarce and expensive and where there was little to choose between the ministrations of regular doctors and the unqualified. Mrs Spouncer of Hull was in business from 1806-1815 and offered cures for insanity, though no records exist of women practitioners in the city before 1800.¹³⁶

¹³² Summers, *Female Lives*, p.9.

¹³³ Amy Denyer, *The Body, Science and the Emergence of Separate Spheres*. Unpublished PhD, University of East Anglia, 2004, Ch. 4.

¹³⁴ Barbara Ehrenreich & Deirdre English, *Witches, Midwives and Nurses: A History of Women Healers*, (London, 1974), p.3.

¹³⁵ A.L. Wyman, "The surgeonness: the female practitioner 1400-1800", *Medical History*, 28, (1984), pp.22-41.

¹³⁶ Bickford, *The Medical Profession in Hull*, pp.123. Mrs Spouncer had no qualifications, but in August 1815 she announced her arrival from York where she had been studying the causes of insanity and had had several successes in removing them.

In Suffolk, as the local medical profession was demonstrably from the ‘middling sort of people’, it is reasonable to conclude that women had some part to play in medicine and that the context described above was highly relevant to it. David van Zwanenberg lists 25 women practitioners active in the eighteenth century, fourteen of these after 1750, though none appear after 1800. Michael Muncaster’s study of Norfolk doctors active in the nineteenth century also does not refer to women doctors or doctresses at all pre-1850, which might support the general contention in current historiographies about the limited role of women.¹³⁷

The 25 specifically named female surgeons in Suffolk active in the eighteenth century support Wyman’s argument. Ann Turner, a Beccles surgeon, was mentioned above as apprenticed to Jesse Leeder and his wife on 5 May 1757 for a premium of £10.¹³⁸ Elizabeth Robinson “4 Sept 1777, a widow”, is listed as a surgeon in Cookley, though nothing is known of her practice. Similarly with Joanne Hunt of Bury St. Edmunds on 16 April 1767 and Francis Clarke of Brandon Ferry in 1770, who were both licensed by the Bishop of Norwich to practise surgery.¹³⁹ Although Episcopal licensing conferred status on any practitioner, its demise during the century was another factor in the absence of women practitioners; they ceased operating in London after 1721, but continued in the provinces in some places until the early 1800s. A number of women were also licensed as phlebotomists, such as Ann Bellward of Beccles in 1753, and Lettice Stannard of Huntingfield in 1770, but there was also an apparent decline in this practice.

Other women practitioners in Suffolk are only known through links with established medical men. Elizabeth Matchett was apprenticed to Henry Meen of Bungay on 31 January 1769 and Penny Stanton to Tyrell Carter {1748-1799}

¹³⁷ Muncaster, *Medical Services*.

¹³⁸ There is no further information about her whereabouts, and the assumption must be that she either moved away or ceased to practise, as otherwise some greater trace of such a rare event would seem likely.

¹³⁹ *SMB*.

in 1772.¹⁴⁰ Thomasina Dowsing, ‘widow of Worlingworth’, was apprenticed to Lawrence Rainbird {1733-1774} in 1716 for £40, although that year a Thomas Dowsing is also listed as apprentice for the same sum, an indication of the unreliability of the data. Priscilla Howes of Beccles, Mary Smith of Ipswich, and Margaret Swayne are listed, but no further information about them has been found to date.¹⁴¹ Martha Prettyman of Long Melford is also listed as having an apprentice in 1715; possibly she was part of the family then practising in the town. As described earlier, Rachael Stebbing (1775-1859), daughter of Ipswich surgeon George Stebbing (1749-1825), was trained as a midwife but assisted her father as a surgeon, though whether her reputation stemmed from practice or association with her father is unclear.¹⁴² Yet others are listed in *SMB* as partners of existing practitioners - Mrs Elizabeth Smith was in partnership with Thomas Mark Firman in Sudbury until this was dissolved for unknown reasons in 1758.

Given the limited corroborating information and the imprecise definitions of professional calling, any figures for Suffolk (and indeed elsewhere) require cautious use, not least because East Anglia was notable for folklore that included “the helpful or spiteful littler folk, the housewifely fairy, the walking ghost of haunted halls, and manor houses, and wise women who injured the cattle”.¹⁴³ These latter “professors of the healing art” could ‘bless’ or ‘charm’ away different maladies, a popular practice in rural counties, where ‘charmners’ were often highly respected members of the community, who had inherited their powers.¹⁴⁴ John Clyde quoted one instance:

“...a woman who obtained ‘hodmidods’ or small snails, which were passed through the hands of the invalids and then suspended in the chimney on a string in the belief that as they died the whooping cough would leave the children”.¹⁴⁵

¹⁴⁰ Percy Boyd, *Alphabetical Index of Apprentices. Inland Revenue Accounts 1768-9*. Typescript in Guildhall Library, City of London.

¹⁴¹ Wallis, *Eighteenth Century Medics*.

¹⁴² van Zwanenberg, “George Stebbing, 1517-1518”.

¹⁴³ Lady Eveline Camilla Gurdon, *Suffolk in Country Folklore*, (London, 1893), Introduction by Edward Clodd, p.3.

¹⁴⁴ The majority were women, though George Eliott’s hero, Silas Marner, was renowned as a charmer in his youth.

¹⁴⁵ John Clyde, *The New Suffolk Garland*, (Ipswich, 1866), p.171. He also quoted an instance at Monk’s Eleigh where a live frog was hung up the chimney in the belief that its death by such means would effect a cure.

Women healers were frequently used in preference to orthodox practitioners where speed was of the essence, for example in cases of household accidents such as scalding.¹⁴⁶ Thomas Sharper Knowlson's study refers to an inquest at Mendlesham Suffolk as late as 1893 where a charmer was sent for when a child pulled boiling soup over herself.¹⁴⁷ Such women were quite unlike quacks or "cunning-folk", when providing direct paid services, since the passage of money was said to deny the charm its efficacy, and "indeed the words 'please' and 'thank you' do not occur during the transaction".¹⁴⁸

They were very different from those paid for nursing, such as Dame Hurrell who appears frequently in the Wissington *Overseers Accounts* in the 1770s for nursing services, usually being paid at the rate of 3s. 0d per occasion.¹⁴⁹ This reference to payments for nursing or to generalised 'Dames' may simply have related to widows of the area with experience of child rearing and nursing, but in the overseers' accounts at Wissington, Dames Brownsmith, Cole, Barron, Burrow and Emony appear time and again in the 1760s. On 25 June 1763, Dame Burrows was paid 6s 0d "for looking after the Widow Lock for 12 weeks", and both Dame Cole and Dame Brownsmith in 1762 were paid for "keeping John Green's child or children". He had died the year before and his wife was ill (since there was an entry for paying for nursing for her in 1762), so it is reasonable to conclude that these good souls were paid to child mind. Sometimes nursing involved no more than laying out, as frequently the bill for nursing is accompanied the same day by a sexton's bill, as for example on April 15 1767 in Wissington, when Dame Green died.¹⁵⁰

This limited evidence suggests that women practitioners operated beyond the level of wifely administration or the bounty of the Lady of the Manor. The paucity and the general 'male' orientation of records and casework prevents

¹⁴⁶ Gurdon, *Suffolk Folklore*, p.12. She quotes pages of reports of such cures and arts, from cures for the whooping cough through preventing "swelling from a thorn" and the nightmare, sty or styney, through to St. Vitus' Dance.

¹⁴⁷ Thomas Sharper Knowlson, *The Origins of Popular Superstitions*, (London, n.d.), p.130.

¹⁴⁸ Clyde, *Suffolk Garland*, p.169.

¹⁴⁹ For example, Wissington, *Overseers Accounts*, 6 November 1770, SRA (Ipswich), FB 65/G1/1.

¹⁵⁰ Wissington, *Overseer's Accounts*, 15 April 1767, SRO (Bury St. Edmunds), FB 65/G1/1.

firm or more detailed conclusions, beyond the suggestion that the woman's role declined as the medical profession became increasingly male dominated. Significant levels of training and education, a formal regulation for entry and the expectations concerning a lifelong vocation that could not be part-time, were also influential. The scattered female practitioners were not sufficiently organised or numerous to form a lobby or establish any kind of rival tradition. Perhaps this change came more slowly in Suffolk than in the major towns, as enforcement of such developments was more difficult, but it nevertheless occurred. Still Elizabeth Garrett Anderson (1813-1903) of Aldeburgh brought the tradition of female healing up-to-date by persuading the Society of Apothecaries to grant her Licentiate status in 1856.

Overall it is difficult to escape Rosemary O'Day's conclusion that full-time male practitioners tended to marginalise the unpaid part-time care formerly provided by women, and "female involvement remained concentrated in the foothills of the profession".¹⁵¹ However, Stephen Jacyna's more recent conclusion that by 1800 medical men had largely succeeded in supplanting women in areas such as midwifery where they had previously been dominant is more risky.¹⁵² This, as with Joan Lane's dismissal of women practitioners prior to the nineteenth century, may be too strong because, before the increased rigor of licensing, there were women practitioners of varying degrees of expertise and specialism in the rural parts of the country like Suffolk. Some were merely continuing their husbands' practices, others actively saw patients. Still others were druggists and empirics, continuing the traditional role of medicine through diet and regimen, rather than science, and more midwives attended to the poor and lower middle classes, if often at the request and under the direction of a male practitioner. These conclusions reflect the need for more research nationally and provincially into other primary sources to evaluate more closely how far this conclusion is a reflection of new evaluations of women's roles in healthcare delivery.

¹⁵¹ O'Day, *The Professions*, pp.144-145.

¹⁵² Stephen Jacyna, "Medicine in transformation 1800-1849", in William F. Bynum *et al.* (eds.), *The Western Medical Tradition 1800-2000*, (Cambridge, 2006), pp.11-110.

CHAPTER 8: INCOME AND STATUS

8.1 Income

“Let both physicians and surgeons never forget that their professions are public trusts, properly rendered lucrative whilst they fulfil them”.¹

Medical professionals, once established, were essentially members of the middle class, not capitalists but, as Max Weber described it, an ‘acquisition’ class basing their position on ability and technical training.² More recently, Penelope Corfield argues that this means that professionals (like doctors) command assets as “mental capital”.³ The emphasis in current historiographies on urban and metropolitan experience in describing the social backgrounds, education and training of medical practitioners is equally apparent when turning to their range of practice, incomes and general standing in the community.

For most Suffolk practitioners it was essential to have several sources of income, because local populations were smaller than in metropolitan areas, the distances involved were great, and the numbers of wealthier private patients prepared to rely solely on a country practitioner were limited. Hospital appointments figured more prominently in the income and standing of urban practitioners, but these were relatively scarce before 1830 in Suffolk.⁴ Nevertheless, other posts, for example relating to Poor Law provision or militia appointments were available, as well as other activities such as farming.

Much research on the income of medical practitioners in the eighteenth and early nineteenth centuries focused on celebrated figures, nearly all practising in London.⁵ Provincial studies, such as Irvine Loudon’s review of the Pulsfords

¹ Thomas Percival, *Medical Ethics or a Code of Instituts and Precepts adapted to the Professional Conduct of Physicians and Surgeons*, (London, 1803), p.52.

² Max Weber, *Wirtschaft und Gesellschaft*, (Turbingen, 1922), trans. as *The Theory of Social and Economic Organisations*, edited by T.Parsons, (New York, 1964), pp.424-7.

³ Penelope J. Corfield, *Power and the Professions in Britain, 1700-1850*, (London, 1995), p.177.

⁴ See Chapter 5, pp.157-158.

⁵ Irvine Loudon, *Medical Care and the General Practitioner 1750-1850*, (Oxford, 1986), p.99.

of Wells, suggest that “the second half of the eighteenth century must have appeared a golden period for medical practitioners”.⁶ However, trying to identify their income sources is a problem because few account ledgers have survived, although there is other evidence in Suffolk such as parish Poor Law records and press reports that no doubt are equally extant in other provincial counties. The danger is that the lack of data from the doctors themselves and their private patients may distort the picture that has emerged. With this in mind, the general conclusion is that most Suffolk practitioners received sufficient income to live moderately well, but at a lower level than implied by Loudon, and they did not become significantly better off over the period under review. If anything, their levels of prosperity in the early nineteenth century decreased, possibly reflecting a continuation of the eighteenth century trend.

Professions in Great Britain are defined by Juanita Burnby as occupations requiring of their members a good education and a particular career specialisation, with an expertise valued by the community.⁷ This definition suggests a notion of public service and an overseeing body with powers of registration, supervision and regulation, and indeed by the middle of the eighteenth century surgeons in London had to satisfy their colleagues of their standard of education and fitness before they could commence training.

However, some Suffolk doctors failed such tests. Aldeburgh surgeon and apothecary George Crabbe (1754-1832) and several of his colleagues were neither accredited in any way nor belonged to a professional organisation. Others, while claiming some qualifications, were not subject to effective regulation: as Chapter 5 demonstrated, qualifications were not always genuine and, despite bitter complaints, some medical practitioners like Crabbe set up and worked without license with fair impunity. Geographical distance often confounded changes in medical regulation and training, making

⁶ Irvine Loudon, “The nature of provincial medical practice in eighteenth century England”, *Medical History*, 29, (1985), 1, pp.1-32.

⁷ Juanita G.L. Burnby, “An examined and free apothecary”, in Vivian Nutton and Roy Porter (eds.), *The History of Medical Education in Britain*, (Amsterdam, 1995), pp.16-36.

professionalism in terms of accredited qualifications and authorised expertise less obvious in counties like Suffolk compared to the more urban areas.⁸

There were however many who, like John Green Crosse (1790-1850), also believed that young doctors who were setting up needed to remember that “People wish not only to be cured but to be amused into the bargain”. He felt that to get on, a practitioner needed to be able to:

“talk well and agreeably besides knowing well his profession, a good person, cheerful manners, assiduity, kindness, humanity... Trickery, vain boasting and irregular professional conduct gain great employment for a time but no permanent renown and no lasting recompense”.⁹

Examples of dedicated doctors include George Stebbing (1749-1825), who served the poor of Ipswich for 50 years, a career celebrated by a gift of 20 guineas presented to his daughter, Rachel, in token of the respect in which he was held.¹⁰ Thomas Gibbons (1731-1803) was an example of a practitioner so concerned to share his experiences and cases that he published a series at his own expense for other doctors to read and comment on.¹¹ If such an act implied an egotistical element, the case notes of William Goodwyn (1746-1815) and William Travis (1786-1873) furnish clear evidence of hard-working, caring, concerned professionals, putting patients’ interests first.¹² There is little evidence that the slender tentacles of regulation provided by the Society of Apothecaries and the RCS reached Suffolk, but there are signs of comparable ethical and committed patient-focussed activity.

Irrespective of the strength of their vocational drive, many practitioners were probably attracted by the potential income of the medical profession, particularly through private practice, where concern for a patient’s health

⁸ See Chapters 4 and 5.

⁹ V. Mary Crosse, *A Surgeon in the Nineteenth Century - the Life and Times of John Green Crosse*, (London, 1968), p.150.

¹⁰ David van Zwanenberg, “George Stebbing of Ipswich 1749-1825”, *British Medical Journal*, 283, (1981), pp.1517-1518.

¹¹ Thomas Gibbons, *Medical Cases and Remarks*, (Ipswich, 1789).

¹² William Goodwyn, *Diaries at Earl Soham 1746-1816*, SRO (Ipswich), IC/AA2/114/81; Ronald B. Beckett (ed.), *John Constable’s Correspondence: The Family at East Bergholt 1807-1837*, (London, 1987).

would no doubt be coupled with concern for his or her wealth. Medicine was a competitive business and “developing a viable practice involved the ability to discern a practice niche, possession of social connections and social networking to develop it”.¹³ Some routes were common to both town and country, and a doctor who inherited a practice from his father or other relative had a particular edge, frequently seen in Suffolk where there were many family connections, like the Beck and Denny dynasties.¹⁴

Each practice area was regarded as an investment and, if not passed to a relative, was sold as a going concern. Some fortunate young doctors had the necessary capital to buy a practice, for example George Green Sampson (1804-1885) who bought William Hamilton’s (1789-1855) practice in Ipswich for £100 in 1827.¹⁵ Others gambled on setting up in growing towns in the vicinity of the existing practice, establishing themselves and then moving into the main practice centre later. Thus, John Girling {1788-1789}, surgeon, apothecary and man midwife advertised in 1788 that he had “taken the shop of the late Mr Reynolds”.¹⁶ This was clearly not a going concern, as he was involved the same year in a careful arrangement with an apothecary, Mr Brunwen, in Nayland to share a practice, one third and two thirds. Girling submitted a one year bill to Brunwen that covered amongst other things his annual board and lodging, allowance for a manservant to look after his horse, the rent of a shop, house and stables and two thirds of his drugs.¹⁷ This presumably served as a trial arrangement, because when Brunwen died a year later Girling took over his practice.¹⁸ Another example was Robert Carew King (1781-1842) who went to live in Yoxford, first in partnership with Saxmundham surgeon Henry Denny (1798-1805), before moving to Saxmundham himself when Denny died, to continue the practice in agreement with Denny’s widow.

¹³ Anne Digby, *The Evolution of British General Practice 1850-1948*, (Oxford, 1999), p.13.

¹⁴ Chapter 3 discussed in detail the medical dynasties in Suffolk.

¹⁵ David van Zwanenberg, Personal communication from Dr D. Ryder Richardson (1893-1973) of Saxmundham, SMB.

¹⁶ *Ipswich Journal*, December 1788. It was possibly the shop of J. Reynolds, who was recorded in the *Journal* as practising in Yoxford and Wickham Market in September 1783.

¹⁷ The bill was found in the papers of the Alston family of Alston Court Nayland, SRO (Bury St. Edmunds), HA 541/1/28-30.

Others without such resources opted for assistantships with established practitioners in the hope of succeeding to the practice. In Aldeburgh in 1774, George Crabbe became assistant to James Maskill {1771-1775}, said to be an odd man and rather loose living.¹⁹ He quit Aldeburgh suddenly for reasons unknown, leaving Crabbe in possession of his apothecary's shop and drugs.²⁰ More conventionally, Vero Kemball {1774-1794} took his former assistant Antony Jones into partnership in November 1794, while Thomas Bayly (1750-1834) went to Stowmarket as an assistant, became a partner and in turn handed his practice to his partner, James Bedingfield (1787-1860) in 1820.

The incumbent could rely on either family reputation or the outgoing doctor's encouragement to patients to transfer their allegiance. Thomas Rust {1710-1764} of Bacton advertised to his predecessor's patients that "he begs all those gentlemen and others who were Mr Spencer's patients etc...".²¹ Similarly, Richard Smith {1751-1788} moved to Sotherton in August 1780 with "hopes for the favour of patients of the late Mr Manning of Wangford".²² Keeping the patients of one's predecessor was clearly vital to early success financially. Noticeably, in rural communities patients might adhere to one doctor through custom and family ties with practitioners actively promoting life long dependence, from birth to death. Local populations were less likely than urban counterparts to consider medical hierarchies and preferred rather to seek the services of more generic than specialist practitioners, with reputation and word of mouth recommendations important in retaining a reasonable clientele. Nevertheless, when William Bevil {1764} took over Edward Beck's {1753-1764} surgery at Needham Market, he felt it important to

¹⁸ *Ipswich Journal*, January 1789.

¹⁹ John Glyde, *New Suffolk Garland* (Ipswich, 1866), p.122. He quotes the following story: "Mr Crabbe, the first time he had occasion to write his name, chanced to misspell it 'Maskwell', and this gave great offence. 'D...n you sir,' he exclaimed 'do you take me for a proficient in deception? Mask-ill - Mask - ill: and so shall you find me'".

²⁰ Revd. George Crabbe, Jnr, *The Poetical Works of Revd. George Crabbe with his Letters and Journal, and His Life*, (London, 1834), pp.9-10.

²¹ *Ipswich Journal*, June 1761.

²² *Ipswich Journal*, April 1780.

increase his attraction by advertising that he had “past attended the lectures of the best Professors in London and was a pupil in the Middlesex Hospital”.²³

By the mid-eighteenth century setting up in medical practice, particularly as an apothecary or surgeon, was seen as a cheap option, with few materials required. According to Richard Campbell, “An ingenious surgeon, let him be cast on any corner of the earth, with but his Case of Instruments in his Pocket, he may live where most other Professions would starve”.²⁴ Yet Suffolk differed from Campbell’s London in terms of presenting rarer opportunities for consulting work, a reduced density of potential private patients, and higher expenses such as the travelling involved and the additional surgery cover, both domestic and clinical. Hence it was harder to become and remain established, let alone make a respectable and sustained living. A practitioner needed a house in which to see patients, some form of transport if his practice was in the country, and domestic servants together with financial support in anticipation of patients. If these were not part of the partnership or inheritance, then considerable capital investment was required, on a scale beyond people like Crabbe.

The early days of practice in country areas were usually the most difficult time, as the young practitioner tried to get established. Christian Esberger in Lincolnshire experienced “a considerable decay in my accounts” in July 1764 and by December “I have at present hardly any patients, not one of any significancy to confine me”.²⁵ His case was replicated in Suffolk and contemporary journals show numbers of doctors relinquishing practice after a short time, or moving to fresh pastures. The *Ipswich Journal* in February 1811 carried an advertisement from a Mr Blake, announcing that he had settled in Halesworth and “intended to practise” and then no more was heard of him. Christopher Armstrong {1728-1783} set up in Bildeston as a surgeon in 1780,

²³ *Ipswich Journal*, March 1764.

²⁴ Richard Campbell, *The London Tradesmen, Being a Compendious View of all the Trades, Professions, Arts, Both Liberal and Mechanical, now Practised in the Cities of London and Westminster*, (London, 1747), p.57.

²⁵ Joan Lane, *A Social History of Medicine: Health, Healing and Disease in England 1750-1950*, (London, 2001), p.15.

but within two years he advertised he was “inclined to leave off practise (sic), and wishes to sell his shop”, selling also his furniture and house in 1783.²⁶ Reasons were not given in most cases. According to one contemporary pamphlet:

“To attract a suitably lucrative clientele, be it among artisans and shopkeepers or among gentry and aristocracy, practitioners had to cultivate appropriate social behaviour as much as acceptable medical knowledge and skill”.²⁷

Charles Dunne similarly noted that:

“the apprenticeship of young surgeons to apothecaries was a most desirable practice... because it was possible by such a system ever to acquire the manners of a gentleman so essential to surgeons in their private practice, whether in the army, the navy or in private practice”.²⁸

Professionals as a social group seemed to have acquired an identity in the late seventeenth and early eighteenth centuries as “interchange and cross-fertilisation of beliefs and standards occurred between clergy and attorneys, medical practitioners of all hues and the parsonage or manse”.²⁹ Indeed, Erasmus Darwin suggested that a young man should first use all means to “get acquainted with people of all ranks, decorate his shop window attractively and appear in public at the farmers’ ordinary on market days, at card assemblies and at dances”.³⁰ This was as true in Suffolk as in London. Thus the apprentices of John Page (1730-1794) of Woodbridge formed a strong social circle with other apprentices, relationships that stood a number in good stead as they became established doctors in the area; for example George Crabbe and William Springall Levett (1755-1774) of Framlingham. Regular church going was also a means of indicating respectability: “I intend to be there [at

²⁶ *Ipswich Journal*, August 1782 and February 1783.

²⁷ Susan C. Lawrence, “Anatomy and address: creating medical gentlemen in eighteenth century London”, in Vivian Nutton & Roy Porter, *The History of Medical Education in Britain*, (Amsterdam, 1995), pp.199-228.

²⁸ Christopher Dunne, *The Chirurgical Candidate or Reflections on Education Indispensable to Complete Navel, Military and Other Surgeons*, (London, 1808), p.36.

²⁹ Rosemary O’Day, *The Professions in Modern England: Servants of the Commonweal*, (Harlow, 2000), p.239.

³⁰ Desmond King Hele (ed.), *The Letters of Erasmus Darwin*, (Cambridge, 1989), p.206.

the Cathedral] every Sunday morning as attention of this kind is necessary in a professional man” wrote a world-weary young man from Norwich in 1783.³¹

Private practice was the desirable bedrock of country practice, involving persons above the scope of the Poor Law or not covered by medical clubs, whose circumstances permitted them to receive medical attention on a paying basis. Generally, private patients ranged in their social and economic ranks from the county nobility through to the tradesmen and farmers, their use of medical practitioners varying as widely as their social class. As suggested in Anthony Trollope’s *Dr Thorne*, the former were more likely to call in a physician or surgeon from London if matters deteriorated, though the local surgeon would have dealt with initial consultations, children and lesser members of the family.³² There are few Suffolk examples and such occasions seem largely to have been in emergencies.³³ Thus, William Norfold (1715-1793) of Bury St. Edmunds attended the Earl of Bristol in 1774, and again in 1776 when the Earl was dragged from his horse.³⁴ The lower gentry, merchant and tradesmen classes were more likely to use the apothecary or surgeon as the equivalent of a modern general practitioner. John Steggall (1789-1881) noted how “rich fat farmers, and their wives and daughters were all our best subjects in the Esculapian profession”.³⁵ If the practitioner had enough wealthy patients and his practice was well managed, he could make a reasonable income. Burnham Raymond (1740-1822), surgeon and apothecary, had a healthy private practice among the relatively small number of the well to do in Aldeburgh, while George Stebbing had a wide range of merchant and gentry clients in Ipswich.³⁶

To acquire a reasonable private practice in the rural provinces, it was essential to have a reputation for skill and kindness. Word of mouth regarding

³¹ Basil Coxens-Hardy (ed.), *The Diary of Syllas Neville 1767-1788*, (London, 1950), pp.312-313.

³² Anthony Trollope, *Dr Thorne*, (first published London, 1858), (Pan Books, London, 1968).

³³ Examples were the Earldoms of Cranbrook at Great Glemham and the Stradbroke of Henham Park, and lesser aristocracy such as the Vernon-Wentworths at Aldeburgh and the Tollemache family at Helmingham Hall.

³⁴ *Ipswich Journal*, July 1776.

³⁵ Richard Cobbold (ed.), *John H. Steggall - a Real History of a Suffolk Man Narrated by Himself*, (London, 1857), p.189.

a successful medical intervention or a considerate and attentive practitioner would carry more effectively than in a busy metropolis where practitioners of all kinds were so prevalent. Moreover, the country doctors lived in the communities they served and needed to ensure that their reputations as social and professional people were maintained and enhanced every time they visited a patient. In country areas (and Suffolk had few major towns) this was even more vital as private patients were scarce and news, both good and bad, would spread quickly.

In addition to their private practice, many Suffolk practitioners held Poor Law contracts or positions of various kinds to supplement their incomes. It is likely that the importance of Poor Law work as part of medical income varied across the country, but its considerable importance for Suffolk practitioners was significant. Robert Kerrison's *Inquiry* noted that:

“it has been the prevailing custom of the Overseers, usually farmers and illiterate traders, who have not correct notions of true medical character, to receive annual tenders at Easter for the medical care of the sick poor of the district, the lowest bidder is the successful candidate. The certain effect of this is to throw the general management of paupers into improper hands”.³⁷

He cited letters from many counties, including Suffolk, illustrating unfeeling conduct by overseers and gross ignorance and culpable negligence among parish doctors. Anne Crowther's study found that the reputation for a parish surgeon was generally low, and overseers usually employed the lowest bidder, with little concern for qualifications.³⁸ Similarly, Anne Digby describes paid offices for medical practitioners as “a hierarchy of esteem with the hospital or government appointment at the peak, and the Poor Law or club appointments at the bottom”.³⁹

³⁶ SMB.

³⁷ Robert Masters Kerrison, *An Inquiry into the Present State of the Medical Profession in England*, (London, 1814), p.35.

³⁸ M. Anne Crowther, “Paupers or patients? Obstacles to professionalisation in the poor law medical service before 1914”, *Journal of the History of Medicine and Allied Sciences*, 39, (1984), pp.33-54.

³⁹ Digby, *Evolution of British General Practice*, p.14.

However, Irvine Loudon concludes that the advantage of the old Poor Law system was that it paid the same rate as private practice and so was not despised by practitioners, while “the parish surgeon was the familiar local doctor whose concern for his reputation in his community would have made him generally careful and considerate to the poor”.⁴⁰ Joan Lane agrees that most surgeon apothecaries looked upon Poor Law work as a useful and reliable source of income, especially where a parish contract was involved rather than a fee for each pauper treated.⁴¹

Clearly the services of a doctor or surgeon in a workhouse were vital because of the prevalence of infirmity, sickness and disease, and the Suffolk evidence suggests that the overseers of the poor often matched private charges. For example, in 1775, those in South Cadbury paid the parish surgeon 15s 6d for one journey and “setting the lad’s collarbone”, a fee comparable to that charged by William Goodwin to a private patient.⁴² However, Loudon and others may be offering an over-optimistic interpretation, since such work might be stigmatised: in Aldeburgh, Crabbe’s willingness to attend on the parish poor in the workhouse discouraged more respectable clients from seeking his help.⁴³ On the other hand, services to medical charities or the parish could also be perceived largely as indirect rewards in securing connections and enhancing reputation. George Stebbing combined a successful private practice with serving as prison doctor and providing Poor Law medical care. Unless a practitioner was well-established like Stebbing, he probably needed the income but, conversely, if he was established in the area, he would not want potential rivals to obtain such work, so competition for Poor Law contracts could be considerable.

Poor Law doctors had to reconcile their obligations to patients with the Poor Law’s intention of deterring paupers from seeking relief, the hard-nosed activities of the overseers, and the additional workload attaching to the

⁴⁰ Loudon, *Medical Care*, p.232.

⁴¹ Lane, *A Social History*, p.18.

⁴² Goodwyn, *Diaries*.

⁴³ Neil Powell, *George Crabbe: An English Life 1754-1832*, (London, 2004), p.34.

task.⁴⁴ There was also considerable ambiguity about the attitude of Poor Law authorities to the medical profession, with many seemingly regarding doctors as ‘two a penny’. By 1826, John Asplin was commenting in his diary:

“April 2 1826: Attended Vestry meeting. They pay the medical men so badly in this Parish for attending the poor that no one will take the parish on the terms offered. £60 per annum is demanded, the parish offer £45 and have risen to £50. Mr Hardwick called in the evening; he tells me that someone from Rayleigh is about to take the parish”.⁴⁵

Sometimes, Suffolk contracts were for the practitioners to attend as necessary and be paid on demand, such as between the Wissington Overseers and surgeons Francis Quarles {1730-1753} of nearby Nayland, and Thomas Mark Firman {1748-1786} of Sudbury in the mid-1760s.⁴⁶ Similarly, Francis David Mudd (Snr.) (1740-1835), surgeon of Gedding, sent a bill for attendance to the Rattlesden Overseers on 2 April 1809:

“...at midwifery for Anne Chinery costing £2 2s, 18 June ten journies, reducing applications and cure of a fractured thigh (Grimwood child) £3 3s, attendance and medicine from March to April 1809 £5 5s”.⁴⁷

More commonly, surgeons were offered a parish-wide contract, solely for workhouse inmates or for the whole parish, for terms between one and five years.⁴⁸ Accordingly the overseers agreed in 1796 to pay “Mr Birch, surgeon, for looking after ye Poore of Little Waldringfield £2 12s 6d”.⁴⁹ Similarly, John Nursey {1758-1791}, surgeon and apothecary of Debenham and Stonham, in April 1764 agreed “to supply the poor of Coddensham with medicine and physick”.⁵⁰

Some were appointed surgeon to the poor to one Division within a Hundred, then the area of local government. For example, Henry Aldrich {1737-1769} in

⁴⁴ Crowther, “Paupers or patients”, p.36.

⁴⁵ *Diary of John Asplin, Surgeon-Apothecary*, 1826, in A.E.F. Brown, *Essex People 1750-1900*, (Chelmsford, 1972), pp.137-145. MS diary is at Colchester Central Library E 029.6.

⁴⁶ Wissington, *Overseers Accounts*, SRO (Ipswich), FB 65/6/1.

⁴⁷ Rattlesden, *Overseers Account Book*, SRO (Bury St. Edmunds), FL 500/7/2.

⁴⁸ Ray Whitehand, *At the Overseer's Door: the Story of Suffolk Parish Workhouses*, (Saxmundham, Suffolk, 2007), p.45.

⁴⁹ Little Waldringfield, *Overseers Book*, SRO (Bury St. Edmunds), FL 645/7/2.

⁵⁰ Overseers accounts, *East Anglian Notes and Queries*, Vol. X111.

1749 charged Wenhamston Parish two guineas to attend its poor, “broken bones extra”.⁵¹ By 1768, when he was appointed surgeon to the poor of the second divisions of Blything Hundred, he was paid £20 per annum.⁵² Wrentham surgeon Hustings Wilkinson (1711-1781) was appointed to the third division of the Blything Hundred at £21 per annum in 1766 and re-elected to that post at £20 per annum a year later after the workload was reviewed.⁵³ This was clearly the going rate, with Bayley Benjamin Primrose (1741-1817) similarly appointed surgeon to the third Division of Blything Hundred in 1768. John Bucke (1756-1839) of Ipswich, Bungay and Mildenhall was paid just £6 6s 0d a year for attending the poor of St. Lawrence Parish in Ipswich, rising to £9 9s 0d in 1813, an illustration perhaps of the differentiation of work between a parish and the large hundreds.

Salaries were negotiated and often subject to tender. For example, in 1823 overseers of St. Mary’s parish in Thetford received tenders for the post of parish doctor from surgeons Henry Woodruffe Bailey (1788-1873) and Henry Waddelow Best (1807-1863). Both offered inclusive terms for medicine, surgery, vaccination, midwifery and casualty treatment at fixed sums of fifteen pounds and fourteen guineas per annum respectively, irrespective of work done.⁵⁴ In contrast, other practitioners had lifelong contracts. George Stebbing was surgeon and apothecary to St. Margaret’s Parish in Ipswich for 50 years.

Workhouses nearer to a large town were more likely to involve a contract, rather than the fluctuating and highly irregular sums paid annually to the surgeons in rural and remote parishes. Some contracts were attached specifically to a House of Industry, as with that in 1825-26 for George Doughty Lynn (1780-1854) “to the House of Industry and Paupers residing in

⁵¹ Wenhamston, *Parish Account Book*, SRO (Ipswich), FC 189 G1/2-19.

⁵² Blything Hundred, *Minute Book*, 1768, SRO (Lowestoft), 124/G11/1. The *Minute Book* of the following year gives a good example of the work of the parish surgeon: “Simon Barnaby, a poor boy lately hurt by an ass who has had his arm taken off being reported by Mr Henry Aldrich, surgeon, well enough to be removed - ordered that he be admitted to the House” (i.e. Blything Hundred House of Industry).

⁵³ Blything Hundred, *Minute Book*, 1767, SRO (Lowestoft), 124/G11/1.

⁵⁴ Thetford, *Overseer’s Account Book*, Norfolk Record Office, C/GP/17.

Woodbridge.⁵⁵ Others stipulated an area, beyond which any visits attracted an additional fee. Thus, R.Y. Bowle {1813} agreed to a contract of fourteen guineas per annum to treat the poor of Redgrave in 1813, but stipulated that he would only visit within two miles of the parish and would expect extra remuneration if he had to go further. A Mr Brooks was paid 18s 6d for journeys and medicine on 6 March 1826 because the deceased lived more than four miles outside the parish boundary of Great Ashfield.⁵⁶

Most importantly, the contract meant that the overseers could predict expenditure on the sick poor, facing additional bills only for such matters as fractures and midwifery, as for example in 1777 when Dr Nelson charged two guineas to the Tostock Overseers for the task of “laying Thomas Copsey’s wife”.⁵⁷ Similarly, Bardwell Ash Parish recorded:

“Mr Cavell to attend the Poor in the Parish of Bardwell Ash and adjoining Parishes for the sum of ten guineas from Easter 1810 to Easter 1811. To be allowed extra for fractures one guinea each, and in cases of Midwifery ten and sixpence each”.⁵⁸

Occasionally practitioners joined forces to tender for Poor Law work. Thus, John Garneys (1727-1798) of Yoxford was appointed along with Robert Denny (1738-1801) as surgeon to the poor of the fourth and fifth divisions of the Blything Hundred at four pounds per annum. When Boxford surgeon William Wynne {1795-1824} agreed to attend the poor within a five mile radius of the village together with Nathaniel Salter (1770-1829) at £21 0s 0d per annum, they negotiated an inclusive contract:

⁵⁵ Other examples are Mr Blomfield of Woodbridge (Bredfield, Boulge, Bromswell, Chardsfield etc); Mr Harsant of Wickham (Campsey Ash, Easton, Hacheston, Marlesford etc); Mr Hughes of Shottisham (Alderton, Bawdsey, Butley, Boyton etc); and Mr Bellman of Earl Soham (Brandeston, Creethingam, Earl Soham, Hoo etc), Suffolk Papers, “*Song of Old Bungay*”, 10351 i10J (BL).

⁵⁶ Great Ashfield, *Parish Accounts*, SRO (Bury St. Edmunds), FL 520/5/13.

⁵⁷ Tostock, *Overseers Account Book*, SRO (Bury St. Edmunds), FL 642/2/6. Similarly John Slaytor (1788-1856), surgeon of Woolpit, having agreed to look after poor of Elmswell in 1822 for £12 0s 0d *per annum*, was paid half yearly on “25 March 1822 paid £12.0s 0d” but charged another guinea for midwifery. (Elmswell, *Town Book*, 25 March 1822, SRO (Bury St. Edmunds), FL 513/7/2) and Patrick Vincent (1805-1885), surgeon of Lavenham, agreed with the overseers of Little Waldringfield to look after the poor for £7 10s 0d *per annum* but with midwifery cases charged similarly, Little Waldringfield, *Overseers Book*.

⁵⁸ Bardwell Ash, *Overseers Account Book*, SRO (Bury St. Edmunds), FL 507/7/1, 15.

“for and in consideration of the sum of twenty pounds of to be paid half yearly lawful money of Great Britain... to attend illnesses, afflictions, and diseases incident and attendant upon the human body, that is to say Small Pox, measles, Fractures, Dislocations of all kinds and shall also administer and apply to the said poor during such Illness as aforesaid such good and sufficient Medicines Potions and Plaisters as shall be thought necessary”.

In addition, midwifery cases were included “where the women employed by this said parish shall not be competent to deliver (but not otherwise)”.⁵⁹

Conversely, some practitioners served more than one parish. Thomas Firmin was not only contracted to Wissington but also to Wiston Overseers. The latter received his bill in 1760 for £6 10s 6d for the period February 10 to April 20 covering numerous journeys, bleedings (1s 0d), elixirs, mixtures pills and potions (1s 0d - 3s 0d), all entirely apothecary activities with no surgery involved at all. In 1767, the same parish appears to have changed to a contract arrangement and paid William Fairclough {1756-1790}, surgeon and man midwife of Nayland, £3 9s 3d for journeys and medicines for six months, again with no surgery involved, but clearly much cheaper. Fairclough seems to have replaced Firmin, and was simultaneously on contract to neighbouring Wissington.⁶⁰ Beccles surgeon Charles Dashwood (1775-1865) was clearly a multi-parish contractor: he advertised over six years for an apprentice “to look after the paupers of 22 parishes and Shipmeadow House of Industry”.⁶¹

Smallpox inoculation was often considered separately too.⁶² Richard Smith was appointed surgeon to the poor at the Blything Hundred Poor House at £36 15s 0d per annum, with inoculations excluded and, when directed to inoculate the children and willing adults in August 1767, he charged 7s 6d per person.⁶³ At Fressingfield, during an outbreak of smallpox in 1797/98, the overseers contracted ‘Dr Girling’ (possibly John Girling of Wickham Market) and ‘Dr French’ (possibly William French of Needham Market) to inoculate twelve inmates.⁶⁴ The *Woolpit Town Book* noted tersely in April 1783 “James Barton

⁵⁹ Boxford, *Overseers’ Accounts*, 1 October 1796, SRO (Bury St. Edmunds), FB 77/G1/3/40.

⁶⁰ Wiston, *Overseers Account Book*, SRO (Bury St. Edmunds), FB 65/G2/16.

⁶¹ *Ipswich Journal*, June 1802, 1806, 1807.

⁶² See Chapter 6 for details of smallpox practice.

⁶³ Blything Hundred, *Minute Book*, 1768-69.

⁶⁴ Fressingfield, *Accounts*, SRO (Ipswich), EG 16.

for spots £1.1s”, and Widow Barton for spots £1.00 in October the same year, and again in the following year.⁶⁵

Surgeons in Suffolk, as elsewhere, were not usually employed by the authorities for conditions such as consumption, jaundice, ringworm, measles and miscarriages, and rarely for fever or burns. Occasionally they were consulted for rheumatism, scrofula, erysipelas, wounds and venereal infections. Oculists were used where they were established in towns like Coventry or Banbury, with patients sent to them for treatment, and board and lodging paid.⁶⁶ There were advertisements for similar in the *Ipswich Journal* throughout the period of review.

There were many instances in Suffolk of disagreements, often based on overseers’ suspicions that they were being overcharged. For example in January 1829, James Bedingfield (1787-1860) was in dispute over payment for attending paupers in Stowmarket, and Richard Freeman (1768-1831) appeared as witness in the ensuing lawsuit.⁶⁷ When George Crabbe started in Aldeburgh as apothecary, his rival, Burnham Raymond (1740-1822) was in dispute with the parish over payments, having agreed in 1770:

“to attend all the parish poore that are now chargeable... for twenty shillings a year for which sum I engage to supply them with all necessaries as are wanting in the Physical Surgery or Midwifery way (fractures excepted)”.

Not surprisingly, the following year he asked for more to help him keep up Raymond Cottage in the High Street and “sport a gold headed cane”,⁶⁸ the overseers begrudgingly raising the rate to £4. 14s. 6d. When the parish then sought “to Imply the Cheapest Doctor that can be found” for inoculation, Raymond did not consider this within his contract and “there was a certain amount of coolness existing between the Towne authorities and the doctor”.⁶⁹

⁶⁵ Woolpit, *Town Book*, SRO (Bury St. Edmunds), FL 657/1/1.

⁶⁶ Lane, *The English Patient*, pp.151-156.

⁶⁷ *Ipswich Journal*, 10 January 1829.

⁶⁸ Arthur T. Winn, *Records of the Borough of Aldeburgh - The Church*, (Hertford, 1926), p.28.

⁶⁹ Aldeburgh, *Parish Vestry Minute Book*, Friday 9 April 1773, SRO (Ipswich), FC 129/E1/1.

By 1775 he was replaced by the younger, cheaper and less difficult Crabbe, and they required him “to cure the boy Howerd of the itch and that whenever any of the poor shall have occasion for a Surgeon or that the Overseer shall apply to him for that Purpose”.⁷⁰ His payment noted in the *Borough Account Book* in January 17 was “Dr Crabbe by bill £4 0s 3d”, an interesting use of title ‘Doctor’, perhaps driven by the fact this ambitious father was a member of the Parish Council.

There were also cases of alleged negligence. For example, in June 1767 a letter from Mr Fisher of Cratfield reported correspondence with Mr Garneys:

“...for our patients at Cratfield to attend Elizabeth Read, a pauper being very ill and Bedrid, and that he had neglected attending. Ordered that the Clerk do write to Mr Garneys and inform him that this Board are greatly displeased at this omission and ordered that he do forthwith attend her and inform the Clerk by letter if it be possible to remove her in a carriage and if so the Clerk do send a Post Chaise from Halesworth for her, and that she be allowed four shillings a week until she can be removed”.⁷¹

Garneys attended the meeting to answer the complaint and informed the Board that he had seen the patient and she could not be removed. In March 1770, following a complaint by Elizabeth Negle against John Howes {1766-1770}, it was alleged:

“that Mr Howes had refused medicine to her sick child and the said Mr Howes not attending this Board to make his report of the sick of the House, resolved that he hath been guilty of a very great neglect of his duty as surgeon of the poor of the House”.⁷²

There is direct information concerning the Poor Law activities of some 40 per cent of the total cohort of Suffolk doctors active in the period 1750-1830, either from Poor Law contracts or bills for individual items. Such work was either seen as a social duty, helpful in establishing community credentials, or was lucrative, or all three. This level of detailed evidence does not appear to have been researched in other counties. Such research may establish if Suffolk was exceptional or there is a need to reassess the importance of the Poor Law

⁷⁰ Aldeburgh, *Minute Book*, 17 September 1775.

⁷¹ Blything Hundred, *Minute Book*, 1767.

⁷² Blything Hundred, *Minute Book*, 1770.

in a country practitioner's income and therefore the viability of practice for provincial doctors.

Did the Poor Law activity in fact ensure the presence of a practitioner for private patients? In Suffolk, the limited nature of other appointments probably led to greater dependence on both private and Poor Law contracts, and the need to expand other income streams. Doctors could look to institutional appointments at dispensaries, hospitals, asylums or prisons, and to an increasing number of bureaucratic tasks and quasi-medical duties such as checking apprentices taking up indentures, men joining the militia, prisoners in gaol, felons being transported and giving expert court evidence. Medical instruction beyond apprenticeship, a significant offshoot of hospital development, possibly provided some individuals, especially surgeons, with profitable livings.⁷³ Of particular importance, a growing number of Friendly Societies required medical practitioners to examine, treat and certify members. As Anne Digby puts it, "these put jam on the bread and butter of medical living, and thus differentiated the economically successful practitioner from the one more likely to fail".⁷⁴

As Chapter 5 showed, the development of hospitals accompanied the growth of trade, the expansion of towns and increased geographical and social mobility, though Britain lagged behind Italy, France and the Low Countries, and Suffolk lagged behind most of Britain. Foart Simmons' *Medical Register* of 1783 showed 73 physicians held civilian appointments, including John Beevor at Norwich, and local physicians in Norwich were also in attendance at institutions for the insane.⁷⁵ As Suffolk had only a few dispensaries and only one hospital founded late in the period under review, such work was less significant as a source of income than for other parts of the country. Consequently, there was less opportunity for Suffolk practitioners to acquire teaching income from pupils or for getting into good standing with local gentry who in other parts of England were largely the benefactors and

⁷³ O'Day, *The Professions*, p.233.

⁷⁴ Digby, *Evolution of British Medical Practice*, p.12.

⁷⁵ Samuel Foart Simmons, *Medical Registers*, (London, 1779, 1783).

governors of infirmaries and hospitals. Hospitals did not therefore provide the contribution to local medical living and reputation in Suffolk as was often available to metropolitan doctors, until the foundation of the Ipswich and Bury Dispensaries and Suffolk General Hospital eventually led to an increasing number of hospital posts after 1830.

As “an important area of growth for a minority of entrepreneurial practitioners”, lunatic asylums also drew on services of doctors, though again this can be overstated for Suffolk.⁷⁶ The Melton Asylum near Woodbridge in Suffolk was the county’s main example, and George Doughty Lynn was Medical Director there for many years, though there is little other evidence in Suffolk that such appointments formed a major part of a practitioner’s income, certainly not before 1826 and not as significant as in the more hospitalised metropolitan areas.

On the other hand, there is much more evidence of practitioners looking to the army, navy and other related institutions to supplement their income or provide alternative careers in spite of meagre pay, uncertain status, prolonged separation from home, serious risks to personal health and other job-related liabilities. The 1749 Act allowed any surgeon (many ill-qualified) who had practised in the army or navy for more than three years, to enter private practice without any examinations or apprenticeship. For example in Suffolk, P. Cloney, a surgeon and man midwife of Stratford St. Mary, advertised in 1808 that:

“he intends to practise having served in the Royal Navy and Army for most of the last war, particularly at naval and military hospitals in many parts of Europe and America. Attended at the greatest lying in hospitals in Europe for nearly a year”.⁷⁷

Concern at their standards of knowledge and experience were expressed. John Cordy Jeaffreson wrote: “The necessities of a long war caused the

⁷⁶ Lane, *A Social History*, p.22.

⁷⁷ *Ipswich Journal*, February 1788.

enrolment of numbers of young men in the ranks of the medical profession, whose learning was not their highest recommendation to respect”.⁷⁸

The number of medical practitioners in the services is difficult to ascertain. William Foart Simmons in 1779 suggested 300, rising during the American War to 370, and to 450 by 1783. Most left the service in peacetime.⁷⁹ In 1793 a privately published list showed 550 surgeons, and in 1806 720.⁸⁰ By 1814 the first official navy list gave fourteen physicians, 850 surgeons, 500 assistant surgeons, 25 dispensators and 50 hospital mates in a navy of 130,000 men.⁸¹

These lists included a significant number of Suffolk practitioners. Some went into the services because they were unable to make their way as country surgeons. For example, Tyrell Carter {1748-1799} from Beccles was “obliged to join His Majesty’s Forces in 1799 as a surgeon and was at sea on the *Glory* of Lord Bridport’s fleet” at the Channel. Others joined the services as a career, particularly during the French Wars. John Bartlet {1795-1835} was appointed surgeon to a sloop of war in 1795, as was John Bennell {1803-1834}, and Joseph Primrose died in 1808 in the West Indies whilst serving as surgeon on Board HMS Jason.⁸² Similarly, Henry Arnot {1825-1867} was appointed as Assistant Surgeon Royal Navy on ‘HMS Doris’ in 1825 and died at sea on 29 October 1867 when ‘The Royal Mail Packet’ sank in a hurricane. William Attree {1806-1846} was appointed Second Assistant Surgeon Ordinance Medical Dept in 1806, and First Assistant Surgeon Ordinance Medical Dept in 1809, and survived to retire on half pay in 1819.⁸³

⁷⁸ John Cordy Jeaffreson, *A Book about Doctors*, (London, 1860), p.301.

⁷⁹ Christopher Lloyd & Jack L.S. Coulter, *Medicine and the Navy 1220-1900* (London, 1961), p.20.

⁸⁰ David Steel, *Steel’s Original and Correct List of the Royal Navy and Hon. East India Company’s Shipping*, (London, 1793 and 1806).

⁸¹ *The Navy List: Containing List of Ships, Establishments and Officers of the Fleet*, (London, 1815).

⁸² *Ipswich Journal*, November 1808.

⁸³ Samuel Denny {1801-1825} was listed in the *Ipswich Journal* as a surgeon in the Royal Navy in 1808, though he clearly never went to sea as in November 1808 he informed the inhabitants of Bacton that he had taken the premises late in the occupation of Mr Prettyman. Similarly, Robert Alling (1790-1848), surgeon of Laxfield, was presented with the Diploma of the Metropolitan Vaccination Institute in testimony of his liberal cooperation during his services in the Navy, according to the *Ipswich Journal*, although there is no clear record of where and on what ships or capacity he served.

As for the army, John Denny (1774-1835) joined in 1795 as a Regimental Surgeon's Mate.⁸⁴ His duties required him to qualify as a veterinary surgeon in 1797, that stood him in good stead as in 1803 he became Assistant Surgeon to the 10th Dragoons and in 1809 Surgeon to the 62nd Foot, before he left the army on half pay in 1811. John Lenny, surgeon of Laxfield, was an Assistant Surgeon of the Royal Artillery, his obituary stating: "...has fallen sacrifice to his professional exertion and died in Spain on 2 January 1813".⁸⁵

The military life was also an option in peacetime. For example, Isaac Brooks (1795-1875) of Bury St. Edmunds joined the army in January 1827 as a Hospital Assistant, and was promoted to assistant surgeon before resigning the following year, an experience sufficiently significant for him still to be describing himself as "retired Army surgeon" in the 1851 census. Others held appointments with military hospitals in their practice areas. John Kerridge {1750-1772} of Ipswich was a surgeon for five years in the navy.

War provided opportunities for career enhancement in other ways. William Henry Williams (1771-1841) became surgeon to the East Norfolk Militia without medical qualifications beyond unspecified experience at the Bristol Royal Infirmary and a year at the borough hospitals. In 1795, the regiment was ordered to Deal, and he was required to look after several hundred Russian sailors with malignant fever and dysentery. In 1797, he invented a simple and efficient tourniquet that was adopted by the Army Medical Board before he went to Cambridge, taking his MB in 1803 and his MD in 1811. He published his first book in 1799 on the ventilation of army hospitals and took up practice in Ipswich.⁸⁶ Ten years later he and George Pearson Dawson {1804-1824} were appointed to care for those who returned from the continent suffering from Walcheren fever at the South Military Hospital.⁸⁷ William Mann Hamilton was

⁸⁴ William Johnston, *Roll of Commissioned Officers in the Medical Service of the British Army 1727-1898*, (Aberdeen, 1917). Reprinted as volume 1 of a 2 volume work, (London, 1968), p.149.

⁸⁵ *Ipswich Journal*, February 1813.

⁸⁶ William Henry Williams, *The Ventilation of Army Hospitals and Barrack Rooms*, (London, 1799).

⁸⁷ George Pearson Dawson, *Observations on the Walcheren Diseases Which Affected the British Soldiers in the Expedition to the Scheldt, Commanded by Lieutenant General The Earl of Chatham*, (Ipswich, 1810). On 30 July 1809, a British armed force of 39,000 men landed on Walcheren, with a view to assist the Austrians in their war against Napoleon, and attack the French fleet moored at Flushing

similarly recruited to assist other sufferers in temporary barracks on Albion Hill in Ipswich.⁸⁸

Some military appointments could be less onerous and limited to providing medical services to the militias that were garrisoned around the countryside. George Crabbe's income was supplemented in 1778 when members of the Norfolk Militia (followed by the Warwickshire Regiment) were quartered in Aldeburgh. They employed Crabbe as the militia doctor until the following spring, leaving him bewailing the loss of income.⁸⁹ Similarly, William Amos (1721-1778) was surgeon to the Eastern Battalion of the Suffolk Militia and John Bolton {1791} of Ipswich was appointed surgeon "by purchase... to the 6th Inniskilling Dragoons" in October 1791.⁹⁰ Other examples include James Baldry (1775-1826) of Wilby and then Framlingham, for many years surgeon to the Hertfordshire Regiment Militia, and Henry Bowers (1750-1822) of Saxmundham and Aldeburgh who was surgeon to the 2nd Regiment of Saxmundham and Aldeburgh Dragoon Guards from 1750 to 1722. Undoubtedly others took such appointments to enhance their status and increase local and national connections.

The East India Company and other explorations represented another avenue for doctors if the world of country practice was too dull or difficult, or for those with a genuine interest in travel and adventure. Usually practitioners were appointed to one of the Company's cruise ships unless they sought an on-shore appointment, since these were reckoned to give more chance of seeing the world and of saving money.⁹¹ The East Indies was the most dangerous station and the navy called on the long experience of East India

(Vlissingen). The expedition was a disaster - the Austrians had already been defeated at the Battle of Wagram and were suing for peace, the French fleet had moved to Antwerp, and the British lost over 4,000 men to 'Walcheren Fever', thought to be a combination of malaria and typhus. The force was withdrawn in December.

⁸⁸ Hamilton also wrote an account of his experiences. William Hamilton, "A statistical report of the Walcharen fever as it appeared among the troops of Ipswich, on their return from Holland", *Medical and Physical Journal*, 43, (1810), p.1.

⁸⁹ Powell, *George Crabbe*, p.40.

⁹⁰ *Ipswich Journal*, 24 October 1791.

⁹¹ J.C. Hudson, *The Parent's Handbook*, (London, 1842), p.165.

Company surgeons, though disease was much more prevalent on a man of war than in passenger ships plying between ports.

There was no restriction on anyone wanting to go to India on a private basis, but there was considerable benefit in attaching to the East India Company. Not surprisingly, in view of the proximity of the sea, numbers of Suffolk doctors were involved with the Company, and many had careers cut short by early death, including the two Cavell brothers, Henry and Robert (1799-1826). The latter died in June 1826 on passage from Calcutta on the ship 'Corunna' on which he served as Assistant Surgeon with the Company, and Henry died a year later at Sebato, some 200 miles from Calcutta, having been with the Company's medical establishment for six years.⁹² Edward King {1790-1817}, also a surgeon with the East India Company, died in camp at Jaulnah, 212 miles from Madras. Others such as Charles Ray (1791-1830) and William Crowfoot (1751-1820) both survived as surgeons to the East India Company, and John Steggall was employed briefly by the Company as a soldier in 1807.

Some doctors sought their fortunes by travelling, including Benjamin Salmon {1797-1821} who was appointed first surgeon to His Majesty's Consul at Dixcove Fort in Africa in 1821. Abel Clarke (1780-1826), surgeon and naturalist, accompanied Lord Amhurst's Mission to China in 1816 that led to a new species of flowering plant named in his honour, *Abelia chinensis*, which came to England (see Plate 2). Two Suffolk medical men joined him - surgeon and physician James Lynn (1770-1732) and Zachariah Poole (1799-1819), who became Abel's assistant.⁹³

⁹² Cavell used arsenic to put an end to an unpleasant disease at Dinapore that started by progressive ulceration of the face. He also treated cholera by bleeding and successfully treated a case of hydrophobia - said to have been reported in *The Lancet*, 1827.

⁹³ The expedition was a failure. Lord Amhurst was refused access to the Emperor and the expedition was forced to retreat. Abel became very ill and did not recover for many weeks. On their return, the ship struck a reef at the entrance to the Strait of Gaspar, and wrecked. Most of Abel's natural history collection was lost, but fortunately he had left some specimens in China, and they were sent to him, and the Chinese *Abelia* was successfully established in the West.

Plate 2: *Abelia chinensis*



There are few mentions of practitioners as coroners in Suffolk, though other state appointments were not uncommon. Bury St. Edmunds' surgeon Reuben Sturgeon (1783-1819) was listed as Commissioner for executing the Act, granting the Crown Duty of Pensions and Offices and Land Taxes.⁹⁴ Prison surgeon roles were generally taken on part-time by local practitioners living nearby, who would inspect prisoners and attend the sick, noting whether "apartments are clean and the Prisoners in General healthy".⁹⁵ They were appointed and paid for by the county's magistrates at Quarter Sessions, but varied considerably and John Howard (1726-1790) felt moved by his observations to recommend that "a surgeon or apothecary be appointed (with a proper salary) to afford the necessary assistance to the sick".⁹⁶ The greatest risk was 'gaol fever' or typhus, and doctors clearly played a role in trying to resolve the incidence of this. Thomas Day of Maidstone was so concerned he

⁹⁴ *Rules of Uggeshall and Sotherton Parish Bank*, Suffolk Papers, BL 1304 ml.

⁹⁵ Joan Lane, *The Making of the English Patient - a Guide to Sources*, (Stroud, 2000), p.144.

devised early though fairly basic air-conditioners to remove the infected air.⁹⁷ There is no clear evidence as to whether Suffolk doctors did likewise, but George Stebbing was associated with Ipswich County Gaol all his life and visited Margaret Catchpole when she was held there.⁹⁸ After his death in 1825, Alexander H. Bartlet (1763-1847), surgeon of Ipswich, became surgeon to the county gaol, followed by Charles Chambers Howard (1793-1876).⁹⁹ George Hubbard Jnr. (1785-1860) was elected surgeon to Bury Gaol in place of his father in 1821.¹⁰⁰

Overall, whilst additional employment opportunities through hospitals and dispensaries were not forthcoming in Suffolk on anything like the scale seen in metropolitan areas, medical livings might be supplemented from Poor Law contracts, the forces and overseas work, as well as some limited civilian appointments.

What incomes did these opportunities deliver in relation to general views held about medical practitioners' remuneration? Adam Smith believed that the professions were much more highly remunerated because of the long and expensive training involved and partly because of the need for them to be of a sufficiently high status to gain and retain the trust so essential to a profession relationship.¹⁰¹ Patrick Colquhoun in 1803 suggested that "a person in the medical, literary or fine arts" might earn £260 per annum compared to a schoolteacher on £150, a lawyer on £350, an artisan on £55 or an agricultural labourer on £31.¹⁰² More recently, Peter Earle concludes that many London professionals were as rich or richer than the wealthy or well-to-do gentlemen of leisure and merchants, including most members of the medical profession.

⁹⁶ John Howard, *An Account of the Present State of the Prisons in the Home Circuit*, (London, 1784), p.x.

⁹⁷ Thomas Day, *Some Considerations on the Different Ways of Removing Confined and Infectious Air; and the Means Adapted with Remarks on the Contagion at Maidstone Gaol*, (London, 1784).

⁹⁸ Richard Cobbold, *Margaret Catchpole*, (London, 1845), p.209. George Stebbings also gave her a character reference, but this did not prevent her deportation to Australia for stealing a horse.

⁹⁹ *SMB*.

¹⁰⁰ *Ipswich Journal*, 18 October 1821.

¹⁰¹ Adam Smith, *An Inquiry into the Nature and Cause of the Wealth of Nations*, (Dublin, 1776), pp.150, 154.

¹⁰² Patrick Colquhoun, *Treatise on Indigence*, (London, 1806), p.23.

Better-off physicians were earning several thousand pounds a year, compared to for example the modest incomes of those who might see themselves as genteel, earning a median of some £50 per annum.¹⁰³ Yet Penelope Corfield notes that there were considerable discrepancies between the very successful and the rest, and cites London general practitioners as earning some £300-£400 per annum by 1830, with their country counterparts typically on £150-200.¹⁰⁴

Similarly, Joan Lane argues that by 1750 “patients increasingly came to spend money on more scientific successful medical attention as part of a higher standard of living, greater disposable income and increased life expectancy”.¹⁰⁵ Together with larger apprenticeship premiums, better incomes and higher social status for practitioners, this made medicine a more attractive profession. Successful provincial practitioners (the examples she gives were all physicians with elite patients and little competition) could make substantial livings, whilst “undistinguished surgeons and apothecaries in rural practice could make a comfortable living of £150 per annum, in spite of slow paying patients”.¹⁰⁶

Peter H. Lindert and Jeffrey G. Williamson, in their work on incomes in the Industrial Revolution, suggest that average earnings for surgeons and doctors in 1781 were nominally £88.35 rising to £217.60 in 1819, an improvement in their financial position greater than for other professional groups.¹⁰⁷ The latter figure fits in with Penelope Corfield for provincial doctors, but Irvine Loudon suspects that the former was too low. Suggesting that mid-eighteenth century medical practice at rank and file level had become both a paying and a respected occupation, he concludes that a “country surgeon-apothecary in the mid- to late-eighteenth century could expect to earn on average £400 a

¹⁰³ Peter Earle, “The middling sort in London”, in Jonathan Barry & Christopher Brooks (eds.), *The Middling Sort of People - Culture, Society and Politics in England, 1550-1800*, (Basingstoke, 1994), pp.141-158.

¹⁰⁴ Corfield, *Power and Professions*, p.235.

¹⁰⁵ Lane, *A Social History*, p.11.

¹⁰⁶ *Ibid.*, p.18.

¹⁰⁷ Peter H. Lindert & Jeffrey G. Williamson, “English workers’ living standards during the Industrial Revolution: a new look”, *Economic History Review*, 2nd series, 36, (1983), 1, 1-25.

year once he was well-established”, a guestimate roughly in line with Adam Smith’s observation that an apothecary in a market town could earn £400-500 a year.¹⁰⁸ Moreover, the surgeon-apothecary was on a par financially and socially with an attorney, upper and middle ranks of the clergy, and better-off farmers. Loudon cites Job Harrison in Chester, who like George Crabbe of Aldeburgh came straight from apprenticeship with no examination or formal qualification, to take on a practice earning £300.¹⁰⁹ These figures are significantly higher than those of Lane and Corfield, and may only reflect the situation in the provincial towns.

Undoubtedly, an elite working outside of the capital was very successful, if invariably associated with a significant town. For example, William Lewis of Oxford left £35,000 in 1772 gained “by his extensive practice”.¹¹⁰ John Green Crosse had a private practice that, towards the end of his life, grossed £3,500 per annum, with lifetime receipts of nearly £47,000.¹¹¹ Crosse can be considered representative of a highly successful city practitioner; Norwich after all still featured among the top five cities of England. However, this merely underlines a considerable gulf, not just between the rewards of fashionable London practitioners and eminent provincial practitioners, but between the latter and those of a country doctor. For a county like Suffolk with few such towns, a lower level is more likely and is supported by such evidence as has been adduced from the Suffolk papers quoted below.

There were surgeons of property and substance like George Stebbing, though again these were largely urban figures, and not part of the army of rural practitioners. For example William Goodwin left £2,000-3,000,¹¹² comparable to the net estate of local landowner, Richard Dix of Smallburgh who left £2,120 in 1828.¹¹³ Maurice Alexander {1764-1787}, surgeon of Lowestoft, left £40 per annum to his wife, with the rest divided between his daughters.

¹⁰⁸ Loudon, *Medical Care*, p.113.

¹⁰⁹ Loudon, *Medical Care*, p.112.

¹¹⁰ Lane, *A Social History*, p.14.

¹¹¹ Crosse, *John Green Crosse*, p.169.

¹¹² *Probate Record*, SRO (Ipswich), IC/AA1/235/38 (OW): IC/AA2/114/81.

¹¹³ *The Dix Family Papers of Smallburgh*, NRO (Norwich), Accn. 24.7.70.

Another Lowestoft surgeon, Aldous Arnold {1754-1792}, left an estate to the value of £300-£600. The life interest in the property was left to his second wife Margaret, then to his son and heir Aldous Charles Arnold. He had property in Oulton and Flexton that he left to his son and an annuity for his daughter Elizabeth Christian.¹¹⁴ Abraham Girling (d. 1803) of Stradbroke left between £600 and £1,000, £50 to his wife and £10 to each of his executors, the rest to be invested so that his wife had a life interest, with his children, John and Ann, eventually to share the capital.¹¹⁵ All these examples are far less grand than the metropolitan and provincial town physicians and surgeons quoted above.

Each practitioner set his own terms for treatment and medicine, but his net income reflected his costs, the energy with which practice was pursued and the severity with which fees were demanded and collected. Sir Robert Kerrison noted how:

“the charge for medicine is sometimes lower at a chemists than at the regular apothecary but apothecary has bad debts, has to visit patients and therefore incur cost of horse and carriage, plus long and expensive education”.¹¹⁶

There is some evidence of practitioners setting out deliberately to be one-man operations serving whole families. Very few were able to live on midwifery alone, with doctors’ fees for attending birth in the first half of the nineteenth century ranging from one to 100 guineas for delivery, plus five shillings or seven shillings and sixpence per visit including medicine, and sixpence or one shilling per mile for any journey over two miles, so the lowest fee was around three or four guineas. Since this added up to several weeks’ wages for a labourer, few could afford this form of conventional medicine.

Adam Smith stated that “The apothecary was the physician of the poor in all cases, and of the rich when the distress or danger is not very great”.¹¹⁷ He

¹¹⁴ *Probate Record*, SRO (Ipswich), IC/AA1/213/1.

¹¹⁵ *Probate Record*, SRO (Ipswich), IC/223/43.

¹¹⁶ Kerrison, *Inquiry*, pp.58-9.

¹¹⁷ Smith, *Wealth of Nations*, p.100.

may have been overstating the case, especially where apothecaries were surgeons as well, and had patients across a wide range of classes both of those who could afford them, or those whose health needs were met through ‘club’ or Poor Law arrangements. The main difference between wholly private patients and the rest was that “every doctor had a vested interest in the survival of a paying patient that was not the case with every poor one”.¹¹⁸ Consequently, doctors would avoid ‘bold’ surgery or untried treatments on their private patients and conversely when treatments were proven, monied patients benefited soonest. A contemporary, surgeon and apothecary William Chamberlaine (1747-1822), bemoaned the lot of the poor apothecary who might attend a patient conscientiously and frequently at no charge for the visits merely for the potions and pills, and yet find himself outranked and out of pocket by the intervention of a physician or surgeon.

“How much it must hurt the feelings of the honest and conscientious Apothecary, who has exerted himself morning, noon and night to effect the recovery of a patient, to find himself cast off - to learn that Doctor X or Doctor Y has been to see the patient, that he prescribed a dram of hemlock to be made into sixty pills and that the doctor insisted that this medicine should be procured from Apothecaries’ Hall...!”¹¹⁹

But it became the custom for practitioners to charge a fee for attendance if no prescription was supplied or, where medicine was supplied, to charge for this if it was considered adequate to cover the treatment.

The outcome of a consultation had little impact on the fee charged, though clearly more was charged for an amputation than for extracting a tooth, and the more attendances were required, the higher the fee. Social status and occupation had surprisingly little influence. Irvine Loudon defines the range of variables that could determine fees: the level of difficulty of the procedure; frequency of attendances and distance involved.¹²⁰ For example, Sir James Paget (1814-1899), working as a surgeon in Great Yarmouth, noted charges as follows:

¹¹⁸ Ruth Richardson, *Death, Dissection and the Destitute*, (London, 1987), p.43.

¹¹⁹ William Chamberlaine, *Tirocinium Medicum (or a Dissertation on the Duties of Youth Apprenticed to the Medical Profession)*, (London, 1812).

¹²⁰ Loudon, “Nature of provincial medical practice”, p.17.

“Droughts - a shilling
Mixture - five shillings or 7s 6d
Pills - half a crown or 3s 6d
Leeches - sixpence each
Bleeding - 5 shillings or 10s 6d
Cupping - guinea”.¹²¹

His charges for ‘mixtures’ were higher than those charged by, for example, Benjamin Pulsford (1716-1784) and his nephew William (1736-1765), surgeons in Wells in a very comparable practice. Like Paget, the Pulsfords appears to have earned their substantial income:

“not from a highly specialised practice amongst the rich but for most part from ordinary simple surgical procedures in a practice of farmers, shopkeepers, and craftsmen living in or close to Wells”.¹²²

For Paget of course, in Suffolk, this latter group would constitute a significant section of his middle to upper classes of patients, and certainly not the poor.

The case of master Day of Yoxford provides a cameo of the complexities of country practice, its competitive nature, the whole issues of fees and the outcomes when etiquette was not observed. In 1799, Richard Langslow {1790-1812} of Halesworth was called to see a 15 year-old boy, who he diagnosed with inflammatory rheumatism. He bled him, gave doses of calomel and Dr James’ powder assisted by saline mixtures, and then “considered my patient as convalescent”. However the boy got worse and Langslow “determined to relinquish several patients at a distance to enable me to pay this unfortunate youth the greater attention”. He then discovered “a Mr Dalton, a surgeon at Yoxford, had called the evening before stating himself to be a friend of Mr Bobbit (the child’s father) but without telling [Mrs T] either his name or profession”. Dalton examined the boy and said he was dying. However, the boy recovered and removed to Peasenhall accompanied by his mother and a nurse with the necessary medicine and dressings. Langslow was told that Mr Dalton was now in charge of him. Langslow saw the father, a tanner of

¹²¹ Stephen Paget (ed.), *Memoirs and Letters of Sir James Paget*, (London, 1901), p.21.

¹²² Loudon, “Nature of provincial medical practice”, p.19.

considerable resource, to explain the dangers of changing medical attendant, and to give his bill. Bobbit said the charge was exorbitant and Langslow brought a case for the recovery of his money, £76 6s 6d.¹²³

The issue for his neighbouring colleagues was that Langslow, ostensibly a physician, practised “generally” because, he argued, “some of the surgeons put up his prescriptions unfaithfully”.¹²⁴ Much of the case rested on the comparative costs of medicines and treatments quoted. Langslow charged £48 17s 6d for three operations, £3 3s 0d for dressings and attendance at Halesworth, £19 19s 0d for medicines and attendance at Peasenhall. Dalton in the witness box said he would have charged £2 2s 6d for 24 or 30 pills, 2s 6d for half a pint and five guineas for the whole case including opening the abscess, lint and salve used.

Many country doctors therefore scraped by on an income that scarcely bought gentility, and a surprising number failed to make a living at all.¹²⁵ There were a number of medical bankruptcies in Suffolk, including surgeons John Ellison {1791} of Gorleston, Davie Keer (1766-1811) and William Jeaffreson (Snr.) (1790-1865) of Framlingham, and John Seaman {1795-1804}, an apothecary, dealer and chapman of Mendlesham. Two at least seem not to have suffered unduly as a result: John Birch/Burch (1730-1782), surgeon of Cavendish and Lavenham, was bankrupt in 1747 and an administrator was appointed, but he continued to practise and in addition was still employed by the Little Waldringfield Overseers; Abel Clarke, before he left for China, was declared bankrupt in Halesworth, declaring a dividend of ten shillings in the pound.

The general conclusion from the evidence available is that Suffolk medical incomes derived from a wide range of sources and approximated to those in provincial counties for which evidence is available. However, more detailed work is needed to establish and analyse further evidence from other counties

¹²³ Richard Langslow, “The case of Master Day of Yoxford”, *Local Pamphlet*, No. X1X, (1801). SRO (Ipswich), p.16.

¹²⁴ *Ibid.*, p.42.

¹²⁵ Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911*, (Cambridge, 1994), p.7.

and to determine how their incomes related to those practitioners working in London. Clearly, many lived comfortably while many others were very poor or failed to survive financially. The majority appear to have earned enough to sustain their families and their position. What is less clear is whether the range of income sources upon which they could call was as great if not greater than in metropolitan areas.

8.2 Status and Standing

In establishing the civic status of Suffolk practitioners, beyond that attaching to those who delivered medical care, there is also evidence from the range of roles that medical practitioners played in provincial society. The pressures of maintaining a practice, both private and public, seem to have been a bar for many practitioners to contribute significantly to Suffolk public life. There is insufficient comparable evidence from the rank and file of London apothecaries and surgeons, let alone other provincial counties, to establish if this was peculiar to Suffolk. Moreover, the intimate relationship with patients and a sometimes misguided belief in practitioners' power of pain relief meant that relations with the upper and middle classes were ambiguous, finely balanced between respect and gratitude for such relief, and distain for the lack of refinement and sensibility surgeons were perceived to need to do their more sordid business. This in part explains the somewhat curious and ambivalent role practitioners played in civic affairs and the place they held on the social ladder. William J. Reader summarises the situation thus:

“the lawyer and the doctor took the lead amongst the middle classes and could make a claim to gentility in the High Street of Middlemarch or in the suburbs of London and Birmingham, even if not in the mess of a fashionable regiment, in the ward rooms of Her Majesty's ships or in the drawing rooms of great country houses”.¹²⁶

Irvine Loudon sees the surgeon apothecary first and foremost as a businessman, “often a very successful one, motivated by a hard sense of commercialism [whose] type of practice was dictated most of all by the

¹²⁶ William J. Reader, *Professional Men: The Rise of the Professional Classes in Nineteenth Century England*, (London, 1966), p.68.

competition and opportunities for business in his chosen area of practice”.¹²⁷ As already shown, they were employed not only for serious life-threatening illness but also for minor self-limiting ones, by both the upper and a wider range of social classes. Public recognition and a sense of corporate identity led after this period to the arrival of practitioners as a profession and, according to Geoffrey Holmes, thereafter their status in society increased.¹²⁸ Suffolk evidence shows a more consistent picture than this in terms of status and income over the period under review, and there seems to have been little change in the way practitioners were esteemed and valued. Possibly they were starting from a higher base across the board than elsewhere, a product of the stable society in which Suffolk doctors worked.

By the late eighteenth and early nineteenth centuries, medical practice at provincial level had generally become both a paying and respected occupation, and books about trades and professions such as Richard Campbell’s *The London Tradesman* in 1747 stressed recent improvements in income and status of the lower grades of practitioners.¹²⁹ In another contemporary account, Jane Austen refers frequently in her diaries to surgeons and apothecaries as well as physicians as part of her social circle.¹³⁰ She clearly saw her apothecary, Mr Lyford, as a social peer.

“Mr Lyford was here yesterday; he came while we were at dinner, and partook of our elegant entertainment. I was not ashamed at asking him to sit down to table, for we had some pease-soup, a sparerib, and a pudding”.

In contrast however, Anne Digby quotes Lady Warwick: “Doctors and solicitors might be invited to garden parties, though never of course to lunch or

¹²⁷ Loudon, “Nature of provincial medical practice”, p.1.

¹²⁸ Geoffrey Holmes, *Augustan England, Professions, State and Society 1680-1730*, (London 1982), p.167.

¹²⁹ Irvine Loudon, “Medical practitioners and the period of medical reform in Britain 1750-1850”, in Andrew Wear (ed.), *Medicine in Society: Historical Essays*, (Cambridge, 1992), pp.219-248.

¹³⁰ Deirdre Le Faye (ed.), *Jane Austen’s Letters*, (London, 2003). For example, Robert Bourne, Professor of Medicine at Oxford and consultant to Miss Elizabeth Leigh of Adlestrop, p.499; Mr T. Coulson, carpenter, physician or apothecary at Lyme Regis, p.505; Mr Chessyre, Miss Bailey’s medical attendant in Hinckley - Chessyre and Wilson, surgeons, p.506; Dr Fellow(e)s, Physician Extraordinary to the Prince of Wales, at 4 Bladud’s Buildings, and later at Axford’s Buildings, Bath, p.521; Dr Gibb(e)s, FRS and physician of 28 Gay Street and later at 11 Laura Place, Bath, p.527; Pierce Hacket MD of 170 High Street, Southampton, p.530.

dinner”.¹³¹ This was the view reflected in Mrs Gaskell’s works. She had a clear concept of the doctor’s place in such society.

“[Dr Hall] ...had always been received with friendly condescension by my lady, who had found him established as the family medical man... but she never thought of interfering with his custom of taking his meals... in the housekeeper’s room”.¹³²

Anthony Trollope has Dr Thorne as a hero, “a conservative who resists the social and intellectual pretensions of the new generation of doctors”.¹³³ George Eliot, in contrast, treats with sympathy and in some ways admiration those such as Tertius Lydgate seeking to change medical theory and practice.¹³⁴

There were logistical reasons for the practitioners’ ambivalent role in society, concerned with their exemption from all military, policing and jury service as a right of privilege. However, office bearing in Margaret Pelling’s words “like marriage, signified adult maturity and fitness to head a household”. She concludes that the direct involvement of medical practitioners (of any description) in the political and civil systems of England was relatively limited. Although, unlike physicians who disengaged themselves from urban life and the *cursus honorum*, surgeons and apothecaries were much more civic minded.¹³⁵ Jeanne Peterson differentiates between the ‘liberal professions’ (law, church and military) and medicine that was seen, she argues, as a “subservient profession”.¹³⁶ This was partly because it was initially ruled by others (hospital governors, patients and bureaucrats), but also because it was in many respects a menial profession. However, Peterson’s work is based largely on London and on evidence from the second half of the nineteenth

¹³¹ Digby, *Making a Medical Living*, p.37.

¹³² Mrs Gaskell, *Wives and Daughters - an Everyday Story*, (first published London, 1866), (Penguin Classics, 2002), p.37.

¹³³ Trollope, *Dr Thorne*, p.31.

¹³⁴ David Daiches, “George Eliot’s Dr Lydgate”, *Proceedings of the Royal Society of Medicine*, 64, (1971), 7, pp.723-724.

¹³⁵ Margaret Pelling, “Politics, medicine and masculinity: physicians and office-bearing in early modern England”, in Margaret Pelling & S. Mandelbroke, *The Practice of Reform in Health, Medicine and Science 1500-2000: Essays for Charles Webster*, (Aldershot, 2005), pp.81-105.

¹³⁶ Jeanne M. Peterson, “Gentlemen and medical men: the problem of professional recruitment”, *Bulletin of History of Medicine*, 58, (1984), pp.457-73.

century, and also tends to ignore the sheer diversity of the medical profession in the late eighteenth and early nineteenth centuries. As a result, as Irvine Loudon concludes, this may amount to a distortion of the provincial experience, and the Suffolk evidence supports his view. Loudon speculates that in the provinces “the general practitioner may have occupied a higher and more secure social position than many of his urban colleagues”.¹³⁷

Medical names are seldom found in the lists of subscribers in Suffolk to any petition or register; the contemporary records and gazettes on towns and villages mention the squire, the clergy, the merchants, the schoolteacher, but rarely the doctor. Suffolk medical men are not often mentioned in gazetteers for their good houses or status. For instance, John Kirby gave an ecclesiastical guide at the end of his *Suffolk Traveller* but no indication of medical care, though this may simply reflect his own interests.¹³⁸ Clerics’ houses are mentioned, but those of doctors rarely. Yet the latter often had substantial premises. The house of Thomas Mark Firmin at Sudbury had:

“seven bedrooms, three front parlours, and an apothecary’s shop, two back parlours, three servants’ bedrooms, a brick stable for six horses, and a coach house for two or three carriages”.¹³⁹

In 1777, Mr Nelson’s “copyold Messuage and Garden” in Woolpit was auctioned, consisting of “three parlours, a kitchen, washhouse and buttery; a good hall and staircase; four good chambers; a large garden with lofty new built wall, plus pasture land”. The surgeon also auctioned another house in Woolpit “suitable for a small genteel family”.¹⁴⁰

Very few practitioners were Poor Law guardians, Michael Muncaster concluding that the most a Norfolk country doctor could hope for was to become a churchwarden or magistrate, though in Yarmouth eleven held

¹³⁷ Loudon, *Medical Care*, p.200.

¹³⁸ John Kirby, *A Suffolk Traveller, or a Journey Through Suffolk*, (London, 1764), p.48 of Appendix.

¹³⁹ *Bury Post*, 26 December 1789.

¹⁴⁰ *Ipwich Journal*, 30 November 1776.

mayoralty, at Thetford five, and Kings Lynn two through this period.¹⁴¹ However, Suffolk information, although scarce, suggests that family doctors might become magistrates, take on civic duties as Mayor or councillor, or hold directorships of local businesses. In large towns like Bury St. Edmunds and Ipswich, there were numerous examples including George Creed (1799-1868) and Reuben Sturgeon, both burgesses of the Common Council of Bury St. Edmunds. Sir Thomas Gery Cullum (1741-1831) was Coroner 1794, Alderman 1780 and 1789 and George Hubbard (1749-1821) was a burgess, a governor and a commoner both of Bury St. Edmunds. John Denny was Chief Magistrate in Ipswich and Town Bailiff; he stood as a Conservative on the Common Council and was a Governor of Christ's Hospital. Similarly, Henry Seekamp (1745-1819) was Senior Portman, Assistant Justice and Assistant Chief Magistrate at Ipswich.

In smaller market towns a similar picture emerges. For example, surgeon John Assey (1742-1798) was Port Reeve of Beccles in 1779, John Sutherland (1782-1852) was Bailiff of Southwold on several occasions from 1822, and in Bungay John Brettel {1813-1840}, surgeon, was appointed Town Reeve in 1825. A slightly different position was obtained by W.J. Crowfoot, who appeared as one of the two managers of the Blything Hundred Savings Bank in December 1829, with the duty "to attend the last Tuesday in every month from Twelve until Three".¹⁴²

One index of the rising prestige of the surgeon-apothecary was the capture of the title 'Dr', the first reference to which appears in Dr Johnson's dictionary in 1751. A learned title conferred status and was undoubtedly attractive to Crabbe senior.¹⁴³ What Crabbe (or at least his father) was actually doing was participating in a social revolution, "the eighteenth century's great leap onto the bandwagon of the rising middle class".¹⁴⁴ Social fluidity tended to

¹⁴¹ Michael J. Muncaster, *Medical Services and the Medical Profession in Norfolk 1815-1911*. Unpublished PhD, University of East Anglia, 1976, p.166.

¹⁴² Suffolk Papers, BL 1304 ml.

¹⁴³ Corfield, *Power and Professions*, p.140.

¹⁴⁴ Kenneth R. Johnston, *The Hidden Wordsworth - Poet, Lover, Rebel, Spy*, (London, 1988), p.43.

encourage zigzag personal trajectories, of which Crabbe's adolescence and early adulthood provides a series of striking instances.¹⁴⁵

The growth of professional clubs to share common collectives and even specialist interests was a feature of this period, as medical practitioners sought, consciously or unconsciously, to develop a visible commonality and community of interests. Club membership was therefore another indication of rank and standing. John Assey was a member of the Gentleman's Club of Bungay from 1771-1776, as was Wolfram Lewis (1728-1823), Edward Cooper {1728-1764} and Lancelot Davey (1783-1816).¹⁴⁶ Sir Thomas Gery Cullum was a member of Suffolk Pitt Club. Town memorials and church monuments were put up to a significant number of practitioners, giving some indication of local esteem, a lifetime of establishing reputation and fostering the local people through face-to-face contact in a range of activities. Robert Carew King "attained great eminence by his skill both in surgery and medicine", as a surgeon of Saxmundham and his epitaph in Winesham churchyard is inscribed on a memorial tablet. Edward Beck has a monumental inscription in Coddesham village church and James Bedingfield has a monument in Bramford churchyard.¹⁴⁷

A successful practitioner could be assessed by his general lifestyle, particularly his house, carriage, acquaintances and clientele. The profession was expected to live up to public expectations of their role, even though John Gregory stated rather portentously that:

"there is no natural propriety in a physician's wearing one dress in preference to another... they frequently supplanted real worth and genius [or indeed that] this dignity [of the profession] is not to be supported by a narrow, selfish, corporation spirit; by self-importance; a formality in dress and manners, or by an affectation of mystery".¹⁴⁸

¹⁴⁵ Powell, *George Crabbe*, p.17.

¹⁴⁶ Brian Goss, *Three Centuries of Bungay Doctors 1662-1978*, (Bungay, 1978), pp.1-2.

¹⁴⁷ Other examples of monuments and memorials include those to John Amyas (1706-1780) surgeon and apothecary of Beccles, Joseph Andrewes (1688-1764) apothecary of Sudbury and the monument to James Baldry (1775-1826) surgeon, man midwife of Wilby and then Framlingham is in Cornard Magna Church.

¹⁴⁸ Olinthus Gregory, *Memoirs of the Life, Writings and Character, Professional and Religious, of the Late John Mason Good*, (London, 1828), p.237.

As Penelope Corfield says, “the visible trappings of wealth worked wonders to help a career”.¹⁴⁹ There was the identifiable garb, the elevated style above the vagaries of passing fashions and individual whim that reinforced the collective image of continuity and trustworthiness.

This was certainly true in provincial towns in Suffolk. For instance, George Stebbing was always neatly dressed in black coat, waistcoat, knee breeches, silk stockings and shoes with silver buckles.¹⁵⁰ Surgeon Alexander R. Bartlet (1763-1847) of the same town was described as “satirical but humorous. Tall and Fine-looking. Black long coat and trousers, shoes, gaiters, white neckerchief and frilled shirt. Clean shaven. Carried a cane. Enjoyed the theatre, Judicious, refined and scholarly”.¹⁵¹ Thomas Bayly was described by John Green Crosse in his diaries as:

“being one of the old school... of fine soft soothing manners, clean dressed with a powdered head - rode slowly on a fine looking horse, in short he was a gentleman and commanded respect of everyone when he entered a house; he was also a skilful and kind surgeon”.¹⁵²

John Clubbe (1741-1811) was described as “a man of considerable humour, most cheerful disposition... Sociability of character, suavity of manners endeared him to a large circle”.¹⁵³ The Bury St. Edmunds surgeon George Bullen (1781-1865) was depicted as:

“a very busy and active surgeon. Considerable local reputation as an efficient surgeon. He was clever, sharp of eye, steady hand, efficient operator. Stern looking but humorous. Sometime irascible and dogmatic”.¹⁵⁴

¹⁴⁹ Corfield, *Power and Professions*, p.21.

¹⁵⁰ David van Zwanenberg, “Interesting GPs of the past - George Stebbing of Ipswich”, *British Medical Journal*, 283, (1981), pp.1517-1518.

¹⁵¹ John Glyde, *Medical Men of Ipswich in 1881*, (Ipswich 1881), p.61.

¹⁵² John Green Crosse, *Diaries*, MSS 465,466,467, Norfolk Record Office (Norwich).

¹⁵³ J. Ford (ed.), *A Suffolk Garland*, (Ipswich, 1818).

¹⁵⁴ Glyde, *Medical Men*, p.54.

His obituary stated that he was “said to be nervous except when handling a knife”.¹⁵⁵

Transport was another indication of status and success. Few country doctors could visit all patients in their practice area by foot. Usually the practice would have a radius of about seven miles around a doctor’s residence, a distance largely determined by the fact that the surgery needed to be available for walking patients. Experience in Suffolk towns would not be dissimilar from that of Wells, where the Pulsfords recorded 62 per cent of their patients within four miles of the surgery, and 92 per cent within seven miles. Only the odd one or two lived as far as ten miles. In the more rural parts this percentage might not have been so high, though William Goodwyn of Earl Soham had extensive territory, probably ten by fifteen miles, with some patients as far as twenty miles away. This was probably due to his good reputation, but also because he only had five competitors within a five mile radius of his surgery.¹⁵⁶ The doctor himself would of course travel extensively across his patch, particularly if he had a horse or carriage, and carried with him “saddlebags full of ointments, lotions, bandages and plasters as well as instruments”.¹⁵⁷ The necessity to get a reputation in a particular area, with a chance to work up local connections in preparation for the death or retirement of a rival, meant that, for example, John Green Crosse in 1816 made a round journey of 52 miles to advise on a single case, and then another of 82 miles.¹⁵⁸ These unusual journeys would have been the result of requests from important patients for consultations.

Forbes Winslow wrote that “a physician who is able to drive his own carriage, is considered extremely clever in his profession, and is patronised accordingly”.¹⁵⁹ This was true for provincial surgeons like Alexander Bartlet, who mostly travelled in hired post-chaise.¹⁶⁰ Other examples come from

¹⁵⁵ *Ipswich Journal*, November 1871.

¹⁵⁶ Digby, *Making a Medical Living*, p.112.

¹⁵⁷ Loudon, “Nature of provincial medical practice”, p.12.

¹⁵⁸ Crosse, *Diaries and Casebook*, p.470.

¹⁵⁹ Forbes Winslow, *Physic and Physicians: a Medical Sketchbook*, (London, 1839), Vol.1, pp.84-5, 345.

¹⁶⁰ Glyde, *Medical Men*, p.31.

reports of fatal accidents concerning carriages: Edmund Goodwyn was thrown out of his gig and died in 1757; Thomas Spurgin (1746-1830), surgeon of Stratford St. Mary, was thrown from a gig in 1830 whilst out with his son, the wheel passing over his temple and he died within three days.

Many more used horseback. Thomas Bayly rode on a fine-looking horse and Dr Standish rode two lumbering horses about the country, according to Jeaffreson:

“Straight on he went, at a lumbering six miles an hour trot - dash, dosh, dash! - through the muddy roads, sitting loosely in his seat, heavy and shapeless as a sack of potatoes”.¹⁶¹

Other information comes more obliquely from the pages of the local press. For example, John Birch had a gelding stolen in 1730, and Samuel Salmon {1720-1783} advertised for the sale of “Five Bay Horses” in April 1759 “at a cover of ½ guinea”. John Page reported a stolen mare in February 1786 and a Dr Simson {1775-1783} had a brown gelding stolen from his stable.¹⁶² When George Stebbing died his horse called Galloway was shot. There were also examples of the dangers of travelling by horseback, including Thomas Mann {1759-1775} of Ixworth, who died after a fall from his horse on 17 September 1775 and Nathaniel Moore (1780-1868) who fractured his arm when he was thrown from his horse in April 1814.

Suffolk practitioners had the same difficulties in setting up practice and becoming established as elsewhere in the country but, as argued here, their opportunities for private patients were limited by low population density and little proximity to towns where merchants and tradesmen lived, and the limited numbers of aristocracy. They appear to have had a wide range of largely lower end income streams that reflected their struggle to gain a living in a low density county. It is clear that some struggled to survive and Suffolk did not produce many very wealthy practitioners, but rather a considerable number of well-respected men of civic stature, who earned enough to live in a

¹⁶¹ Jeaffreson, *Book About Doctors*, p.285.

¹⁶² *Ipswich Journal*, February 1773.

manner similar to minor gentry or town merchants, and many more who lived closer to the working and lower classes. Most had Poor Law contracts to supplement their incomes, and often a military or civic appointment.

A more positive picture emerges in relation both to income and status of practitioners, possibly more so than for the same rank and file in London and the larger cities, though more work is needed on them to demonstrate this more clearly. It supports the argument that country practitioners became part of the professional establishment and their incomes were generally sufficient to maintain a credible lifestyle and enable them to mix and entertain the local middle and merchant classes, and even minor aristocracy. They were far from country bumpkins and many held civic offices, although not figuring highly in national or even local politics. There is insufficient evidence from comparable counties to tell if the picture drawn here is typical of the provinces, but sufficient data is produced to underline the argument made throughout this study for further research to generalise the conclusions more widely. Indeed, insufficient attention has been paid to the more lowly practitioners in the metropolitan areas themselves to establish a firm basis for comparison between town and country. Overall, this is a rather different picture of the pre-1830 provincial general practitioner from that presented by Margaret Pelling and Jeanne Peterson, and more in line with Irvine Loudon's view that "the local doctor was the equal of other professionals in his area".¹⁶³

¹⁶³ Loudon, *Medical Care*, p.200.

CHAPTER 9: CONCLUSIONS

The catalyst for this study was earlier research into the life of sometime Aldeburgh surgeon and apothecary George Crabbe (1752-1834). It revealed an apparent lack of interest in or information about the way medical practice was delivered in Suffolk in a period that spanned the industrialisation of much of England, and the beginning and end of the French Wars and the introduction of the 1815 Apothecaries Act. Few secondary sources specific to Suffolk or even East Anglia were found, and thus was created an increasing awareness that the conclusions reached from what seemed predominantly metropolitan and city evidence did not apply in the same way to a rural county. This in turn provoked research into the antecedent of practitioners, their education and training, the practice of medicine, the place of women and the income and status of medical practitioners, which in turn led to the major research questions posed in the beginning. These were:

- Does the predominantly metro-centric view of medical practice in the period concerned need modifying or even radically changing in the light of the Suffolk evidence?
- Are conventional beliefs about (for example) the education, training and practice of surgeons and apothecaries supported by the Suffolk evidence?
- Was medicine in Suffolk between 1750 and 1830 distinguished by doctors effectively playing ‘catch up’ with their London colleagues and those from other large cities?
- Or, did they represent a link in the development of general medical services, from the healers of the sixteenth century to the general practitioners of the mid-nineteenth century, that has been ignored so far?

This chapter provides an opportunity to summarise how the evidence and arguments of the intervening chapters has led to the conclusions reached, and summarises how further research could help identify how generalisable these findings are across the country.

9.1 Key Research Questions

The first issue is whether the predominantly metro-centric view of medical practice in the period concerned needs modifying or even radically changing in the light of the Suffolk evidence. The general conclusion from this research is that most modern historiographies have been metro-centric, to the detriment of a true picture across the country of the nature of medical care in this period. The picture of ‘backwoodsmen’, following well behind the exciting developments of London medicine does not fit that revealed by detailed evidence for Suffolk, and calls into serious question whether historians should rely so heavily on metropolitan data. It is important to remember that, although between 1750 and 1830 there was a marked increase in the proportion of those living in urban areas, nevertheless in 1801 this was still only 25 per cent of the population, including the nine or ten per cent who lived in London.¹ Anne Digby recognises the importance of country practice numerically, but she also points out that London evidence largely concerns those medical practitioners who were well known and well established, rather than the mass of anonymous surgeons and apothecaries working in the less glamorous and less affluent parts of the city.² Margaret Pelling has also drawn attention to the difficulties of analysing London medical practice, not only because of the complexity and evolutionary nature of the capital’s medical organisations, but also because of the lack of information about lower ranks.³ This raises the further point that the traditional picture of provincial practice may be further distorted by reliance upon an essentially London image that in itself is a poor reflection of the true situation in the capital. Provincial rural medicine will always be significantly different from that of large towns and metropolitan areas - not least by reason of population density, poorer travel and communication links, and less

¹ Phyllis Deane & William A. Cole, *British Economic Growth 1688-1959 - Trends and Structure*, (Cambridge, 1993), p.9.

² Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911*, (Cambridge, 1994), p.110.

³ Margaret Pelling, “Knowledge command acquired: the education of unlicensed medical practitioners in early modern Britain”, in Vivian Nutton & Roy Porter, *History of Medical Education in Britain*, (Amsterdam, 1995), pp.250-279.

competition - and it is that essential difference that not been reflected sufficiently in modern historiographies.

The research has produced other findings, some tentative and requiring more work, and others throwing up differences of interpretation and alternative theories around many aspects of country doctors' lives, their education, training and practice. These challenge some significant generalisations made in current or recent historiographies. Nevertheless, those writings have of course provided an invaluable background to the social and historical developments that form the backdrop to this study. Modern writers have presented varying conclusions in recent historiographies as the political and dialectic fashion has changed, and there are wide interpretations. For example, the impact of industrialisation upon the way healthcare was delivered and the roles played by practitioners. Roy Porter concludes that before 1800, most of the population was dependent for its healthcare on a ragbag of lesser and lay expedients.⁴ Margaret Pelling similarly considers that the major resource of the countryside in terms of medicine was, albeit in a slightly earlier period, "the cunning men and women".⁵ More recently, Stephen Jacyna concludes that, although the appearance might be of a traditional societal structure, the reality of politics (including medical) in early nineteenth century Britain represented "a microcosm of the class conflict that defined industrial society". He seems to see society almost entirely as urban and industrial, and expresses the change in medical politics as "an elite majority exploiting a medical proletariat".⁶ His emphasis again is on urban living and such wording does not resonate with the evidence of the Suffolk society and professional class presented here. More helpful is the work of Ian Mortimer, albeit again for a slightly earlier period, which concludes that by 1720 "there were some rural practitioners who... were general practitioners to their communities".⁷

⁴ Roy Porter, *Health for Sale - Quackery in England 1660-1850*, (Manchester, 1989).

⁵ Margaret Pelling, *The Common Lot - Sicknes, Medical Occupations, and the Urban Poor in Early Modern England*, (London, 1998), p.249.

⁶ Stephen Jacyna, "Medicine in transformation 1800-1849", in William F. Bynum *et al.* (eds.), *The Western Medical Tradition 1800-2000*, (Cambridge, 2006), pp.11-110.

⁷ Ian Mortimer, "The Rural Medical Marketplace c.1570-1720", in Mark Jenner & Patrick Wallis, *Medicine and the Market in England and its Colonies c. 1450-c. 1850*, (London, 2007), pp.69-87.

The study has also been hampered by the relative scarcity and often contradictory nature of secondary works covering provincial medicine in this period. An exploration of indexes and footnotes in the secondary literature, both general and specific on medicine and health, yields little or no mention of Suffolk or East Anglia, nor indeed much mention of rural medicine at all in the period of this review.⁸ Half a century ago, John Kett asserted that the differences between metropolitan and provincial practice were more compelling than the similarities.⁹ However, Edward A. Wrigley's contrary assertion has subsequently become the more prevalent view, namely that if "it is fair to assume that one adult in nine in England in this period had direct experience of London life, it is probably fair to assume that this must have acted as a powerful solvent of the customs, prejudices and modes of action of traditional rural England", in other words, that the influence of London was all pervasive.¹⁰ Later authors, such as Irvine Loudon and Rosemary O'Day, appear to have followed this line and depend heavily on London-based evidence in drawing their conclusions. In countering this, it has been helpful to start from the point of view of the county as an independent entity, looking to London in some respects for developments and new techniques but also rejecting (if only by ignoring) those elements of the ripple out from the centre that did not suit or have relevance. For example, the attitude to apprenticeship post-1815 does not appear to have been as draconian as Irvine Loudon believes, in basing his conclusion on the London and urban examples he had to hand.¹¹ The concept that the effect of change in London on the provinces was smooth, continuous or even extensive needs to be challenged.

⁸ For example, Irvine Loudon, *Medical Care and the General Practitioner 1750-1850*, (Oxford, 1986), Anne Digby, *Making a Medical Living*, Margaret Pelling, *The Common Lot*, Rosemary O'Day, *The Professions in Modern England; Servants of the Commonwealth*, (Harlow, 2000), Joan Lane, *A Social History of Medicine: Health, Healing and Disease in England 1750-1950*, (London, 2001).

⁹ Joseph F. Kett, "Provincial medical practice in England 1730-1815", *Journal of the History of Medicine*, 29, (1964), 1, pp.17-29.

¹⁰ Edward A. Wrigley, "A simple model of London's importance in changing English society and economy 1650-1750", in Daniel A. Baugh (ed.), *Aristocratic Government and Society in the Eighteenth Century*, (New York, 1975), pp.62-95.

¹¹ Loudon, *Medical Care*, p.48.

Of course, such metropolitan condescension is not universal and some investigation of provincial medicine reveals a less familiar history, yet still concentrating where it occurs largely on urban centres rather than the rural context, and frequently based on just one or two case studies. For example, Mary Fissell's work on Bristol is based primarily on the records of one physician, Richard Smith, and she discusses mainly the medical service provided within the city with little reference to its county setting.¹² John Pickstone's work on medical developments in Manchester and its regions, in spite of its title, rarely strays outside the major towns.¹³ Margaret Pelling and Charles Webster, covering a rather earlier period than the one discussed here, focus largely on urban Norwich, England's second city, rather than the countryside.¹⁴ However, their work is valuable and relevant because it demonstrates that there was diverse and rich medical practice ranging from a small elite of humanistically trained medical graduates to soothsayers by the late sixteenth century in places like Ipswich. Saxmundham, a smaller Suffolk market town, similarly had at least nineteen practitioners between 1550 and 1600, judging from the number of Episcopal licences granted.

Margaret Pelling also confirms that medical practitioners were not a heterogeneous group and that many others also delivered healthcare in rural communities, not least because medicine at the time was so integrated within local traditions and customs.¹⁵ She asserts that healthcare in rural areas was delivered by medical practitioners, supplemented by midwives, nurses and laymen of all social classes. In particular, the relationship between food and health meant that the woman's role in delivering the former gave her a significant place in the latter. Nevertheless, the numbers of medical practitioners appear to have been extensive, and Monica H. Green argues more recently that men were in fact much more involved in women's

¹² Mary Fissell, *Patients, Power and the Poor in Eighteenth Century Bristol*, (Cambridge, 1991).

¹³ John V. Pickstone, *Medicine and Industrial Society - A History of Hospital Development in Manchester and its Regions 1752-1946*, (Manchester, 1985).

¹⁴ Margaret Pelling & Charles Webster, "Medical practitioners", in Charles Webster (ed.), *Health, Medicine and Mortality in the Sixteenth Century*, (Cambridge, 1979), pp.165-236.

¹⁵ Pelling, *The Common Lot*, p.10.

healthcare than has previously been acknowledged.¹⁶ That certainly would relate to the evidence from Suffolk of male practitioners' involvement in childbirth and family health well before 1800.

The strengths of the research argument can be seen in all areas of a medical practitioner's life. Suffolk evidence shows a wider range of antecedents than generally described - across all the classes and not just as traditionally depicted from the middle class and lower aristocracy. Depictions concerning the educational backgrounds of practitioners may well have been over-simplified by the assumptions of authors such as Irvine Loudon that the vast majority attended grammar schools, when evidence on schooling from Suffolk materials suggests a much wider range of scholastic backgrounds for provincial practices.¹⁷ Arguably, this over-emphasis reflected a number of factors: the skewed listings in the *DNB*; no precise or universal definition of the term 'grammar school'; the unwillingness of some practitioners to reveal their schooling if it was not significant to their future career and particularly if it was considered of a lower level; and the fact that only major schools maintained their register of pupils. Indeed, the very lack of extant school registers from the myriad of private and independent schools that littered the countryside gives strength to the view that any generalisation based on those that do exist (largely from public and major grammar schools) will be flawed. Furthermore, it is reasonable to suppose that, of those for whom there is little data, the majority were attending local schools. The Suffolk evidence includes individual case histories and although it is a small dataset from which any firm conclusion would be unsafe, it points to a varied range of schooling backgrounds.

The evidence on apprenticeship is more extensive. Irvine Loudon maintains that apprenticeship was finished by the time of the 1815 Apothecaries Act, and others see the Act as a watershed for that form of educational

¹⁶ Monica H. Green, "Gendering the history of women's healthcare", in Alexandra Shepard & Garthine Walker, *Gender and Change: Agency, Chronology and Periodisation*, (Chichester, 2009), pp.43-82.

¹⁷ Loudon, *Medical Care*, p.35.

background.¹⁸ However, Suffolk evidence suggests otherwise. Close communities and social ties, poor communications and the limited local hospital and dispensary facilities, common in rural areas of the country like Suffolk, meant less opportunity for hospital-based developments. Perhaps, as a result, such evidence presents a more settled picture of apprenticeship as the dominant and accepted educational background for a practitioner. Moreover, regulation outside the metropolitan areas was difficult and often lax, so that the minimum length of term was not enforced, nor even the details of the apprenticeship contract itself. The popularity of apprenticeships amongst both masters and the parents of aspiring practitioners was illustrated by the high numbers of masters with multiple apprenticeship contracts, with the average length and size of premium increasingly unlike those of London and other metropolitan areas, where the Act and the changes by the College of Surgeons impacted much earlier.¹⁹

Eighteenth and nineteenth century hospitals were mainly for the poor and sometimes provided ways of improving techniques in order to try them out later on private patients. Suffolk was not involved in this development until the 1820s, although by 1800 there were over 30 hospitals across the English provinces. This local situation arose almost certainly because, although there were many small market towns, these were not necessarily or naturally linked to a larger urban hub and were inclined to assert their independence and self-reliance. The history of the rivalry between east and west Suffolk and its two main towns, Ipswich and Bury St. Edmunds, was also a contributing factor. There was difficulty in reaching agreement as to location and more than one hospital would have strained local philanthropy. It was an indication of the strength of that local rivalry that the Bury Dispensary of 1789 did not develop into a hospital sooner, bearing in mind that a hospital gave status and reputation to an area and those who worked in it, with access through patrons and the local benefactors, and increasingly through offering teaching. This was not the case for Suffolk, an important factor in suggesting that there was

¹⁸ Loudon, *ibid.*, p.172.

¹⁹ See Chapter 4.

stability and a lack of pressure for change on medical practitioners who practised there.

The second main question raised by this research was whether medicine in Suffolk between 1750 and 1830 was distinguished by doctors effectively playing 'catch up' with their London colleagues and those from other large cities.

Significantly, this does not necessarily mean that the nature of the medicine or the health of the population suffered, bearing in mind that generally the best that a doctor could do in this period was to diagnose and reassure. Indeed, interventions were often much safer in a patient's kitchen than in a hospital in terms of infection control, so the lack of hospital facilities could have benefited the rural population. Nevertheless, the picture of a backward, unadventurous and unscientific medical community in Suffolk is incorrect. Chapter 6 provided examples of the significant papers and research coming out of Suffolk, many of which reached national or even international audiences, and described how one of the most important landmarks in preventative medicine (smallpox inoculation) developed largely in Suffolk. Although it was overtaken by Jenner's more effective vaccination method, inoculation was an important step along the road to understanding the public health issues that dominated nineteenth century social policy and medicine.

Because of the generalist nature of rural country practice and the fact that country practitioners were normally already involved in midwifery, there is no evidence of significant changes in midwifery during this period in Suffolk. Many doctors saw their presence at childbirth as an essential activity in order to gain and retain a family as patients for life. There were a few calling themselves man midwives specifically, though others may have been carrying out the role without the title. Female midwives in Suffolk were probably less like the polemical and skilled Elizabeth Nihell and more like the drunken untrained Sairey Gamp.²⁰ Extant records of women in other roles in medicine

²⁰ Further information on these two extremes are given in Chapter 7.

are scarce too, though this does not mean they did not exist. A recent collection of essays gives evidence of female activity more widely, in times, places and hitherto overlooked groups, including healthcare.²¹ While there is no evidence of female surgeons or apothecaries in Suffolk, there were female apprentices, whose later careers are not reported. In some instances, women clearly were the active business partners of their doctor husbands, and they appear to have been acting as the forerunners of the practice managers of today, often carrying the business on after their husband's death, albeit essentially as a commercial undertaking, rather than delivering healthcare themselves.

Much of the attraction of the medical profession for families was the relative security of income stream and the resulting standard of living produced. However, attempting to compare incomes is almost a study in itself and one almost certainly doomed to disappointment. There is little hard evidence from case and account books of practices in Suffolk to compare effectively, although the literary and contemporary sources indicate that the status and standing of practitioners reflected a lower to middle class income and life style. There were fewer really rich and distinguished country doctors than in London, but most seemed to have earned a reasonable living and secured the respect of their communities. It is, however, impossible to know if this was through their skills as a doctor, through their educational attainments or in some cases through their social backgrounds and antecedents.

Lastly is the question of whether provincial and rural practitioners represent a link in the development of general medical services that has been ignored so far.

Suffolk evidence points to a possible new link in the development from the healers of the sixteenth and seventeenth centuries to the general practitioner of the nineteenth. The lives and practice of the generic country medical practitioner as exemplified in Suffolk justify the conclusion that country

²¹ Shepard & Walker (eds.), *Gender and Change*.

practitioners were providing quality medical practice based on inquiring and often research-based activity that met the needs of their communities. There are several areas in which conventional approaches need to take account of the history of Suffolk in this period, in reviewing for example the pace and impact of developments in medicine and medical structures and attitudes beyond the major cities, and the nature of the contemporary evidence and its interpretation. From examining these, the overriding conclusion is that the Suffolk evidence is sufficiently extensive and robust to suggest that medicine and its practitioners here differed in many ways during the period 1750-1830 from conventional or national views.

Clearly, conclusions about the rate and extent of medical developments and the changing nature of practice are coloured by the evidence used. Geoffrey Holmes and Irvine Loudon both suggest that doctors ‘arrived’ in the late seventeenth and early eighteenth centuries because of the Rose case, and that the development of the dual roles of surgeon and apothecary was enhanced by the improvements in medical education through attendance at hospitals and medical schools.²² The conclusion here is that such views seemingly applied less to Suffolk before 1830, not least because of the insignificant attendance at hospitals for teaching and training. New developments were rather difficult to highlight, because the surgeons and apothecaries and even to some degree physicians, worked as all-rounders, providing internal medicine, surgery and drugs. There was less awareness of political movements and of regulatory developments in Suffolk, though whether this is more widely reflected elsewhere in the country requires others to research. It also reflects less local direct competition, and the generally lower income from practices in Suffolk than the urban areas, with less income to be shared. Moreover, this thesis has demonstrated the essential complexity of regional and local medical systems and services. Relationships and communities were in many ways less clear cut than the metropolitan situation, leading to the proposition that there may have been a different sort of practitioner working in the provinces.

²² Details of the Rose case are given in footnote 66, Chapter 1.

9.2 Evidential Strengths and Weaknesses

Much of the argument here relies on the power of the evidence presented – both in quantity and quality. This study began by suggesting that “even where data is limited, a review of a whole county such as Suffolk within a defined period (c.1750-1830) justifies testing and, if necessary, challenging current historical thinking”.²³

The period chosen was one of relative stability, with limited commercial or industrial development in Suffolk. Its towns were growing only slowly, fuelled by migration elsewhere and from the surrounding countryside. Jonathan D. Chambers’ picture of “a mobile country population incessantly engaged in the process of moving for the purposes of improving their condition, above all seeking their future in the towns” may have been true of the Vale of Trent, but was less so of Suffolk.²⁴ The prevalence of the large farming communities with strong inheritance implications in Suffolk meant that the pressures to move were less powerful, together with a lack of industrial development to fuel the pull of towns. Even when those labouring on the land were forced into greater mobility, for example because older siblings left small crowded family cottages to live elsewhere, this was usually only to another farm and not to an urban life or occupation. The main exception where there was some movement was in the narrow coastal areas, where travel was simplified by the proximity of the sea and ports. Medical practitioners were similarly largely stationary, often working where they were born and apprenticed, and frequently within family firms.²⁵

Regional studies such as this add value, both as exercises in methodology and for what they reveal about the validity of alleged ‘national’ trends that dominate the conceptual framework within which medical historiography is

²³ Chapter 1, p.11.

²⁴ Jonathan D. Chambers, *Population, Economy and Society in Pre-Industrial England*, (Oxford, 1972), p.45.

²⁵ Chapter 3 gives examples of short distance mobility, and precisely because of the numbers, mapping mobility to demonstrate visually has proved impractical.

located. More recently, though still over ten years ago, Steven King and Alan Weaver stated that:

“Regional studies can suggest new strands of motivation, belief and experience that might otherwise remain buried, providing an historical foundation for understanding the enduring regional and local disparities in health, doctor-patient ratios, and mortality that characterised the period between 1700 and 1900”.²⁶

As this study has shown, reviewing a county has the advantage of providing a significant amount of data with a sufficiently diverse range of social, economic and geographical types within its evidence base, thereby allowing conclusions substantial enough to serve as the basis for some generalisations or projections. Apart from the value of a county study in its own right, the conclusions reached have legitimacy not achievable if based on a geographically smaller research area. Histories at the local or parish level are generally based on evidence that is too narrow to allow secure generalisations.²⁷ At the other end of the spectrum national studies, while providing more plentiful and accessible data, may be simply too generalised or skewed towards urban experience. It is acknowledged that Suffolk was a very rural county with few large towns and no hospitals before 1826, and that few other counties were markedly similar in these respects. Moreover, the lack of comparable county studies on health and medical services available, to ascertain whether Suffolk was unique or markedly atypical, poses problems; but nevertheless, the differences seen in Suffolk require explanation and their impact upon current historiographies should be assessed.²⁸

There is a great deal of information to be found in the provinces and, although as Porter says “the past is often silent”, a significant quantity of evidence on its own can form an important underpinning of an otherwise tentative conclusion. Even where conclusions seemingly rest upon flimsy

²⁶ Steven King & Alan Weaver, “Lives in their hands: the medical landscape in Lancashire 1700-1820”, *Medical History*, 45, (2000), pp.172-200.

²⁷ Joseph L. Barona & Steven Cherry (eds.), *Health and Medicine in Rural Europe 1830-1945*, (Valencia, 2005), p.20.

²⁸ *Victoria County Histories* do not usually consider health and doctoring.

evidence, or a small number of case studies, cumulatively such information can present a more compelling story.²⁹ That is what is argued here. The fact that it is difficult to adduce conclusive evidence that points one way or the other has been recognised where necessary, for example in the section on apprenticeship.³⁰ One can work only with the sources that are accessible, recognising the need for caution in using such evidence, but corroboration for the interpretations placed upon ambiguous documents such as letters, contemporary commentaries and literature has been obtained wherever possible. The evidence has covered all aspects of practitioners' lives, from early education onwards. It has explored the role women have played, whilst not putting too much focus on women as experts, bearing in mind Green's recent warning that we should avoid gendering the history of women's healthcare in particular.³¹

9.3 What Remains to be Done?

The argument is thus cumulative, with some elements stronger than others and this thesis has shown that there was so much diversity in the delivery of medical care between 1750 and 1830 that no single template will suffice. More research is needed from other counties to test further the hypotheses set out here and the challenges these raise to some accepted historiographies. John Pickstone, writing thirty years ago, believes that local historians "skilled in the use of directories and census records, wills and newspapers could contribute a great deal".³² This call to research has not resonated significantly, nor produced major contributions to the debate, though the social history of medicine has grown as social history has developed. It is hoped that this study will do so, but more importantly that it will stimulate more research particularly across the country, including London. Enough questions have been raised about significant aspects of a medical practitioner's antecedents, education and practice life in this period to demand further county-level studies, particularly of the rural counties. This

²⁹ Roy Porter, *Disease, Medicine and Society 1550-1860*, (Basingstoke, 1987), p.9.

³⁰ See Chapter 4.

³¹ Green, "Gendering".

would establish whether Suffolk was peculiar in all these respects or whether some crucial aspects of provincial medicine have been overlooked.

The relatively stable nature of society, the prevalence of medical dynasties and the lack of mobility meant that more generalised family medicine remained a strong feature of medical practice in rural areas well into the twentieth century. Whether the development of family practice and healthcare in the twenty first century has fundamentally changed this is yet to be established. However, if the pathway to Loudon's modern general practitioner is not a direct step from the sixteenth century healer, then the medical practitioner revealed between 1750 and 1830 in the provinces was an established link in that development. Such practitioners were not backwoodsmen, but delivered medical care that was often as advanced and focused on the patient's best interests as much as that delivered in the metropolis; professionals in their own right, not simply the occupier of a transitional space. Such a conclusion has implications for the way medical development prior to 1750 and post-1830 have been described, as well as for the historiographies of the period itself. Further research in other areas of the country and in the periods leading up to and following these dates would clarify this.

³² John V. Pickstone, *Health, Disease and Medicine in Lancashire 1750-1950*, (Manchester, 1980), p.3.

Appendices

Appendix A: Practitioners in Suffolk and their Antecedents

Name	Occupation	Location	Occupation of Father
Acton, Edward	Surgeon	Grundisburgh	Brewer
Barker, R	Surgeon	Ixworth	Yeoman
Bartlet, Alexander R.	Surgeon	Ipswich	Clergyman
Blomfield, Charles	Surgeon	Bury St. Edmunds	Military
Cavell, Henry	Surgeon	East India Company	Landowner
Cavell, Robert	Surgeon	East India Company	Landowner
Clubbe, John	Surgeon	Ipswich	Clergyman
Cockle, George	Surgeon	Woodbridge	Vintner
Cockle, John	Surgeon	Woodbridge and Trimley	Vintner
Crabbe, George	Surgeon and apothecary	Aldeburgh	Saltmaster
Craddock, James	Surgeon	Stowmarket	Clergyman
Crosse, John Green	Surgeon	Stowmarket and Norwich	Landowner
Cullum, Sir Thomas Gery	Surgeon	Bury St. Edmunds	Baronet
Davie, Jonathan	Surgeon	Ipswich	Farmer
Hammond, Charles Chambers	Surgeon	Ipswich	Attorney
Hasted, Roger	Surgeon and apothecary	Bury St. Edmunds	Carpenter
King, Edward	Surgeon	Witnesham	Rector/Headmaster
King, Robert Carew	Surgeon	Saxmundham	Rector/Headmaster
Leeds, Edward	Surgeon, apothecary	Coddenham, Needham Market	Usher at Bury School (grandfather Headmaster)
Mudd, Richard	Surgeon	Gedding	Farmer
Quarles, Francis	Surgeon	Nayland	Brewer
Rose, William	Surgeon	Hartest	Clergyman
Scarnell, Samuel	Surgeon	Woodbridge	Cordwainer
Sharpe, John	Surgeon and apothecary	Bury St. Edmunds	Clergyman
Symonds, Thomas	Surgeon	Saxmundham	Clergyman
Williams, William Henry	Surgeon and physician	Ipswich	Hopseller
69 others			Medical Practitioners*

*Appendix B gives more detail of these family relationships.

Appendix B: Medical Dynasties*

1: Families

The Beck Family

Father: Edward Bigsby (1760-1845) of Needham Market.
Sons: Henry (1799-1891) of Needham Market apprenticed to father, later partner.
Francis Diggan (1804-1882) of Needham Market, apprenticed to both father and brother Henry at Creeting, later partner.
Thomas Batman of Needham Market (1806-1885), apprenticed to both father and brother Henry at Creeting, later partner.

The Crowfoot Family

Father: William of Beccles (1751-1820), surgeon of Beccles.
Son: William John (1789-1871), surgeon of Beccles.
Nephew: William Henchman (1780-1848) of Framlingham and Beccles, apprenticed to uncle.
William Edward (1806-1887) of Beccles, apprenticed to father, William H.

The Denny Family

Father: John (1774-1835) of Ipswich.
Nephew: George Green Sampson (1804-1885) of Ipswich.
Father: Robert (1738-1801) of Yoxford.
Sons: Henry {1803-1805} of Saxmundham.
William {1770-1820} in partnership with brother.

The Freeman Family

Father: Daniel {1742-1757} of Earl Stonham.
Son: Daniel (1742-1810) of Earl Stonham, Stonham Aspel & Stowmarket, apprenticed to father.
Grandsons: Robert {1769-1810} of Stowmarket.
Richard (1768-1831) of Stowmarket.
John Frederick (1780-1834) of Stowmarket.
Gt. Grandson: Spencer (1804-1883) of Stowmarket, apprenticed to Richard.
Robert (1776-1845) of Saxmundham.
Henry Lankester (1795-1877) of Saxmundham, apprenticed to brother Robert.

The Growse Family

Father: John (1761-1840), surgeon, apothecary and man midwife of Boxford & Bildeston.
Sons: John (1796-1854), surgeon, apothecary and man midwife of Hadleigh.
Robert (1798-1877) of Bildeston/Hatcham, and apprenticed to father.
Grandsons: Robert (1828-1870), apprenticed to father Robert.
John L. {1821-1854}, apprenticed to father Robert.

The Jeaffreson Family

Father: William (1790-1865) of Framlingham.
Son: William (1818-1846) of Framlingham, apprenticed to father.
Grandson: George Edward (1835-1911).

The Jones Family

Father: Anthony (1764-1832) of Bildeston.
Son: Robert (1800-1855) of Long Melford, apprenticed to father.
Grandson: Robert Edwards (1825-1883) of Long Melford, apprenticed to father.

The Lynn Family

Father: James (I) (1700-1775) of Woodbridge.
Sons: James (II) (1740-1828) of Woodbridge.
John {1766-1780} of Debenham and Ufford.
Grandsons: James (III) (1770-1832), surgeon, physician of Woodbridge, Bury St. Edmunds.
George Doughty (1780-1854), surgeon, physician of Melton Asylum.

The Mudd Family

Father: Richard (1736-1796) of Gedding.
Son: Francis David (Snr.) {1794-1835} of Gedding, in partnership with father.

Father: William (1781-1841) of Hadleigh.
Son: William {1804-1832} of Hadleigh, apprenticed to and then in partnership with father.

The Sutton Family

Father: Robert (Snr.) (1707-1788), surgeon and inoculator of Kenton.
Sons: Daniel (1735-1819), inoculator.
Henry {1751}, inoculator of Framlingham and Beddingfield.
Robert (1732-1797), inoculator of Chevington.
Thomas (nd), inoculator of Braiseworth.

The Spurgin Family

Father: Thomas (1746-1830) of Stratford St. Mary.
Son: Charles Stribling (1799-1875) of Stratford St. Mary, apprenticed to father 1822-1828.
Grandson: Frederick William {1862} of Stratford St. Mary.

2: Fathers and Sons

Father: John Birch/Burch of Cavendish and Lavenham {1730-1782}.
Sons: John Birch/Burch of Lavenham {1780-1830}, followed in father's practice.
Thomas Birch/Burch of Lavenham {1782-1840}, followed in father's practice.

Father: Nathaniel Bucke (1717-1786) of Debenham and Ipswich.
Sons: Nathaniel Chenery Bucke {1810} of Ipswich and Holbrook.
John Bucke (1756-1839) of Ipswich, Bungay and Mildenhall.

Father: Bantoft Bunn (1762-1822), surgeon and apothecary of Hadleigh.
Son: William Pryse Bunn (1798-1883), surgeon and apothecary.

Father: Nathaniel Cooper Snr. {1769} of Saxmundham.
Son: Nathaniel Cooper Jnr. {1800} of Saxmundham.

Father: John Stevens Creed (1756-1829) of Bury St. Edmunds.
Son: George Creed (1799-1868) of Bury St. Edmunds, apprenticed to father.

Father: John Dalton Snr. (1771-1844) of Bury St. Edmunds.
Sons: Rowland Dalton (1801-1890) of Bury St. Edmunds, apprenticed to father.
John Dalton Jnr. (1803-1859) of Bury St. Edmunds, apprenticed to father.

Father: Henry Sallows Davey (1781-1855) of Beccles.
Son: Henry William Robert Davey (1798-1870) of Beccles, apprenticed to father.

Father: John Debenham {1742} of Debenham.
Sons: Thomas Debenham (1740-1770), surgeon and man midwife of Debenham.
John Yull Debenham {1744} of Debenham.

Father: William Ahearn Freeman (1776-1848) of Rickingham and Walsham le Willows.
Son: Mallous Freeman {1802} of Walsham le Willows.

Father: Waller Gibbs {1755}, apothecary of Ixworth.
Son: Thomas Waller Gibbs {1757} of Ixworth.

Father: Edmund Goodwyn Snr. (1732-1757) of Framlingham.
Son: Edmund Goodwyn Jnr. (1756-1829), surgeon & apothecary.

Father: Thomas Harsant (1764-1852) of Wickham Market.
Son: Charles Harsant (1801-1829) of Wickham Market, apprenticed to father.

Father: Samuel Haward (1792-1834) of Walpole and Halesworth.
Son: Horace {1815-1847} of Halesworth.

Father: William Henchman (1744-1824) of Earl Soham.
Son: Joseph Elias Henchman {1813} of Halesworth and Grundisburgh.

Father: George Hubbard Snr. (1749-1821) of Bury St. Edmunds.
Son: George Hubbard Jnr. (1785-1860) of Bury St. Edmunds.

Father: John Kent {1800-1850} of Stanton.
Son: Walton Kent (1803-1862) of Walsham le Willows apprenticed to father.
James Henry (1810-1855) of Stanton, apprenticed to father.

Father: Flamwell Le Neve {1770-1836} of Barrow.
Son: George Flamwell Le Neve {1805-1837} of Barrow, apprenticed to father.

Father: William Levett {1753-1772}, surgeon and apothecary of Aldeburgh.
Son: William Springall Levett (1753-1774) of Framlingham.

Father: Robert Muriel {1730}, surgeon of Ely.
Son: William Muriel (1794-1858), surgeon of Wickham Market.

Father: Benjamin Primrose (1741-1817) of Wrentham.
Son: John Thomas Primrose (1778-1851) of Wrentham.

Father: John Ralling (1722-1791), apothecary of Bury St. Edmunds.
Son: Edward Ralling {1780}, apothecary of Bury St. Edmunds.

Father: Robert Rose (nd) of Hartest.
Son: William Rose {1760} of Hartest.

Father: John Smith (1776-1830) of Bury St. Edmunds.
Sons: Joshua Smith (1792-1818), apprenticed to father 1808-1815.
Charles Case Smith (1802-1873) of Bury St. Edmunds, apprenticed to father 1818-1823.

Father: John Smith Snr. (no dates) of Lawshall.
Son: John Smith Jnr. (d. 1829) of Hundon.

Father: George Stebbing (1749-1825) of Ipswich.
Daughter: Rachel Susannah Stebbing (d. 1859), midwife of Ipswich and assistant to father.

Father: William Steggall (1745-1813) of Woolpit.
Son: William Steggall (1783-1851) of Grundisburgh.

Father: William Travis (1761-1835) of East Bergholt.
Son: William Hardy Travis (1786-1873) of East Bergholt, in partnership with father.

Father: Robert Wilson (1750-1833) of Peasenhall.
Sons: Charles Wilson (1779-1848), surgeon and physician of Yoxford.
George Wilson {1804-1839} of Yoxford.

Father: William Collins Worthington (1800 -1885) of Lowestoft.
????: Thomas Knights Worthington {1802-1840} of Lowestoft, apprenticed to him.

*Unless otherwise stated, all titles are 'surgeon'.

Appendix C: Ratio of Practitioners Identified Against Populations of the Larger Towns and Villages in Suffolk in 1801 and 1831

Place of Practice	Doctors active 1750- 1830	Doctors active in 1795-1805	Population in 1801*	Ratio of Doctors to population in 1801	Doctors active in 1825-35	Population in 1831*	Ratio of Doctors to population in 1831
Aldeburgh	8	1	804	1:804	2	1341	1:675
Ashfield	8	3	522	1:178	0	783	0
Bacton	3	1	585	1:585	1	758	1:758
Barrow	3	2	614	1:307	2	856	1:428
Beccles	51	24	2788	1:115	13	3862	1:297
Bildeston	6	3	744	1:271	2	836	1:418
Botesdale	6	2	565	1:283	2	655	1:328
Boxford	14	7	636	1:910	5	874	1:173
Brandon	9	5`	1148	1:275	0	2065	0
Bungay	28	12	2349	1:195	6	3734	1:622
Bures St. Mary	8	2	702	1:351	2	996	1:498
Bury St. Edmunds	69	20	7655	1:383	18	11436	1:636
Clare	8	2	1033	1:516	2	1619	1:809
Debenham	11	2	1215	1:608	3	1629	1:543
Earl Soham	9	4	563	1:116	1	762	1:762
East Bergholt	9	2	970	1:485	5	1360	1:272

Eye	15	6	1734	1:289	3	2313	1:770
Framlingham	19	7	1854	1:290	6	2445	1:408
Hadleigh	23	4	2332	1:566	6	3425	1:571
Halesworth	21	5	1676	1:355	6	2473	1:410
Hollesley	2	1	461	1:461	1	604	1:604
Hopton (by Lowestoft)	4	1	202	1:202	1	260	1:260
Ipswich	107	36	10845	1:301	31	19855	1:640
Ixworth	8	1	827	1:827	2	1061	1:530
Lavenham	11	3	1776	1:592	7	2107	1:301
Laxfield	7	2	1008	1:504	1	1158	1:1158
Long Melford	13	3	2204	1:735	5	2514	1:503
Lowestoft	20	3	2332	1:777	6	4238	1:706
Mendlesham	5	1	1051	1:1051	1	1233	1:1233
Mildenhall	16	5	2283	1:457	7	3267	1:468
Nayland	12	4	881	1:220	4	1047	1:262
Needham Market	23	7	1348	1:193	5	1466	1:293
Norton	4	2	533	1:267	2	802	1:401
Orford	3	2	751	1:376	1	1302	1:1302
Peasenhall	4	3	532	1:177	1	773	1:773
Saxmundham	19	10	885	1:850	8	1048	1:131
Southwold	10	7	1054	1:150	8	1875	1:234
Stowmarket	18	6	1761	1:292	5	2672	1:532

Stradbroke	15	5	1215	1:242	3	1527	1:509
Stratford St. Mary	4	2	502	1:251	2	630	1:315
Sudbury	38	7	3283	1:469	9	4677	1:719
Walpole	2	1	494	1:494	1	658	1:658
Walsham le Willows	4	1	993	1:993	3	1167	1:389
Wangford	11	4	477	1:119	6	636	1:109
Wattisfield	3	2	520	1:260	0	592	0
Wickham Market	13	5	896	1:179	7	1358	1:194
Wickhambrook	2	1	1002	1:1002	2	1400	1:700
Woodbridge	37	15	3020	1:201	16	4769	1:293
Woolpit	4	1	625	1:625	1	880	1:880
Wrentham	3	2	822	1:411	1	1022	1:1022
Yoxford	11	7	851	1:122	4	1149	1:287
Not known	6						

* Source: Peter Northeast, *The Population of Suffolk Parish by Parish Compiled from Government Census Returns*, unpublished MSS, SRO (Ipswich), 312.0942.

excluding border towns such as Newmarket and Diss, and where figures for doctors only are only partial as defined by J. Hodkinson, *Map of Suffolk*, (London, 1783).

Notes: The first column gives the overall number of practitioners identified as active in the period 1750-1830. It then uses two ten-year spans (1795-1805 and 1825-1835) to arrive at a doctor-population ratio approximating for each of 1801 and 1831. This has been done to reduce the risk of errors arising from the assumptions that have been made about the number of active doctors in any one year, which on their own might be very unreliable or produce wider fluctuations.

Appendix D: Known Schooling of Suffolk Medical Practitioners

School	Practitioner	Title	Dates	Place of Practice
Bury School	Acton, Edward	Surgeon	1828-1860	Grundisburgh
“	Creed, George	Surgeon	1799-1868	Bury St. Edmunds
“	Hasted, Roger	Surgeon and Apothecary	1720-1794	Bury St. Edmunds
	Howman, Roger	Physician	1707-1766	Ditchingham
“	Kerrich, John	Physician	1693-1762	Bury St. Edmunds
	Jeaffreson, William Snr.	Surgeon	1790-1865	Framlingham
“	Leeds, Edward Isaac	Surgeon and Apothecary	1716-1786	Coddenham
	Lynn, James (II)	Surgeon	1740-1848	Woodbridge
“	Lynn, James (III)	Surgeon	1770-1832	Woodbridge
	Rose, William	Surgeon	{1765-1767}	Hartest
“	Sharp(e), John	Surgeon and Apothecary	1729-1761	Bury St. Edmunds
	Spinluff, John Jnr.	Surgeon	{1732-1779}	Bardwell
“	Upcher, Robert	Surgeon	{1738-1786}	Sudbury
Charterhouse	Cullum, Sir Thomas Gery	Surgeon	1741-1831	Bury St. Edmunds
Dedham School	Beck, Edward	Physician	1794-1862	Ipswich
Ipswich School	Davie, Jonathan	Surgeon	1781-1858	Ipswich
“	Denny, John	Surgeon	1774-1835	Ipswich
“	Hammond, Charles	Surgeon	1793-1876	Ipswich
“	King, Edward	Surgeon	1791-1817	East India Company

“	King, William	Physician	1786-1864	Ipswich
“	King, Robert Carew	Surgeon	1781-1842	Saxmundham
“	Lynn, George Doughty	Physician	1780-1854	Woodbridge
“	Sampson, George Green	Surgeon	1804-1885	Ipswich
Oundle School	Bullen, George Snr.	Surgeon, Medical Officer	1791-1871	Ipswich
Private Schools	Crabbe, George	Surgeon and Apothecary	1754-1832	Aldeburgh
“	Crosse, John Green	Surgeon	1790-1850	Stowmarket and Norwich
“	Newdigate, Edmund	Physician	1702-1779	Ipswich
“	Steggall, John	Surgeon	1789-1881	Rattlesden
St. Paul's School, London	Venn, Edward	Physician	1717-1780	Ipswich
Colchester Grammar School	Drury, Robert	Surgeon	{1750-1800}	St. Osyth
At Home	Good, John Mason	Apothecary	1764-1827	Sudbury

Appendix E: Apprentices by Place of Birth Where Known, Place of Apprenticeship and Place of Practice

Name	Dates Known	Place of Birth	Place of Apprenticeship	Place of Practice
Levett, William Springall	1767-1774	Aldeburgh	Framlingham	Framlingham
Crabbe, George	1768-1781	Aldeburgh	Wickhambrook / Woodbridge	Aldeburgh
Cockle, George	1786-1836	Aldgate	Woodbridge	Woodbridge
Jones, Robert	1820-1855	Bildeston	Bildeston	Long Melford
Symmons, Benjamin Francis	1827-1866	Bures	Havardwest	Bures
Creed, George	1824-1868	Bury St. Edmunds	Bury St. Edmunds	Bury St. Edmunds
Hasted, Roger	1729-1794	Bury St. Edmunds	Bury St. Edmunds	Bury St. Edmunds
Smith, Joshua	1815-1818	Bury St. Edmunds	Bury St. Edmunds	Bury St. Edmunds
Smith, Charles Case	1825-1874	Bury St. Edmunds	Bury St. Edmunds	Bury St. Edmunds
Cullum, Sir Robert Gery	1758-1785	Bury St. Edmunds	Cambridge	Bury St. Edmunds
Cuthbert, William Snr	1796-1858	Chelsworth	Bildeston	Mendlesham
Jeaffreson, Robert	1736-1777	Clopton	Great Ashfield	Melton, Ufford, Wickham Market
Baird, Andrew Wood	{1800-1882}	Colchester	Ipswich	Ipswich
Barker, John	1828-1850	Debenham	Saxmundham	Ipswich
Freeman, Daniel Jnr	1758-1810	Earl Stonham	Earl Stonham / Woodbridge	Earl Stonham, Stonham Aspal, Stowmarket
Travis, William Hardy	1808-1848	East Bergholt	East Bergholt	East Bergholt
Bartlet, Alexander R.	1795-1847	Edinburgh	Woodbridge	Ipswich
Muriel, William	1828-1858	Ely	Ely	Wickham Market
Goodwyn, Edmund	1772-1829	Framlingham	Woodbridge	London, Woodbridge

Crosse, John Green	1806-1812	Great Finborough	Stowmarket	Stowmarket and Norwich
Baker, James	1821-1856	Hadleigh	Hadleigh	Hadleigh
Mudd, William	1826-1882	Hadleigh	Hadleigh	Hadleigh
Lenny, John Grimsby	1821-1834	Halesworth	Laxfield	Halesworth
Brooks, Isaac	1827-1875	Horringer	Bury St. Edmunds	Bury St. Edmunds
Bartlet, Alexander Henry	1824-1887	Ipswich	Ipswich	Ipswich
Pitcher, John	1828-1880	Ipswich	Ipswich	Ipswich
Sampson, George Green	1825-1885	Ipswich	Ipswich	Ipswich
King, Robert Carew	1798-1842	Ipswich	Ipswich	Saxmundham
Hammond, Charles Chambers	1819-1876	Ipswich	Norton	Ipswich
Barsham, Thomas	1826-1864	Ixworth	Diss	Norton
Symonds, Thomas	1772-1830	Kelsale	Woodbridge	Saxmundham
Garneys, Charles	1827-1882	Kenton	Sudbury	Bungay
Crowfoot, William Henchman	1794-1848	Kessingland	Beccles	Bury St. Edmunds
Chapman, James	1818-1857	Kirton	Yoxford	Yoxford
Vincent, Patrick	1827-1885	Little Waldingfield	Little Waldingfield	Lavenham
Bedingfield, John Lea	1824-1832	Melton	Framlingham, Wangford	Grundisburgh
Beck, Thomas	1806-1885	Needham Market	Needham Market	Needham Market
Beck, Francis Duggan	1826-1834	Needham Market	Needham Market	Needham Market
Beck, Henry	1829-1881	Needham Market	Needham Market	Needham Market
Bayly, Thomas	1775-1834	Norfolk	Norfolk	Stowmarket
Blomfield, Charles	1824-1830	Otley	Bury St. Edmunds	Stowmarket
Sparham, Edward	{1712-1765}	Saxmundham	Cotton	Saxmundham
Kemball, George	1730-1762	Shotley	East Bergholt	Holbrook
Kent, Walton	1828-1862	Stanton	Stanton	Walsham le Willows

Spurgin, Charles Stribling	1828-1875	Stratford St. Mary	Stratford St. Mary	Stratford St. Mary
Freeman, Mallous	1825-1830	Walsham le Willows	Walsham le Willows	Walsham le Willows
Clubbe, John	1741-1811	Whatfield/Debenham	Colchester	Ipswich
Jeaffreson, William Snr.	1813-1836	Wickham Market	Woodbridge	Framlingham
Lynn, George Doughty	1805-1854	Woodbridge	Needham Market	Woodbridge, Melton
Garneys, John	{1743-1790}	Yoxford	Saxmundham	Yoxford
Bowers, Robert Arnold	{1823}		Aldeburgh	Aldeburgh, Romford
Day, Charles Robert	1752-1787		Bardwell	Ixworth
Le Neve, George Flamwell	1828-1837		Barrow	Barrow
Ashby, John S.	{1800-1830}		Beccles	Beccles
Assey, Charles	{1790}		Beccles	Beccles
Colman, Thomas	{1800-1820}		Beccles	Beccles
Dashwood, Charles	1790-1863		Beccles	Beccles
Davey, Henry Sallows	1788-1855		Beccles	Beccles
Davey, Henry William	1815-1857		Beccles	Beccles
Fennell, Samuel	{1805-1830}		Beccles	Beccles
Gillum, Raphael	{1790-1810}		Beccles	Beccles
Kinneir, Henry	{1770-1800}		Beccles	Beccles
Le Grys/Grice, Robert Thomas	{1726-1764}		Beccles	Beccles
Matthews, Thomas	{1762-1792}		Beccles	Beccles
Minter, William	{1763-1997}		Beccles	Beccles
Penny, Stanton	{1778-1808}		Beccles	Beccles
Pierson, William	{1798-1818}		Beccles	Beccles
Purvis, Bartholomew	1714-1753		Beccles	Beccles
Revaire, John	{1760-1790}		Beccles	Beccles

Seaman, William B.	{1805-1830}		Beccles	Beccles
Sherriffe, Robert	{1785-1815}		Beccles	Beccles
Smith, William	{1808-1830}		Beccles	Beccles
Termyn, Joseph	{1787-1817}		Beccles	Beccles
Turner, Ann	{1762-1782}		Beccles	Beccles
Ward, John	{1794-1814}		Beccles	Beccles
Ward, Isaac Blowers	{1823-1830}		Beccles	Beccles
Wilkinson, Phil	{1760-1780}		Beccles	Beccles
Wormall, Christopher	{1775-1815}		Beccles	Beccles
Chapman, John Strange	1820-1854		Beccles	Beccles and Army
Henchman, William	1743-1798		Beccles	Earl Soham
Spalding, William	1745-1807		Beccles	Framlingham
Payne, Horace	1808-1844		Beccles	Gislingham
Revans, John	1766-1800		Beccles	Halesworth
Revans, Stebbing	1770-1812		Beccles	Halesworth
Clayton, Benjamin Lane	1781-1819		Beccles	Norton
Cassey, John James	{1730-1753}		Beccles	South Elmham, St. Margaret
Baldry, James	1801-1826		Beccles	Wilby/Framlingham
Fuller, James	{1790-1810}		Beccles	
Blomfield, Barrington	1828-1870		Beccles, Falkenham	Coddenham
Harcourt, John	{1765-1795}		Beccles/Gt. Yarmouth	Beccles/Great Yarmouth
Martin, Henry	1825-1850		Billericay	Haverhill
Alston, Thomas	{1709-1757}		Boxford	Boxford
Alston, Joseph	{1757-1787}		Boxford	Boxford
Bacon, Montague	{1753}		Boxford	Boxford

Bringloe, Porter	1775-1820		Boxford	Boxford
Searley, Warwell	{1766-1796}		Boxford	Boxford
Bolton, Thomas	{1768-1798}		Boxford	Stoke by Nayland, Glemsford
Hawkins, John Thomas	1747-1769		Boxford	Stowmarket
Growse, Robert	1821-1877		Boxford/Bildeston	Bildeston, Hitcham
Griffin, John	{1782-1812}		Brandon	Brandon
Tozer, Francis Edward	{1818-1830}		Bristol	Mildenhall
Atthill, Robert Snr.	1819-1870		Brooke, Norfolk	Ipswich
Cooper, Joseph	{1766-1786}		Bungay	Bungay
Copping, Westgate	{1788-1808}		Bungay	Bungay
Dack, John	{1774-1814}		Bungay	Bungay
Dade, George	{1799-1819}		Bungay	Bungay
Fish, Nathaniel	{1777-1807}		Bungay	Bungay
Howard, Charles	{1807-1830}		Bungay	Bungay
Matchett, Elizabeth	{1773-1803}		Bungay	Bungay
Mills, Joshua	1770-1800		Bungay	Bungay
Roope, George	{1792-1822}		Bungay	Bungay
Towler, Denny	{1803-1813}		Bungay	Bungay
Mornement, James	1826-1827		Bungay	Bury St. Edmunds
Say, James	1744-1809		Bungay	Framlingham
Gooch, James Wyard	1817-1863		Bungay	Stradbroke
Buck, Thomas	{1763-1793}		Bures	Bures
Cardinal, Thomas	{1785}		Bures	Bures St. Mary
Chinnery, William	{1807-1820}		Bury St. Edmunds	Bury St. Edmunds
Brown, John	1758-1810		Bury St. Edmunds	Bury St. Edmunds

Barns, John	{1762-1792}		Bury St. Edmunds	Bury St. Edmunds
Bentley, Thomas	{1790-1820}		Bury St. Edmunds	Bury St. Edmunds
Bullen, George	{1809-1815}		Bury St. Edmunds	Bury St. Edmunds
Caldecott, John	{1796}		Bury St. Edmunds	Bury St. Edmunds
Carter, Dansie	{1808-1830}		Bury St. Edmunds	Bury St. Edmunds
Dalton, John Jnr.	1825-1859		Bury St. Edmunds	Bury St. Edmunds
Dalton, Rowland	1828-1866		Bury St. Edmunds	Bury St. Edmunds
Hall, William	{1756-1786}		Bury St. Edmunds	Bury St. Edmunds
Hubbard, George Snr.	1763-1821		Bury St. Edmunds	Bury St. Edmunds
Jackson, Edward Isaac	1719-1766		Bury St. Edmunds	Bury St. Edmunds
Payne, Charles	{1790-1810}		Bury St. Edmunds	Bury St. Edmunds
Plumb, Edmund	{1799-1819}		Bury St. Edmunds	Bury St. Edmunds
Sawyer, James	1810-1830		Bury St. Edmunds	Bury St. Edmunds
Sharpe, John Martin	{1750-1780}		Bury St. Edmunds	Bury St. Edmunds
Simpson, Ellis	1769-1783		Bury St. Edmunds	Bury St. Edmunds
Smith, Richard	{1803-1830}		Bury St. Edmunds	Bury St. Edmunds
Watson, Samuel	1797-1817		Bury St. Edmunds	Bury St. Edmunds
Ball, Thomas	1753-1764		Bury St. Edmunds	Mildenhall
Cooper, Nathaniel Snr.	1700-1769		Bury St. Edmunds	Saxmundham
Pyman, Brice	1750-1776		Bury St. Edmunds	Needham Market
Smith, William Bestoe	1819-1889		Cambridge	Sudbury
Wraight, Thomas	1750-1758		Cavendish	Cavendish
Bevil, William	{1764-1767}		Cavendish	Coddenham. Needham Market
Brown, Robert	{1762-1802}		Cavendish	Southwold
Nurse, John	1758-1791		Coddenham	Debenham, Woodbridge

Nunn, John	1825-1837		Colchester	East Bergholt
Thomas, Samuel J.	1718-1773		Cotton	Lavenham
Knights, George	1818-1853		Debenham	Debenham
Tallent, Edward	1823-1830		Debenham	Debenham
Cowell, George Kersey	1828-1848		Debenham	Ipswich
Sutton, Robert Snr.	1735-1788		Debenham	Kenton, Ingatestone
Denny, John	{1795-1815}		Earl Soham	Earl Soham
Harrison, Philip Joseph	{1784-1804}		Earl Soham	Earl Soham
French, James	{1778-1808}		Earl Soham	Harleston
Harsant, Thomas	1787-1852		Earl Soham	Wickham Market
Stubbin, Partridge	{1775-1795}		East Bergholt	East Bergholt
D'Oyly, Thomas Thorowgood	{1763-1798}		East Bergholt	Hadleigh
Ashford, Hector	1828-1833		Eye	Eye
Isaacson, Thomas	{1788-1808}		Eye	Eye
Metcalf, John	{1778-1808}		Eye	Eye
Rose, George	{1818-1830}		Eye	Eye
Ross, John	{1790-1810}		Eye	Eye
Smythe, Thomas	{1783-1813}		Eye	Eye
Goodwyn, Edmund	1753-1757		Framlingham	Framlingham
Hunt	1733-1751		Framlingham	Framlingham
Read, William	{1782-1802}		Framlingham	Framlingham
Terry, Sidney Chum	{1754-1784}		Framlingham	Framlingham
Mayhew, George	1808-1844		Framlingham	Stradbroke
Lawton, John	1824-1842		Gedding	Boxford
Rush, John	{1776-1806}		Great Ashfield	Ashfield

Phillips, John	{1779-1819}		Great Ashfield	Bury St. Edmunds
Chinery, George	{1765}		Great Ashfield	Great Ashfield
Clarke, John Gibbs	{1772}		Great Ashfield	Great Ashfield
Robinson, James Grace	{1758-1788}		Great Ashfield	Great Ashfield
Stewart, Richard	{1782-1802}		Great Ashfield	Great Ashfield
Spinluff, Baptist	{1762-1792}		Great Ashfield	Rickingham
Lillie, Charles	{1821-1830}		Great Yeldham	Sudbury
Rust, Thomas	{1716-1762}		Hadleigh	Bacton, Eye
Ablett, Ralph	{1760-1790}		Hadleigh	Hadleigh
Benyone, George	1770-1800		Hadleigh	Hadleigh
Bunn, William Prise	{1800-1830}		Hadleigh	Hadleigh
Hastings, John	1826-1830		Hadleigh	Hadleigh
Williams, Lewis	{1779-1809}		Hadleigh	Hadleigh
Ray, James	1760-1767		Halesworth	Eye
Bedingfield, Joseph	1765-1795		Halesworth	Halesworth
Bowler, John	1824-1830		Halesworth	Halesworth
Haward, Horace	1822-1847		Halesworth	Halesworth, Norfolk
Smith, Richard	1757-1787		Halesworth	Middleton, Halesworth, Sotherton
Gibson, William	1756-1796		Halesworth	Westleton/Wangford
Bedingfield, John	{1760-1790}		Halesworth	
Abel, Clarke	1808-1815		Harleston, Norfolk	Halesworth
Reeve, Richard	1753-1808		Hartest	Gislingham, Botesdale
King, George	1820-1870		Hartest	Hartest
Parminster, John	{1772-1800}		Haverhill	Haverhill
Westrop, William	{1792-1812}		Haverhill	Haverhill

Cavell, Charles	{1772-1808}		Ipswich	Bardwell
Bumstead, Thomas	1740-1768		Ipswich	Boxford
Amys, Thomas	1728-1768		Ipswich	Ipswich
Baddeley, John	1764-1794		Ipswich	Ipswich
Baddeley, Gill	{1764-1794}		Ipswich	Ipswich
Baggott, Sam	{1775-1795}		Ipswich	Ipswich
Bolton, Sam	1771-1801		Ipswich	Ipswich
Bryant, James	{1794-1830}		Ipswich	Ipswich
Clarke, Samuel	{1775}		Ipswich	Ipswich
Clute, John	{1778-1808}		Ipswich	Ipswich
Coote, Chidley	{1800-1820}		Ipswich	Ipswich
Cunningham, Joseph	{1779-1809}		Ipswich	Ipswich
Dunningham, Joseph	{1779-1819}		Ipswich	Ipswich
Febb, Charles	{1730-1767}		Ipswich	Ipswich
Fildes, William	{1792-1812}		Ipswich	Ipswich
Frost, Murdows	{1770-1800}		Ipswich	Ipswich
Harmer, Carrington	{1800-1830}		Ipswich	Ipswich
Hunter, Thomas	{1786-1816}		Ipswich	Ipswich
Jackson, John	{1780-1800}		Ipswich	Ipswich
Kerridge, John	1756-1772		Ipswich	Ipswich
Kerrison, Thomas	{1795-1825}		Ipswich	Ipswich
Roper, Thomas	{1807-1830}		Ipswich	Ipswich
Rudland, Miles	1761-1781		Ipswich	Ipswich
Smyth, Thomas	{1782-1812}		Ipswich	Ipswich
Sparke, William	1763-1831		Ipswich	Ipswich

Taylor, Edmund	{1762-1782}		Ipswich	Ipswich
Taylor, Anthony	{1800-1830}		Ipswich	Ipswich
Thomas, Henry	{1786-1816}		Ipswich	Ipswich
Trusson, John	{1779-1809}		Ipswich	Ipswich
Tweed, James	{1775-1815}		Ipswich	Ipswich
Wastell, Richard	1751-1760		Ipswich	Ipswich
Webber, William	{1770}		Ipswich	Ipswich
Amis, Thomas	1729-1784		Ipswich	Stowmarket
Andrews, James	{1767-1797}		Ixworth	Ixworth
Daniel, James	1728-1759		Lavenham	Felsham
Richardson, Lewes	{1766-1796}		Lavenham	Lavenham
Steward, Thomas	1735-1780		Lavenham	Lavenham, Bury St. Edmunds
Devereux, James	{1803-1830}		Lidgate	Lidgate
Ashford, Seaman	1828-1858		London	Eye
Francis, James Ougham	1815-1860		London	Ipswich
Denny, Samuel	1801-1830		London	Woodbridge, Bacton
Barnes, John	{1820-1830}		Long Melford	Long Melford
Marsh, Richard	{1792-1822}		Long Melford	Long Melford
Patterson, John Duggan	{1825-1845}		Long Melford	Long Melford
Wright, Samuel	1750-1772		Long Melford	Stowmarket
Arnold, Alderman	{1763}		Lowestoft	Beccles
Clarke, Jon	1728-1763		Lowestoft	Beccles
Crowfoot, William	1770-1820		Lowestoft	Beccles
Jenkenson, Miles Richard	1750-1754		Lowestoft	Framlingham
Arnold, Aldous	1760-1792		Lowestoft	Lowestoft

Rennells, John Vezey	{1766-1796}		Lowestoft	Lowestoft
Worthington, Thomas Knights	1828-1830		Lowestoft	Lowestoft, Dover
Green, John	{1801-1830}		Mildenhall	Mildenhall
Tipping, Ben	1775-1805		Mildenhall	Mildenhall
Partridge, Thomas	1823-1830		Nayland	Boxford
Living, Edward	1819-1843		Nayland	Nayland
Quarles, Francis	1730-1753		Nayland	Nayland
Davie, Lancelot	{1805-1816}		Needham Market	Bungay
Costerton, Charles	{1811-1830}		Needham Market	Needham Market
Dean, John	{1774-1804}		Needham Market	Needham Market
Dod, Charles	{1795-1815}		Needham Market	Needham Market
Frost, William	1818-1823		Needham Market	Needham Market
Hunt, William Hearn	{1791-1821}		Needham Market	Needham Market
Manning, Alderman	{1787-1807}		Needham Market	Needham Market
Upcher, Robert	1745-1785		Needham Market	Sudbury
Edwards, George	1823-1853		Newmarket	Newmarket
Isaacson, Philip	1770-1800		Newmarket	Newmarket
Minterm, Michael	{1828}		Newmarket	Newmarket
Sandiver, William John	1732-1784		Newmarket	Newmarket
Sankey, Edward	{1820-1830}		Newmarket	Newmarket
Sharpe, Thomas	{1796-1816}		Newmarket	Newmarket
Haylock, Thomas Busick	1827-1830		Newmarket	Newmarket, Essex
Worthington, William Collins	1822-1885		Norfolk	Lowestoft
Hodgkin, Joseph Flott	{1820-1841}		Norton	Lowestoft
Burman, James	{1802-1830}		Norton	Norton

Norford, William	1754-1793		Norwich	Halesworth, Bury St. Edmunds
Wade, Cornelius	{1766-1796}		Orford	Orford
Gross, Edward	1828-1865		Saxmundham	Earl Soham
Amys, Thomas	{1761}		Saxmundham	Grundisburgh
Reeve, William	1723-1753		Saxmundham	Harleston
Bond, Edward	1802-1830		Saxmundham	Saxmundham
Cooper, Nathaniel Jnr.	1762-1800		Saxmundham	Saxmundham
Edgar, Deveur	{1763-1793}		Saxmundham	Saxmundham
Freeman, Henry Lankester	1813-1877		Saxmundham	Saxmundham
Kett, John	{1808-1830}		Saxmundham	Saxmundham
Woods, William	{1803-1823}		Saxmundham	Saxmundham
Turner, John	{1823-1830}		Saxmundham	Saxmundham, High Wycombe
Shribb	{1745-1780}		Saxmundham	Southwold
Pierson, John	{1789-1819}		Southwold	Southwold
Winter, Thomas	{1805-1825}		Southwold	Southwold
Wallet, Edward	{1798-1818}		Stoke	Stoke
Postie, Tolver	{1828-1848}		Stourbridge	Felsham
Armstrong, Christopher	1735-1783		Stowmarket	Bildeston
Hammond, Thomas James	1821-1850		Stowmarket	Bury St. Edmunds
Pyman, Francis Charles	1827-1838		Stowmarket	Bury St. Edmunds
Freeman, Spencer	1826-1883		Stowmarket	Stowmarket
Webber, William	1800-1875		Stowmarket	Stowmarket, Botesdale
Smith, Robert	{1770-1771}		Stradbroke	Hoxne
Daniel, Zachariah	{1765-1795}		Stradbroke	Stradbroke
Fox, Stephen	{1792-1812}		Stradbroke	Stradbroke

Girling, Simon	{1743-1792}		Stradbroke	Stradbroke
Gowing, William	{1813-1843}		Stradbroke	Stradbroke
Green, John	1770-1773		Sudbury	Glemsford
Hem(p)sted, Stephen	1746-1783		Sudbury	Haverhill
Fairclough, William	1756-1790		Sudbury	Nayland
Eyre, Benjamin	{1777-1783}		Sudbury	Sudbury
Firman, Thomas Mark	1748-1786		Sudbury	Sudbury
Hall, William	{1760-1790}		Sudbury	Sudbury
Hawes, Edward	{1773-1803}		Sudbury	Sudbury
Hunn, William Thomas	{1795-1815}		Sudbury	Sudbury
Mummings, Leonard	{1769-1799}		Sudbury	Sudbury
Newton, Thomas Alston	{1758-1788}		Sudbury	Sudbury
Sharpe, George Horatio	{1821-1841}		Sudbury	Sudbury
Smith, John	{1777-1817}		Sudbury	Sudbury
Garnham, Baptist Thomas	{1756-1786}		Thetford	Thetford
Clarke, Thomas Edward	{1800-1846}		Wangford	Wangford
Collings, Williams	{1800-1820}		Wangford	Wangford
Linton, William	{1826-1830}		Wangford	Wangford
Rudland, Miles Willis	1823-1854		Wangford	Wangford
Smith, James	{1795-1815}		Wangford	Wangford
Denham, William Hempson	{1829-1847}		Wickham Market	Wickham Market
Harsant, Charles	1824-1829		Wickham Market	Wickham Market
Pattle, John	{1803-1833}		Wickham Market	Wickham Market
Taylor, Anthony	{1796-1816}		Wickham Market	Wickham Market
Townsend, Dennis	{1807-1827}		Wickham Market	Wickham Market

Dutton, William	1818-1842		Woodbridge	Bacton
Leggett, William	1821-1854		Woodbridge	East India Company
Matthews, Thomas Leman	1819-1861		Woodbridge	East India Company
Keer, Davie	1787-1811		Woodbridge	Framlingham
D'Oyley, Charles	{1766-1815}		Woodbridge	Hadleigh
Ashley, Robert	1758-1774		Woodbridge	Ipswich
Knutton, George	{1783-1813}		Woodbridge	Mildenhall
Pett, Ellis	1758-1774		Woodbridge	Walsham le Willows
Bacon, Samuel	1828-1869		Woodbridge	Woodbridge
Baldery, Thomas	{1786-1816}		Woodbridge	Woodbridge
Culham, Benjamin	{1781-1801}		Woodbridge	Woodbridge
Gunning, Thomas	{1796-1816}		Woodbridge	Woodbridge
Isaacson, John	{1780-1810}		Woodbridge	Woodbridge
Nix, William	1826-1830		Woodbridge	Woodbridge
Salmon, Benjamin	1819-1830		Woodbridge	Woodbridge
Syer, John	1761-1823		Woodbridge	Woodbridge
Walker, John	{1783-1803}		Woodbridge	Woodbridge
Whimper, Thurston	1767-1794		Woodbridge	Woodbridge
Whincopp, William	1781-1832		Woodbridge	Woodbridge
Walford, Joseph	1753-1774		Woodbridge	Woodbridge, Bredfield
Eagle, Rowland	{1762-1792}		Woodbridge	
Darby, John Howes	{1787-1820}		Wrentham	Lowestoft
Purves, Robert	1768-1803		Yoxford	Beccles
Reynolds, Joseph	1779-1796		Yoxford	Wangford
Davie, Nunn	{1785-1805}		Yoxford	Yoxford

Appendix F: Apprentices by Population Centres **1772-1815 and 1815-1858**

Place of Practice	Population in 1801*	Apprentices 1770-1815	Population in 1831*	Apprentices 1815-1858 #
Aldeburgh	804	0	1,341	1
Ashfield	522	1	783	0
Bacton	585	0	758	1
Barrow	614	0	856	1
Beccles	2,788	21	3,862	22
Bildeston	744	1	836	9
Botesdale	565	0	655	1
Boxford	636	3	874	4
Brandon		1		0
Bungay	2,349	8	3,734	16
Bures St. Mary	702	1	996	1
Bury St. Edmunds	7,655	12	11,436	25
Clare	1,033	0	1,619	1
Debenham	1,215	1	1,629	5
Earl Soham	563	4	762	2
East Bergholt	970	1	1,360	1
Eye	1,734	5	2,313	2
Framlingham	1,854	3	2,445	6
Hadleigh	2,332	1	3,425	14
Halesworth	1,676	1	2,473	11
Harlesdon		1		0
Haverhill		2		
Hollesley	461	0	604	1
Hopton (by Lowestoft)	202	0	260	2
Ipswich	10,845	20	19,855	39
Ixworth	827	0	1,061	1
Lavenham	1,776	0	2,107	1
Laxfield	1,008	0	1,158	3
Lidgate		1		
Long Melford	2,204	1	2,514	6
Lowestoft	2,332	0	4,238	12
Mendlesham	1,051	0	1,233	2
Mildenhall		3		
Nayland	881	1	1,047	7

Needham Market	1,348	7	1,466	3
Newmarket		2		
Norton	533	1	802	10
Orford	751	0	1,302	1
Saxmundham	885	2	1,048	12
Stowmarket	1,761	1	2,672	16
Stratford St. Mary	502	0	630	1
Sudbury	3,283	3	4,677	9
Walsham le Willows	993	0	1,167	2
Wangford	477	2	636	7
Wickham Market	896	3	1,358	4
Wickhambrook	1,002	1	1,400	1
Woodbridge	3,020	13	4,769	16
Woolpit	625	0	880	2
Wrentham	822	2	1,022	3
Yoxford	851	4	1,149	6
Plus 1 at Bristol Infirmary				

Sources: # Peter Northeast, *The Population of Suffolk Parish by Parish*, compiled from Government Census Returns, SRO, (Ipswich) 312.0942, unpublished.
 * David van Zwanenberg, "Apprentices".

**Appendix G: Known Further Training of Surgeons and Apothecaries
by Hospital/Dispensary with Dates and Length of Stay**

Hospital	Name	Forename	Place of Practice	Date	Length of Stay	Profession
Addenbrooke's Hospital	Say	John	Framlingham	1822	4 years	Surgeon
Bloomsbury Dispensary	Wilkin	Henry	Walton	1824		Surgeon, Medical Officer
Borough Hospitals	Bailey	Henry W.	Thetford	1809	1 years	Surgeon
Borough Hospitals	Crowfoot	William H.	Bury St. Edmunds	1799		Surgeon
Borough Hospitals	Garneys	Charles	Bungay	1816		Surgeon
Borough Hospitals	Jeaffreson Snr.	William	Framlingham	1812	1 year	Surgeon
Borough Hospitals	Living	Edward	Nayland	1817		Surgeon
Borough Hospitals	Smith	Joshua	Bury St. Edmunds	1815	1 year	Surgeon
Borough Hospitals	Williams	William H.	Ipswich	1790	6 months	Surgeon
Central Infirmary	Bond	Edward	Saxmundham	1828		Surgeon, physician
Central Infirmary	Haylock	Thomas B.	Newmarket, Essex	1826	6 months	Surgeon
Chelsea & Brompton Disp.	Chapman	James	Yoxford	1820	1 year	Surgeon
City Dispensary	Harsant	Charles	Wickham Market	1821	6 months	Surgeon
City Dispensary	Lillie	Charles	Sudbury	1821	6 months	Surgeon
City Dispensary	Nunn	John	East Bergholt	1824	6 months	Surgeon
City Dispensary	Partridge	Thomas	Boxford	1822	9 months	Surgeon
General Dispensary	Freeman	Spencer	Stowmarket	1825	6 months	Surgeon
General Dispensary	Atthill Snr.	Robert	Ipswich	1818	6 months	Surgeon

General Dispensary	Freeman	Mallous	Walsham le Willows	1824	9 months	Surgeon
General Dispensary	Barnes	John	Long Melford	1820	9 months	Surgeon
General Dispensary	Gross	Edward	Earl Soham	1827	6 months	Surgeon
General Dispensary	Jones	Robert	Long Melford	1819		Surgeon
General Dispensary	Lawton	John	Boxford	1823	6 months	Surgeon
General Dispensary	Quilter	James C.	Ipswich	1826	6 months	Surgeon
General Dispensary	Sharpe	George H.	Sudbury	1820	9 months	Surgeon
General Dispensary	Turner	John	Saxmundham, High Wycombe	1822	6 months	Surgeon
General Dispensary	Webber	William	Stowmarket, Botesdale	1821	6 months	Surgeon
General Dispensary	Woodhouse	Charles T.	Indian Medical Service	1825	6 months	Surgeon
Guy's Hospital	Beck	Thomas	Needham Market	1830	9 months	Surgeon
Guy's Hospital	Bedingfield	John L.	Grundisburgh	1824	1 year	Surgeon
Guy's Hospital	Blomfield	Barrington	Coddenham	1820	9 months	Surgeon
Guy's Hospital	Le Neve	George F.	Barrow	1827	6 months	Surgeon
Guy's Hospital	Mudd	William	Hadleigh	1826	6 months	Surgeon
Guy's Hospital	Pitcher	John	Ipswich	1828	6 months	Surgeon
Guy's Hospital	Rudland	Miles Willis	Wangford	1823	6 months	Surgeon
Guy's Hospital	Smith	Charles C.	Bury St. Edmunds	1823	6 months	Surgeon
Guy's Hospital	Ashford	Hector	Eye	1820	6 months	Surgeon
Guy's Hospital	Ashford	Seaman	Eye	1832	6 months	Surgeon
Guy's Hospital	Clarke	Thomas E.	Wangford	1813	1 yr	Surgeon
Guy's Hospital	Denham	William H.	Wickham Market	1828	1 year	Surgeon
Guy's Hospital	Patterson	John D.	Long Melford	1824	5 years	

Guy's Hospital	Sampson	George G.	Ipswich	1826	6 months	Surgeon
London Dispensary	Beck	Francis D.	Needham Market	1826	6 months	Surgeon
London Dispensary	Beck	Henry	Needham Market	1820	6 months	Surgeon
London Dispensary	Crabbe	George	Aldeburgh	1776	9 months	Surgeon
London Dispensary	Edwards	George	Newmarket	1822	6 months	Surgeon
London Dispensary	Edwards	Charles	Newmarket	1823	9 months	Surgeon
London Dispensary	Tallent	Edward	Debenham	1822	6 months	Surgeon
London Hospital	Dutton	William	Bacton	1817	9 months	Surgeon
London Hospital	Ebden	Thomas	Thetford	1769	6 months	Surgeon
London Hospital	King	George	Hartest	1819	1 year	Surgeon
London Hospital	Tozer	Francis E.	Mildenhall	1817		Surgeon, apothecary & male midwife
Marylebone Dispensary	Haward	Horace	Halesworth, Norfolk	1821	6 months	Surgeon
Marylebone Dispensary	Salmon	Benjamin	Woodbridge	1818	1 year	Surgeon
Marylebone Dispensary	Ward	Isaac B.	Beccles	1822	6 months	Surgeon
Middlesex Hospital	Bowler	John	Halesworth	1823	6 months	Surgeon
Middlesex Hospital	Brooks	Isaac	Bury St. Edmunds	1825	6 months	Surgeon
Middlesex Hospital	Davey	Henry W.R.	Beccles	1820	6 months	Surgeon
Middlesex Hospital	Hammond	Thomas J.	Bury St. Edmunds	1820	6 months	Surgeon
Middlesex Hospital	Lenny	John G.	Halesworth	1826	6 months	Surgeon
Middlesex Hospital	Worthington	William C.	Lowestoft	1820	6 months	Apothecary
Norfolk and Norwich	Worthington	Thomas K.	Lowestoft, Dover	1827	6 months	Surgeon
Pembrokeshire Dispensary	Symmons	Benjamin F.	Bures	1826		Surgeon
Royal Infirmary, Edinburgh	Crowfoot	William E.	Beccles	1823	1 year	Surgeon

Royal Infirmary, Edinburgh	Anderson	Robert	Sudbury	1785	1 year	Surgeon
Royal Naval Hospital	Smith	Frederick P.	Lowestoft	1822		Surgeon
South London Dispensary	Barker	John	Ipswich	1827	2 years	Surgeon
South London Dispensary	Acton	Edward	Grundisburgh	1827	9 months	Surgeon
South London Dispensary	Hastings	John	Hadleigh	1825	9 months	Surgeon
South London Dispensary	Vincent	Patrick	Lavenham	1826	1 year	Surgeon
St. Bartholomew's	Bullen Snr.	George	Ipswich	1813	9 months	Surgeon
St. Bartholomew's	Bayly	Thomas	Stowmarket	1772		Surgeon
St. Bartholomew's	Mornement	James	Bury St. Edmunds	1825	6 months	Surgeon
St. Bartholomew's	Postie	Tolver	Felsham	1827	6 months	Surgeon
St. Bartholomew's	Winthrop	Stephen	Bury St. Edmunds	1796		Physician
St. George's & James' Disp	Nix	William	Woodbridge	1825	9 months	Surgeon
St. George's & St. James' Disp	Bowers	Robert A.	Aldeburgh, Romford	1817	5 years	Surgeon
St. George's & St. James' Disp	Dalton Jnr.	John	Bury St. Edmunds	1824	9 months	Surgeon
St. George's & St. Bart's	Webster	William H.B.	Royal Navy	1818		Surgeon
St. George's Hospital	Crosse	John Green	Stowmarket, Norwich	1811	1 year	Surgeon
St. George's Hospital	Creed	George	Bury St. Edmunds	1822	6 months	Surgeon
St. George's Hospital	Martin	Henry	Haverhill	1824		Surgeon
St. Thomas' Hospital	Baker	James	Hadleigh	1820	9 months	Surgeon
St. Thomas' Hospital	Rose	George	Eye	1817	9 months	Surgeon
St. Thomas''Hospital	Cowell	George K.	Ipswich	1827	9 months	Surgeon
Surrey Dispensary	Bacon	Samuel	Woodbridge	1826	9 months	Surgeon
Surrey Dispensary	Barsham	Thomas	Norton	1825	6 months	Surgeon

Surrey Dispensary	Bartlet	Alexander H.	Ipswich	1821	9 months	Surgeon
Surrey Dispensary	Blomfield	Charles	Stowmarket	1824	9 months	Surgeon
Surrey Dispensary	Dalton	Rowland	Bury St. Edmunds	1827	6 months	Surgeon
Surrey Dispensary	Gooch	James W.	Stradbroke	1816		Surgeon
Surrey Dispensary	Growse	Robert	Bildeston, Hitcham	1818	9 months	Surgeon
Surrey Dispensary	Kent	Walton	Walsham le Willows	1727	6 months	Surgeon
Surrey Dispensary	Knights	George	Debenham	1817	6 months	Surgeon
Surrey Dispensary	Leggett	William	East India Company	1820	9 months	Surgeon
Surrey Dispensary	Linton	William	Wangford	1825	6 months	Surgeon
Surrey Dispensary	Matthews	Thomas L.	East India Company	1818	9 months	Surgeon
Surrey Dispensary	Minter	Michael	Newmarket	1823	9 months	Surgeon
Surrey Dispensary	Muriel	William	Wickham Market	1828	9 months	Surgeon
Surrey Dispensary	Rose	John	Eye	1827	6 months	Surgeon
Surrey Dispensary	Sankey	Edward	Newmarket	1820	9 months	Surgeon
Surrey Dispensary	Spurgin	Charles S.	Stratford St. Mary	1828	6 months	Surgeon
Surrey Dispensary	Hammond	Charles C.	Ipswich	1818		Surgeon, apothecary & male midwife

Appendix H: Known Higher Educational Attainment of Suffolk Medical Practitioners

Name	Place of Practice	LSA	MRCS	FRCS	MD
* Lovell, Robert	Ipswich, Bristol				1778
Salmon, William	Wickham Market				1821
Whincopp, William	Woodbridge				1821
Crosse, John Green	Stowmarket, Norwich		1813	1843	1845
Dunthorn, J.	Wickhambrook		1808		1847
Bartlet, Alexander H.	Ipswich	1821	1823	1844	1859
# Anderson, Robert	Sudbury				
Goodwyn, Edmund	London, Woodbridge				ND
Chapman, John Strange	Beccles, Army	1820		1843	
Jeaffreson, William (Snr.)	Framlingham		1812	1844	
Bullen, George (Snr.)	Ipswich	1816	1813	1844	
Worthington, William Collins	Lowestoft	1820	1819	1844	
Smith, Charles Case	Bury St. Edmunds	1823	1821	1844	
Creed, George	Bury St. Edmunds	1822	1841	1844	
Crowfoot, William E.	Beccles	1828	1828	1845	
Bailey, Henry Woodruffe	Thetford		1810	1852	
Matthews, Thomas Leman	East India Company		1820	1852	
Jones, Robert	Long Melford	1819	1820	1853	
Cullum, Sir Robert Gery	Bury St. Edmunds		1800		
Denny, Samuel	Woodbridge, Bacton		1801		
Dawson, George Pearson					
Manning, Alderman	Peasenhall		1805		
Wilson, George	Yoxford		1805		
Slaytor, John	Woolpit		1808		
Travis, William Hardy	East Bergholt		1808		
Martin, George	Clare		1809		
Murray, Charles	Sudbury		1809		
Hubbard, George (Jnr.)	Bury St. Edmunds		1810		
Harris, Robert	Botesdale		1815		
Garneys, Charles	Bungay	1816	1816		
Living, Edward	Nayland	1817	1817		
King, Edward	East India Company		1817		
Wilde, George Reynolds	Mildenhall	1817	1818		
Hammond, Charles Chambers	Ipswich	1818	1819		

Blomfield, Barington	Coddenham	1820	1819		
Francis, James Ougham	Ipswich	1821	1820		
Dalton, John (Jnr.)	Bury St. Edmunds	1824	1820		
Leggett, William	East India Company	1820	1821		
Baker, James	Hadleigh		1821		
Beck, Henry	Needham Market	1820	1822		
Webber, William	Stowmarket, Botesdale	1821	1822		
Woodhouse, Charles Theodore	Indian Medical Service	1825	1824		
Nunn, John	East Bergholt	1824	1825		
Wilkin, Henry	Walton	1824	1826		
Barsham, Thomas	Norton	1825	1826		
Beck, Francis Diggan	Needham Market	1826	1826		
Pyman, Francis Charles	Bury St. Edmunds	1826	1826		
Vincent, Patrick	Lavenham	1826	1826		
Martin, Henry	Haverhill	1824	1827		
Bacon, Samuel	Woodbridge*	1826	1827		
Sampson, George Green	Ipswich	1826	1827		
Cowell, George Kersey	Ipswich	1827	1827		
Gross, Edward	Earl Soham	1827	1827		
Dalton, Rowland	Bury St. Edmunds	1827	1828		
Muriel, William	Wickham Market	1828	1828		
Pitcher, John	Ipswich	1828	1829		
Spurgin, Charles Stribling	Stratford St. Mary	1828	1829		
Day, Charles Robert	Ixworth	1830	1830		
Lucas, James Owen	Cockfield, Elmswell		1830		
Beck, Thomas	Needham Market	1830	1831		
Moore, Nathaniel	Woodbridge		1841		
Freeman, Spencer	Stowmarket	1825	1847		
Mudd, William	Hadleigh	1826			
Beck, Edward	Coddenham				
Smith, William Bestoe	Sudbury	1813			
Smith, Joshua	Bury St. Edmunds	1815			
Webster, William Henry Bailey	Royal Navy	1816			
Chapman, James	Yoxford	1817			
Dutton, William	Bacton	1817			
Frost, William	Needham Market	1817			
Tozer, Francis Edward	Mildenhall	1817			
Atthill, Robert (Snr.)	Ipswich	1818			

Thomas, Edward	Wangford	1818			
Gooch, James Wyard	Stradbroke	1818			
Growse, Robert	Bildeston, Hitcham	1818			
~ Hammond, Thomas James	Bury St. Edmunds	1820			
Sankey, Edward	Newmarket	1820			
Lillie, Charles	Sudbury	1821			
Quilter, James Chapman	Ipswich	1821			
Partridge, Thomas	Boxford	1822			
Smith, Frederick Parson	Lowestoft	1822			
Turner, John	Saxmundham, Wycombe	1822			
Bowler, John	Halesworth	1823			
Rudland, Miles Willis	Wangford	1823			
Blomfield, Charles	Stowmarket	1824			
Bedingfield, John Lea	Grundisburgh	1825			
Nix, William	Woodbridge	1825			
Symmons, Benjamin Francis	Bures	1826			
Acton, Edward	Grundisburgh	1827			
Kent, Walton	Walsham le Willows	1827			
Le Neve, George Flamwell	Barrow	1827			
Postie, Tolver	Felsham	1827			
* Wilson, Charles	Yoxford	1832			
Abbott, Robert	Needham Market				

Key: All were surgeons, except as marked below:
 * Surgeon, physician
 # Surgeon, apothecary & man midwife
 ~ Apothecary

Appendix I: Practitioners with ‘Midwife’ in their Preferred Title

Preferred Title	Practitioner	Place of Practice	Dates
Surgeon, apothecary & man midwife	Aldis, George	Stowmarket	{1791-1810}
Surgeon, apothecary & man midwife	Amys, Thomas (Jnr.)	Needham Market/Stowmarket	1760-1790
Surgeon, apothecary & man midwife	Anderson, Robert	Sudbury	1785-1838
Surgeon & man midwife	Baldry, James	Wilby/Framlingham	1801-1826
Surgeon, apothecary & man midwife	Bevil, William	Coddenham, Needham Market	{1764-1767}
Surgeon, apothecary & man midwife	Bolton, Thomas	Stoke by Nayland, Glemsford	{1768-1798}
Surgeon & man midwife	Cloney, P.	Stratford St. Mary	{1788-1808}
Surgeon, apothecary & man midwife	Darby, John Howes	Lowestoft	{1787-1820}
Man midwife	Davis, Timothy	Brandon	{1785-1805}
Surgeon & man midwife	Debenham, Thomas	Debenham	{1749-1764}
Surgeon, apothecary & man midwife	Decks, John	Long Melford	1765
Surgeon & man midwife	Downes (Downs), Joseph	Sudbury	1761-1790
Surgeon & man midwife	Eastcott, George	Stoke by Clare	1780-1795
Surgeon, apothecary & man midwife	Easto	Gorleston	1791
Surgeon, apothecary & man midwife	Ebden, Thomas	Thetford	1769
Surgeon & man midwife	Fairclough, William	Nayland	1756-1790
Surgeon & man midwife	Gibbons, Thomas	Sudbury	{1761-1775}
Surgeon, apothecary & man midwife	Girling, John	Wickham Market	1788-1789

Surgeon, apothecary & man midwife	Green, John	Glemsford	1770-1773
Surgeon & man midwife	Grove, Edward	Sudbury	1750-1763
Surgeon, apothecary & man midwife	Growse, John (Snr.)	Hadleigh	1810-1854
Surgeon, apothecary & man midwife	Harrington, George	Needham Market	1760-90
Surgeon & man midwife	Hingeston, Robert	Ipswich	{1750-1760}
Surgeon, apothecary & man midwife	Keable, Thomas	Stoke by Nayland	1764-1774
Surgeon & man midwife	Kemball, George	Holbrook	1730-1762
Surgeon, apothecary & man midwife	Kerridge, John	Ipswich	1756-1772
Surgeon, apothecary & man midwife	Kitchener, J.	Brandon	{1786-1800}
Physician& man midwife	Malfalqueyrat, Misael Remon	Bury St. Edmunds	1735-1789
Surgeon & man midwife	Mann, Thomas	Ixworth	1759-1775
Surgeon, apothecary & man midwife	Mitchell, John Bonham	Haverhill	{1791-1821}
Surgeon, apothecary & man midwife	Page, John	Woodbridge	1758-1794
Surgeon & man midwife	Phillips, R.	Sudbury	1754
Surgeon, pharmacist & man midwife	Prince, William	Botesdale	1780-1799
Surgeon, apothecary & man midwife	Rudland, William	Halesworth	{1790-1820}
Surgeon, apothecary & man midwife	Smith	Hoxne	1797
Surgeon & man midwife	Steward, Thomas	Lavenham, Bury St. Edmunds	1735-1780
Surgeon & man midwife	Walford, Joseph	Woodbridge, Bredfield	1753-1774
Surgeon, apothecary & man midwife	Willson, John	Framlingham	1822-1841
Man midwife	Wraight, Thomas	Cavendish	1750-1758

Appendix J: List of Some Doctors Attending Births Between 1750 and 1830

Robert Abbott of Needham Market (1750-1830):

3 April 1780, John Cock and wife Mary - a daughter, Lucy.

1 January 1781, Samuel Alexander and wife Elizabeth - a son.

Aldous Arnold {1792}, surgeon of Lowestoft:

February 1789 at Pakefield, John Scales and wife Margaret - a son, John.

31 August 1789, John Scales, grocer, and wife Mary - a daughter, Phoebe Elizabeth.

7 January 1792, John Seales (q.v. Scales), farmer, and wife Margaret - a daughter, Mary.

William Baker, surgeon of Lavenham {1818-1844}:

25 March 1825, paid by Little Waldringfield Overseers, £1 1s for delivery of Thompson's wife on and above salary.

Robert Barker {1808}, surgeon of Ixworth:

13 July 1808 at Barningham, David Day and wife Sarah - a daughter, Ann.

James Brookes of Ipswich (1759-1832):

29 January 1790, John Perry, clothier, and wife Anne - a son, Stephen.

23 June 1790, William Candler and wife Elizabeth - a daughter, Sarah.

13 August 1793, John Perry, clothier, and wife Anne - a son, William.

18 August 1799, parents unknown, twin girls - Martha (the younger) and Mary (the elder).

7 June 1808, Charles Barritt and wife Mary Ann - a daughter, Eliza.

Tyrell Carter (d. 1799), surgeon of Beccles:

12 July 1776 at Mutford, Isaac Beamish, yeoman, and his wife Carolina - a daughter, Carolina.

15 September 1779, Joseph Ashby and wife Sarah - a son, John Marshall.

February 1782, Sarah Ashby, widow of Joseph Ashby, draper - a daughter, Sarah.

7 July 1785, Phillip Pullynn and wife Katherine - a daughter, Katherine;

17 November 1787, unknown child who probably died;

20 July 1789, a son, Phillip, who probably died because;

30 August 1791, a son, Phillip.

Nathaniel Cooper (Jnr.) {1800}, surgeon of Saxmundham:

in Middleton, John Holmes, farmer, and wife Ann - a son, William.

Timothy Davis {1790}, man midwife of Brandon:

16 July 1790, John Foote and wife Mary - a son, Richard.

Robert Denny (1738-1801), surgeon at Yoxford:

8 February 1788 at Middleton, John Goldsbury, farmer, and wife Susanna - a son, John Sparrow;

11 April 1789, a son, Joseph;

21 February 1791, a son, Charles;

18 June 1792, a daughter, Susanna.

Joseph Downes (Downs) {1781-1790}, surgeon & man midwife of Sudbury:
8 August 1781, John Clark, watchmaker, and wife Martha - a daughter, Elizabeth;
2 December 1785, a son, James.

Robert Freeman (1776-1845), surgeon of Saxmundham:
23 September 1807 at Leiston, Robert Everett and his wife Sarah - a son, Roberton.

John Green {1784}, surgeon of Troston:
20 July 1784, John Day, farmer, and wife Deborah - a son, Charles.

George Hubbard Snr. (1749-1821), surgeon of Bury St. Edmunds:
2 August 1797, Edward Hallman and wife Abigail - a daughter, Elizabeth Stott.
1 August 1806, Robert Kemp, leather cutter, and wife Ann - a son, Henry Cook;
23 August 1807, a daughter, Eliza Kate.

John Morgan (1754-1817), surgeon of Ipswich:
13 March 1801, William Cheselden and wife Mary - a daughter, Phoebe.

John Newson (1754-1829), surgeon of Woodbridge:
17 August 1792, Joseph Plumbly, schoolmaster, and wife Sarah - a son, John Sparrow.
28 October 1798, Jonathan Wasp, cordwainer, and wife Phoebe - a daughter, Ann;
4 September 1794, a daughter, Phoebe;
17 January 1798, a son, Robert Gibbs;
2 April 1800, a son, Joseph;
16 April 1801, a daughter, Elizabeth.
11 May 1795 at Clopton, Joseph Goldsbury and wife Susannah - a son, Samuel.
6 April 1797 at Sutton, John Wright, farmer, and wife Ann - a daughter, Mary.

John Page (1730-1794), surgeon, apothecary and man midwife of Woodbridge:
3 April 1777, at Woodbridge, Benjamin Jessup, merchant, and wife Martha - a son, Alexander;
9 October 1778, a daughter, Sarah;
4 December 1781, a daughter, Lucy;
18 July 1783, a son, Benjamin;
18 July 1784, a son, Jeremiah;
9 November 1786, a daughter, Elizabeth;
19 April 1789, a daughter, Abigail.
21 August 1787, William Brown, farmer, and wife Elizabeth - a daughter, Mary;
19 September 1788, a daughter, Elizabeth;
12 February 1791, a daughter, Mary;
30 May 1792, a daughter, Maria.
9 July 1785, Thomas Brewster, merchant, and wife Ann - a son, Richard.

Henry Hall Smith {1808}, surgeon of Barking, attended birth at Barking:
10 December 1808, John Squire and wife Rachel - a daughter, Margaret.

John Smith (1776-1830) Surgeon of Bury St. Edmunds attended births:
29 April 1801 in the parish of St. James, David Wright and wife Ann - a daughter, Kezia;
7 January 1803, a son, David;
16 January 1805, a son, William Stock;
6 February 1807, a son, Robert;
14 February 1809, a daughter, Susannah.
8 May 1808, Artiss Bentley and wife Jane - a daughter, Priscilla.

William Sparke (1746-1831), surgeon of Ipswich, attended births at St. Lawrence:

3 August 1794, William Candler, schoolteacher, and wife Elizabeth - a daughter, Rachel;

4 May 1796, a daughter, Caroline.

5 August 1808, Joshua Head, brewer, and wife Isabella - a daughter, Priscilla Maria
(these were normally George Stebbing's patients).

26 February 1809, John Maw, Chandler, and wife Maria - a son, Alexander (also normally Stebbing's patients).

Thurston Whimper attended a birth at Woodbridge:

Daniel Perry and wife Elizabeth - a son, Joseph.

Robert Wilson (1750-1833), surgeon of Peasenhall, attended a birth at Peasenhall:

Samuel Hunton and wife Hannah - a daughter, Margaret.

Appendix K: Social Origins of Practitioners' Spouses¹

1. Marriage into a medical family (surgeon unless otherwise specified):

Robert Brown of Southwold to Miss Revans, daughter of Mr. Revans of Southwold in 1796.

George Cockle of Woodbridge to Mary, daughter of Charles Roope of Pulham St. Mary, Norfolk (2nd wife) in 1768.

John Cockle of Woodbridge and Trimley to Miss Weeding, sister of Samuel Weeding of Alderton in 1802.

John Green Crosse of Stowmarket and Norwich to Dorothy, daughter of Thomas Bayly of Stowmarket in 1816.

G.F. Edmonson, son of Richard Edmonson of Clare to Sarah, daughter of G. Daking of Cavendish in 1822.

John Goodey of Sudbury to the daughter of John Godfrey of Coggeshall.

Samuel Haward of Walpole and Halesworth to the eldest daughter of his previous partner, John Walker of Walpole in 1812.

Edward Isaac Jackson, apothecary of Bury St. Edmunds, to the daughter of Walter Raye of Bury St. Edmunds

George Doughty Lynn, physician, to Miss Abbott, daughter of his master, Robert Abbott of Needham Market

Richard Smith, surgeon and apothecary of Middleton, Halesworth and Sotherton to Miss Deeks in 1765. There was a John Deeks practising in Sudbury at the time - he died in 1784.

Samuel Taylor of Norton to Miss Walford, the daughter of Joseph Walford of Woodbridge in 1785.

Henry Wilkin of Walton to Elizabeth, the sister of his apprentice (and later partner) John Cockle in 1828.

¹ Largely from local journals such as the *Bury Post*, 1782-1785, the *Bury and Norwich Post*, 1786-1931, The *Ipswich Journal*, and *Weekly Mercury*, 1720 onwards.

2. Other recorded marriages:

Isaac Brooks of Bury St. Edmunds to his housekeeper (2nd wife) in 1761.

George Crabbe, surgeon and apothecary of Aldeburgh to Sarah Elmy, daughter of James Elmy of Beccles in 1783. His father-in-law was a tanner who went bankrupt in 1759. Her uncle, James, however, inherited and married wealth. He became a landowner and farmer.

Robert Cream of Long Melford to Sophia, youngest daughter of the Rev. Temple Chevallier in 1812.

Patrick MacIntyre of Bury St. Edmunds to Frances Orridge, daughter of the governor of Bury Gaol in 1824.

Vero Kemball of Stoke by Nayland and Bildeston to Miss Gurdon of Hadeigh in 1776 - "an agreeable young lady with a genteel fortune".²

Thomas Steward, surgeon and man midwife of Lavenham and Bury St. Edmunds to the daughter of Thomas Ball. Gent. Steward was mentioned in Ball's will, of which Steward was executor and legatee along with John Ralling.³

² *Ipswich Journal*, 16 July 1776.

³ Will of Thomas Ball, SRO (Bury St. Edmunds).

REFERENCES AND BIBLIOGRAPHY

PRIMARY SOURCES

1. Unpublished Archives

a) Suffolk Record Office (Bury St. Edmunds)

Assington, *Parish Accounts*, FL 521/7/1-2.

Badwell Ash, *Overseers Account Book*, FL 507/7/1.

Boxford, *Overseers' Accounts*, FB 77/G1/3/40.

Elmswell, *Town Book*, FL 513/7/2.

Hepworth, *Parish Council Town Bills*, FL 582/5/32-85.

Hopton, *Parish Book*, FL 588/1/2.

Great Ashfield, *Parish Accounts*, FL 520/5/13.

Lavenham, *Vestry Minute*, FL 508/1/1-6.

Little Waltringfield, *Overseers Book*, FL 645/7/2.

Rattlesden, *Overseers Account Book*, FL 500/7/2.

Tostock, *Overseers Account Book*, FL 642/2/6.

Wiston, *Overseers Account Book*, FB 65/G2/16.

Woolpit, *Town Book*, FL 657/1/11.

St. Leonard's Hospital, Sudbury, *Rules*, 1867, ID 501/15.

The State of Bury Dispensary, 1790, 942.64.

Suffolk General Hospital, *Rules*, 1826, 52942.53.

Suffolk General Hospital, *First Annual Report*, 1826, ID 503/27.

Act 30 12 for Erecting Hospitals and Workhouses within the Town of Sudbury,
1701, HD 717/1364/1.

Queen Elizabeth Free Grammar School, Boxford, *Governors Papers*, 1778, GD 603/8.

King Edward VI Grammar School, Bury St. Edmunds, *Minutes 1776-1836*, E/5/9/202.2.

King Edward VI Grammar School, Bury St. Edmunds, *School List*, 373.42644.

Colchester School, *Admissions List*, 373.426723.

West Suffolk Friendly Society, *Rules*, 1830, GF 502/1.

Stoke and Melford Union Association, 1828, *Rules*, GF 501/3/1.

Brandon Loyal St. George Lodge, *Book of Laws*, GF 500/1.

Alston Family Papers, FL 541/1/28-30.
Cullum, Sir Thomas Gery, *Diaries and Commonplace Book*, 7326 dd 3.
Oakes, James, of Bury St. Edmunds, *Diary*, HA 521/1-14.
The Probart Papers, 2753/4/31.

b) Suffolk Record Office (Ipswich)

Aldeburgh, *Parish Vestry Minute Book*, FC 129/E1/1.
Barking, *Vestry Minute Book*, FB 15/A1/2.
Barking, *Overseers Accounts*, FB 15/G1/2.
Bardeswell, *Parish Papers*, FL 507/7/64-66.
Blything Hundred, *Minute Book*, ADA 1/AB3/1 & 2.
Brent Eleigh, *Overseers Accounts*, FL 537/7/1.
Bury Court of Guardians, *Minute Book*, SRO (Bury St. Edmunds), F 2541.
Debenham, *Parish Bills and Vouchers*, FB 47 A6/1-22.
Eye, *Borough Records*, EE2/D2/2.
Fressingfield, *Accounts*, EG 16.
Glamsford, *Overseers Book*, FL 575/1/2.
Hepworth, *Parish Council Town Bills*, 1799, FL 582/5/32-85.
Wangford, *Parish Meeting Notes*, HA 85 3116/8529.
Wenhaston, *Parish Account Book*, FC 189 G1-/2-19.
Wissington, *Overseers Accounts*, FB 65/6/1.
Yoxford, *Overseers Accounts*, FC 73/A1/2

Register of the Bishops of Norwich, *Surgeons, Phlebotomists and Midwives*, Vols. 30-33, JC1/5/11.

Society of Friends (Quakers), *Register of Births, Marriages and Deaths*, J 424/1.

Suffolk Medical Book Society, *Rules*, R 8/1.

Ipswich Friends School, *Minute Book 1789-1800*, FK 6/3/73.

King Edward VI School, Ipswich, *School List*, 373.42644.

Stoke and Melford Union Association, *Rules*, GF 501/3/1.

Ipswich and Southdown Turnpike Trust, *Minute Book*, EN 1/C1/1-4.

Parham, *Loan Agreement for Workhouse Construction*, FC 110/G5/1&1.

Brooke, Sir Philip, *Journals*, HA93/10/6-82.

Crawford, *Notes on various Crowfoot Surgeons at Beccles*, SEA 1/C50/4.

Glyde, John, *Collection of Books and Papers*, S 058.

Goodwin, William, *Diaries at Earl Soham, 1746-1816*, HD 365/1-3.

Iveagh Papers, HD 1538/43.52.

Langslow, Richard, *The Case of Master Day of Yoxford*, Local Pamphlet No. X1X, 1801, S347.9.

Young, George, "Friendly Societies in 1793", C1) B 105/2/49.

Will of Richard Andrews of Ipswich, IC/AA1/213/1.

Will of Abraham Girling of Stradbroke, IC/223/43.

Will of William Goodwin/wyn, IC/AA1/235/38, IC/AA2/114/81.

c) Suffolk Record Office (Lowestoft)

Beccles, *Town Council Minute Book*, F 2541.

Blything Hundred, *Minute Book*, 1767/8, 124/G11/1.

William Collins Worthington, *Diary*, 89/1/28.

d) British Library

Brandon Loyal St. George Lodge of Independence, *Book of Laws*, 1833, GF 500/1.

Rules and Orders for the Government of the Suffolk General Hospital, Established in Bury St. Edmunds, 1825, YC 1996a3678.

A Sketch or Short Description of Dr Graham's Medical Apparatus Erected about the Beginning of the Year 1780 which Claimed the Cure of Disease, Tracts 821.

Suffolk Papers, *Rules of Uggeshall and Sotherton Parish Bank*, 1304 ml.

Suffolk Papers, *Rules and Orders for the Government of the Ufford New Friendly Society*, Jan 4 1803.10351i10 J.

Suffolk Papers, "Song of Old Bungay", 1-13610351.i.24.

The Dispensary and Dispensary Physicians Vindicated, 777.1.1(70).

A Memorial of the Medical Committee addressed to the inhabitants of the City of Norwich and the County of Norfolk in Support of a Plan for the Extinction of the Smallpox by a General Inoculation for the Cow Pox, Tracts T83.

e) Other

Colchester Central Library:

Asplin, John, Surgeon apothecary 1826, *Diary*, E 029.6.

Essex Record Office:

Chelmsford Strutt papers: *Letters of B Gascoyne MP to John Strutt of Terling Place*.

Guildhall Library:

Court of Examiners, *Society of Apothecaries, 1815-1858*.

Boyd, Percy, *Alphabetical Index of Apprentices*, Inland Revenue Accounts, 1768-1769.

Ipswich Central Library:

Autobiography of William King.

Medical Library, N. Essex and Colchester Hospital:

Colchester Medical Society, *Records*.

Norwich and Norfolk Records Office:

Crosse, John Green, *Diaries and Casebook*, MSS 465-8.

Dix, *Family Papers*, Accn. 24.7.70.

Thetford, *Overseers Account Book*, C/GP 17.

Public Records Office:

Beaufort papers, SP 37/9 H 43 & 44 SK 180.

Wellcome Institute Library:

Medical recipe books probably written by Elizabeth Okeover, (Adderley), MS 3712 / 7931.

2. Parliamentary Papers

The Anatomy Act, 1831, (2&3 Will. 1V c.75).

The Apothecaries Act, 1815, (55 Geo. 111 c.194).

Barber - Surgeons Act 1745 (19 Geo. 11).

The Turnpike Act, 1773 (13 Geo. 111 c.84).

Workhouse Test Act 1722-23 (alias the Knatchbull Act) (9 Geo. 1 c.7).

Statute for the Founding of Bury School 1665 (Mus. Brit. Biblio. Lansdowne 119 Pl LXX111).

Statute or Ordinances Concernynge of Artificers, Servants and Labourers, Journeymen and Prentyses, 1562 (5 Eliz. 1 c.4).

Abstract of Returns Relative to the Expense and Maintenance of the Poor, Presented to the House of Commons, 1804.

Report of the Royal Commission for Inquiring into the Administration and Operation of the Poor Laws, 1834, (44), XXV11-XXX1X.

Report of the Select Committee on Anatomy, London, 1828.

Report of the Select Committee on the Education and Practice of the Medical Profession in the United Kingdom, London, 1834 (602.1, 11 and 111).

3. Newspapers

The *Bury Post*, 1782-1785.

The *Bury and Norwich Post*, 1786-1931.

The *Ipswich Journal* or *Weekly Mercury*, 1720 onwards.

The *Suffolk Chronicle*, 1810-1899.

4. Contemporary Periodical Publications

East Anglian Notes and Queries, (1st Series), 1858-1870.

East Anglian Magazine.

Edinburgh Medical and Surgical Journal.

The Gentlemen's Magazine.

The Ipswich Magazine.

The Lancet.

The London Medical Gazette.

The London Medical Repository and Review.

Medical Quarterly Review.

The Medical and Physical Journal.

The London Medical and Physical Journal.

The Spectator.

5. Primary Sources and Material Published Before 1900

A Lady, *The Whole Duty of Woman or a Guide to the Female Sex From the Age of 16-60*, (London, 1701).

A Medical Practitioner, *Quacks and Quackery: A Remonstrance Against the Sanction Given by Government, The Press, and The Public, to the System of Imposture and Fraud Practiced on The Ignorant and Credulous in the Quackeries of the Day*, (London, 1844).

Adair, James Makittrick, *Commentaries on the Practice of Physic... to Which is Prefaced an Essay on the Education and Duties of Medical Men*, (London, 1772).

Adair, James Makittrick, *Medical Cautions for the Consideration of Invalids*, (Bath, 1786).

Addison, Joseph, writing as 'Clio', *The Spectator*, 2, 24 March 1711.

Aveling, James Hobson, *English Midwives: Their History and Prospects*, (London, 1872).

Bailey, *Bailey's British Directory, or Merchant's and Trader's Useful Companion*, (London, 1784).

Baines, Thomas, *An Account of the Woollen Manufacture of England in Yorkshire Past and Present*, (London, 1875).

Ball, John, *The Female Physician or Every Woman Her Own Doctress*, (London, 1770).

Bland, Robert, *Some Calculations of the Number of Accidents or Deaths Which Happen in Consequence of Parturition Etc from the Midwifery Reports of the Westminster General Dispensary*, (London, 1781).

- Blunt, John (pseudonym of S.W. Coves, Bookseller, No 3 Piccadilly), *The Man Midwifery Dissected or the Obstetric Family Instructor for the Use of Married Couples*, (London, 1793).
- Borde, Andrew, *A Breviary of Health*, (London, 1595).
- Buchan, W., *Domestic Medicine or the Family Physician*, (Edinburgh, 1769).
- Campbell, Richard, *The London Tradesman, Being a Compendious View of all the Trades, Professions, Arts, both Liberal and Mechanical, now Practised in the Cities of London and Westminster*, (London, 1747).
- Caulfield, James, *Portraits, Memoirs and Characters of Remarkable Persons*, (London, 1819-1820).
- Chamberlaine, W., *Tirocinium Medicum (or a Dissertation on the Duties of Youth Apprenticed to the Medical Profession)*, (London, 1812).
- Chandler, Benjamin, *An Essay Towards an Investigation of the Present Successful and most General Method of Inoculation*, (London, 1767).
- Clarke, Abel, *Narrative of a Journey in the Interior of China and of a Voyage to and from that Country in the years 1816-1817*, (London, 1818).
- Clarke, George R., *History and Description of Town and Borough of Ipswich, Including the Villages and Country Seats in its Vicinity*, (Ipswich, 1830).
- Cobbett, William, *Rural Rides*, 11, (March 1830), pp.225-228.
- Cobbold, Richard (ed.), *John H. Steggall - a Real History of a Suffolk Man Narrated by Himself*, (London, 1857).
- Cobbold, Richard (ed.), *Margaret Catchpole*, (London, 1845).
- Collyer, Joseph, *Parents and Guardians Directory and Youth's Guide in the Choice of Profession or Trade*, (London, 1761).
- Colquhoun, Patrick, *Treatise on Indigence*, (London, 1806).
- Cooper, Sir Astley, *A Treatise on Dislocations and Fractures of the Joints*, (London, 1822).
- Cooper, Bransby Blake, *The Life of Sir Astley Cooper*, (London, 1843).
- Corfe, George, *The Apothecary (Ancient and Modern) of the Society, London, Blackfriars*, (London, 1885).
- Crabbe, Revd. George Jnr., *The Poetical Works of Revd. George Crabbe with his Letters and Journals and his Life*, (London, 1834).

- Crabbe, George, *Cullings from Crabbe with a Memoir of his Life and Notices of his Writings*, (Bath, 1832).
- Craighton, William, *An Account of the Gifts and Legacies that have been Given and Bequeathed to Charitable Uses in the Town of Ipswich*, (Ipswich, 1747).
- Creighton, Charles, *A History of Epidemics in Britain*, (Cambridge, 1894).
- Crosse, John Green, *A History of the Variolous Epidemic Which Occurred in Norwich in the Year 1819*, (London, 1820).
- Crowfoot, William, *Observations on the Opinion of Dr. Longslaw*, (Yarmouth, 1800).
- Dawson, George Pearson, *Observations on Walcharen Disease Which Affected the British Soldiers in the Expedition to the Scheldt*, (Ipswich, 1810).
- Day, Thomas, *Some Considerations on the Different Ways of Removing Confined and infectious Air; and the Means Adapted with Remarks on the Contagion at Maidstone Gaol*, (London, 1784).
- Defoe, Daniel, *A Tour Through the Whole Island of Great Britain*, (London, 1724).
- Dunne, Christopher, *The Chirurgical Candidate, or Reflections on Education Indispensible to Complete Naval, Military and other Surgeons*, (London, 1808).
- Eden, Sir Frederick Morton, Bart., *The State of the Poor or a History of the Labouring Classes in England*, (London, 1797).
- Eden, Sir Frederick Morton, Bart., *An Estimate of the Numbers of Inhabitants in Great Britain and Ireland*, (Piccadilly, London, 1800).
- Foart Simmons, *Samuel Foarts' Medical Register*, (London, 1779).
- Foart Simmons, *Samuel Foarts' Medical Register*, (London, 1783).
- Ford, J., *A Suffolk Garland*, (Sudbury, 1818).
- General Description of Trades Digested in Alphabetical Order, By Which Parents, Guardians and Trustees may, with Greater ease and Certainty, make Choice of Trades Agreeable to the Capacity, Education, Inclination, Strength and Fortune of the Youth Under their Care*, (London, 1747).
- Gibbons, Thomas, *Medical Cases: Notes and Remarks*, (Ipswich, 1799).
- Gillingwater, Edmund, *An Essay on Parish Workhouses: Containing Observations on the Present State of English Workhouses with some Regulations Proposed for their Improvement*, (Bury St. Edmunds, 1786).

- Gisborne, Thomas, Rev., *Enquiry into the Duties of Man in the Higher and Middle Classes and Society in Great Britain*, (London, 1794).
- Glaister, John, *Dr William Smellie and his Contemporaries - A Contribution to the History of Midwifery in the Eighteenth Century*, (Glasgow, 1894).
- Glyde, John, *Medical Men of Ipswich in 1881*, (Ipswich, 1881).
- Glyde, John, *New Suffolk Garland*, (Ipswich, 1866).
- Gooch, B., *A Practical Treatise on Wounds and other Chirurgical Subjects*, (Norwich, 1867).
- Good, John Mason, *The History of Medicine, so far as it Relates to the Profession of the Apothecary*, (London, 1795).
- Goodwin/wyn, William, "Epidemics and contagious fevers", *Medical Physical Journal*, 9, (1802), p.509.
- Gough, Roger, *The History of Myddle*, (London, 1834).
- Green, Richard, *The History, Topography, and Antiquities of Framlingham and Saxtead*, (London, 1834).
- Gregory, Olinthus, *Memoirs of the Life, Writings and Character, Professional and Religious of the late John Mason Good*, (London, 1828)
- Gregory, John, *Lectures on the Duties and Qualifications of a Physician*, (London, 1772).
- Gromsey, B.P., *Monograph on the Parish of St. Mary Stoke, Ipswich*, (Ipswich, 1885-1887).
- Gurdon, Lady Eveline Camilla, *Suffolk in Country Folklore*, (London, 1893).
- Hamilton, William Mann, "A statistical report of the Walcharen Fever as it appeared among the troops of Ipswich on their return from Holland", *Medical and Physical Journal*, 43, (1810).
- Hanway, Jonas, *A Candid Historical Account of the Hospital for the Reception of Exposed and Deserted Young Children*, (London, 1759).
- Harrison, Edward, *Remarks on the Ineffective State of the Practice of Physic*, (London, 1806).
- Haygarth, John, *Sketch of a Plan to Exterminate the Casual Small Pox from Great Britain and to Introduce General Inoculation (1793)*, (London, 1793).

- Hemming, William, *The Medical Student's Guide, or Plain Instructions as to the Best Course to be Pursued by Those Entering the Medical Profession*, (London, 1876).
- Hodkinson, J., *Map of Suffolk*, (London, 1783).
- Holden, W., (publisher), *Annual Directory Comprising London and Separate Towns in England, Scotland, Ireland and Wales and the Isles of Jersey, Guernsey etc*, (London, 1814-1817).
- Houlton, Robert, *The Practice of Inoculation Justified, a Sermon Preached at Ingatestone, Essex, October 12 1766 in Defence of Inoculation*, (Chelmsford, 1766).
- Howard, John, *An Account of the Present State of the Prisons on the Home Circuit*, (London, 1784)
- Howlett, Rev. John, *Observations on the Increased Population of Maidstone*, (Maidstone, 1782).
- Hudson, J.C., *The Parents' Handbook*, (London, 1842).
- Jeaffreson, John Cordy, *A Book About Doctors*, (London, 1860).
- Jenner, E., *An Inquiry into the Causes and Effects of the Variolae Vaccinae, A Disease Discovered in Some Western Counties of England Particularly Gloucestershire, and Known by the Name of Cow Pox*, (London, 1798).
- Johnson, Daniel, *Advice and Maxims for Young Students and Practitioners of Medicine*, (London, 1820).
- Kerrison, Robert Masters, *An Inquiry into the Present State of the Medical Profession in England*, (London, 1814).
- Kirby, John, *A Suffolk Traveller, or a Journey Through Suffolk*, (London, 1764).
- Langdon, Roger, *The Life of Roger Langdon*, (London, n.d.)
- Langslow, Richard, *An Address to the Inhabitants of Halesworth and the Neighbourhood, July 18 1796*, (Bungay, 1800).
- Lettsom, John Coakley, "Memoir of Edward Jenner: M.D. Oration delivered before the Medical Society of London, on the 8th of March 1804", in Lettsom, Thomas, *Tracts*, (London, 1807).
- Lettsom, John Coakley, *Of the Improvement of Medicine in London on the Basis of Public Good*, (London, 1775).
- Lettsom, John Coakley, *Medical Memoirs of the London Dispensary*, (London, 1874).

- Lewis, John, *Utilising and Monopolizing of Farms, Proved Plainly Disadvantageous to the Landowners and Highly Prejudicial to the Public*, (Ipswich, 1767).
- Lipscomb, George, *Cautions and Reflections on Canine Madness with the Method of Preventing Hydrophobia in Persons that Have been Bitten*, (London, 1807).
- Lipscomb, George, *A Manual of Inoculation for the Use of the Faculty and Private Families, Pointing out the Most Approved Method of Inoculating and Conducting Patients Through Smallpox... Extracted from the Writings of Dimsdale, Sutton etc.*, (London, 1806).
- Lucas, James, *A Candid Inquiry into the Education, Qualifications and Offices of a Surgeon-apothecary*, (Bath, 1800).
- Mann, John, *Recollections of My Early Professional Life*, (London, 1887).
- Marryat, T., *Therapeutics or the Art of Healing*, (Birmingham, 1785).
- Maubray, John, *The Female Physician Containing all the Diseases Incident to that Sex, in Virgins, Wives and Widows... To Which is Added the Whole Art of new, Improved Midwifery etc.*, (London, 1724).
- Merchant and Tradesman's London Directory for 1787*, (London, 1787).
- Moore, James Carrick, *The History of Smallpox*, (London, 1815).
- Navy List, *Navy List Containing Lists of Ships, Establishments and Officers of the Fleet*, (London, 1815).
- "Nectemere", *London Medical Repository and Review*, 16, (1822), pp.186-9.
- Nihell, Elizabeth, *Treatise on the Art of Midwifery*, (London, 1760).
- Percival, Thomas, *Medical Ethics; or a Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons*, (London, 1803).
- Pigot and Co., (publishers), *London and Provincial New Commercial Directory for 1823-24*, (London, 1824).
- Pinel, Philippe, trans., Weiner, D. (1980), *The Clinical Training of Doctors*, (1793).
- Potts, Lawrence Holker, *The Hospital Pupil's Guide*, (London, 1818).
- Priestley, Joseph, *Essays on a Course of Liberal Education for Civil and Active Life*, (London, 1765).
- Provincial Medical Directory*, (London, 1847).
- Raynbird, William & H., *The Agriculture of Suffolk*, (London, 1849).

- Reid, J., "Accounts of the disease in London from 20th December to 20th January under the care of physicians of the Finsbury dispensary", *Monthly Magazine*, 83, (1802), 13, pp.74-75.
- Rogers, Timothy, *The Character of a Good Woman: in a Funeral Discourse on Prov. 3. 10... Occasion'd by the Decease of Mrs Elizabeth Dunton*, (London, 1697).
- Royal College of Physicians, *The Necessity of the Dispensary Asserted by the College of Physicians*, (London, 1702).
- Ruston, Thomas, *An Essay on Inoculation for the Smallpox*, (London, 1767).
- Sharp, Jane, *The Midwives Book or the Whole Art of Midwifery Discovered*, (London, 1671).
- Smellie, William, *A Treatise on the Theory and Practice of Midwifery*, (London, 1752).
- Smith, Adam, *An Inquiry into the Nature and Causes of the Wealth of Nations*, (Dublin, 1776).
- Sowerby, Leonard, *The Ladies Dispensatory*, (London, 1652).
- Steel, David, *Steel's Original and Correct List of Royal Navy and Honorary East India Company's Shipping*, (London, 1793 and 1806).
- Stephens, Margaret, *Domestic Midwife*, (London, 1795).
- Stone, Sarah, *A Complete Practice of Midwifery*, (London, 1737).
- Taylor, John, *History of the Travels and Adventures of the Chevalier John Taylor*, (London, 1761).
- Thicknesse, Phillip, *Man Midwifery Analysed and the Tendency of that Practice Detected and Exposed*, (London, 1764).
- Torlesse, Charles, *Some Account of Stoke by Nayland*, (London, 1877).
- The Traveller's Suffolk Directory, Containing an Alphabetical List of the Towns and Villages in the County of Suffolk*, (Beccles, 1830).
- Trial of John Dowsing*, (Bury St. Edmunds, 1789).
- Tupper, Mr., "Comment", *Medical and Physical Journal*, 8, (1802), pp.500-504.
- Tymms, J., *A Handbook of Bury St. Edmunds in the County of Suffolk*, (Bury St. Edmunds, 1854).
- Watts, Giles, *A Vindication of the New Method of Inoculating for the Smallpox, Against the Arguments and Objections of Dr. Langton and Mr Bromfield*, (London, 1767).

- Wesley, John, *Primitive Physic*, (London, 1747).
- Whincopp, William, *A Case of Hydrothorax*, (Woodbridge, 1822).
- White, William, *History, Gazetteer and Directory of Suffolk*, (Sheffield, 1844).
- Willcock, John William, *The Laws Relating to the Medical Professions*, (London, 1830).
- Williams, William Henry, *The Ventilation of Army Hospitals and Barrack Rooms*, (London, 1799).
- Willoughby, Perceval, (ed. Henry Blenkinsop), *Observations in Midwifery*, (London, 1868).
- Wilson, Charles, *Observations on Gout and Rheumatism, Including an Account of a Speedy, Safe and Effectual Remedy for Those Diseases with Numerous Cases and Communications*, (Ipswich, 1815).
- Winslow, Forbes, *Physic and Physicians: a Medical Sketchbook*, (London, 1839).
- Woodforde, James, *The Diary of a Country Parson 1759-1802*, (London, 1985).
- Yeatman, J.C., "Remarks on medical care of the parochial poor", *The London Medical and Physical Journal*, 1818.
- Yeatman, J.C., "Sick and hurt", *The London Medical and Physical Journal*, 1817.
- Yelloly, Joseph, *Observations on the Relief of the Sick Poor Addressed in a Letter to the Right Honourable Lord John Russell*, (London, 1837).
- Young, Arthur, *A Six Weeks Tour Through Southern Counties of England and Wales*, (London, 1768).
- Young, Arthur, *A General View of the Agriculture of the County of Suffolk*, 1813, (London, 1794).

6. Literary Sources (Original Publication Dates and Editions Referenced)

- Austen, Jane, *Emma*, (first published London, 1816), Oxford Illustrated Jane Austen, (3rd edn., 1932, reprinted Oxford, 1978).
- Austen, Jane, *Pride and Prejudice*, (first published London, 1811), Oxford Illustrated Jane Austen, ed. R. Chapman, (3rd edn., 1932, reprinted Oxford, 1986).
- Austen, Jane, *Sense and Sensibility*, (first published London, 1811), Oxford Illustrated Jane Austen, (3rd edn., 1936, reprinted Oxford, 1973).

- George Crabbe, *The Complete Poetical Works of George Crabbe*, edited by Norma B. Dalrymple-Champreys & Arthur Pollard in three volumes, (Oxford, 1988).
- Dickens, Charles, *Dombey and Son*, (first published London, 1848), Oxford World Classics, (1st edn., 1973, reprinted Oxford, 2001).
- Dickens, Charles, *Martin Chuzzlewit*, (first published London, 1844), Oxford Illustrated Edition, 1984.
- Eliot, George, *Middlemarch - a Study of Provincial Life*, (first published Edinburgh and London, 1871), Penguin English Library Edition, first published 1965.
- Gaskell, Mrs., *Wives and Daughters - an Everyday Story*, (first published London, 1866), Penguin Classics Edition, first published 2002.
- Sterne, Lawrence, *The Life and Opinions of Tristram Shandy, Gentleman*, (first published Dublin, 1759), reprinted Clarendon Press, (Oxford, 1983).
- Trollope, Anthony, *Dr Thorne*, (first published London, 1858), Everyman Edition, first published 1908.

SECONDARY SOURCES

1. Publications Post-1900

- Ackernecht, Erwin H., "From barber-surgeon to modern doctor", *Bulletin of History*, 58, (1984), pp.545-555.
- Adamson, John, *A Short History of Education*, (Cambridge, 1919).
- Anning, S.T., "A medical casebook - Leeds 1781-1784", *Medical History*, 28, (1984), pp.22-41.
- Anning, S.T., "Provincial medical schools in the nineteenth century" in Frederick Noel Lawrence Poynter (ed.), *The Evolution of Medical Education in Britain Since 1600*, (London, 1964), pp.121-134.
- Armstrong, Alan, *Stability and Change in an English Country Town - a Social History of York*, (London, 1974).
- Aspin, Robert, "Illustrations from the Wellcome Library: Who was Elizabeth Okeover?", *Medical History*, 44, (2000), pp.531-540.
- Bailey, Mark, *Medieval Suffolk - an Economic and Social History 1200-1500*, (Woodbridge, Suffolk, 2007).

- Barona, Joseph L. & Cherry, Steven (eds.), *Health and Medicine in Rural Europe, 1830-1945*, (Valencia, 2005).
- Barry, Jonathan, "Publicity and public good: presenting medicine in eighteenth century Bristol" in William F. Bynum & Roy Porter (eds.), *Medical Fringe and Medical Orthodoxy 1750-1850*, (London, 1987), pp.29-39.
- Barry, Jonathan & Brooks, Christopher (eds.), *The Middling Sort of People: Culture, Society and politics in England 1550-1800*, (Basingstoke, 1994).
- Bauer, Daniel A. (ed.), *Aristocratic Government and Society in the Eighteenth Century*, (New York, 1975).
- Beckett, Ronald B. (ed.), *John Constable's Correspondence: The Family at East Bergholt 1807-1837*, (London, 1962).
- Beer de, Esmond S. (ed.), *John Evelyn's Diary*, (Oxford, 1955).
- Beier, Lucinda McCray, *Sufferers and Healers: the Experience of Illness in Seventeenth Century England*, (London, 1987).
- Beier, Lucinda McCray, "The creation of the medical fringe 1550-1700", *Society for the Social History of Medicine*, Bulletin 29, (1981), pp.29-32.
- Berg, M., "What difference did women's work make to the Industrial Revolution?", in Pamela Sharpe (ed.), *Women's Work - The English Experience 1650-1914*, (London, 1998), pp.149-171.
- Bickford James A.R., & Bickford, Margaret E, *The Medical Profession in Hull 1400-1900*, (Kingston Upon Hull, 1983).
- Bivins, Roberta & Pickstone, John, *Medical Madness and Social History - Essays in Honour of Roy Porter*, (Basingstoke, 2007).
- Blackbourne, Neville, *The Restless Ocean: the Story of George Crabbe, the Aldeburgh Poet*, (Lavenham, 1972).
- Blatchley, John (ed.), *David Elisha Davy's A Journey of Excursions Through the County of Suffolk, 1823-1844*, (Woodbridge, 1982).
- Bonner, Thomas Neville, *Becoming a Physician: Medical Education in Britain, France, Germany and the United States 1750-1945*, (Oxford, 1995).
- Booth, John (ed.), *Framlingham College - the First 60 years*, (Ipswich, 1925).
- Bourdillon, Hilary, *Women as Healers: A History of Women in Medicine*, (Cambridge, 1988).
- Brockbank, E.M., *The Foundations of Provincial Medical Education*, (Manchester, 1936).

- Brockbank, W. & Kenworthy F. (eds.) *Diary of Richard Kay 1716-1751, of Baldingstone, near Bury, a Lancashire Doctor*, (Manchester, 1968).
- Brockliss, Laurence, "Consultation by letter in early Eighteenth century Paris", in Ann La Berge & Mordechai Feingold (eds.) *French Medical Culture in the Nineteenth Century*, (Amsterdam, 1994), pp.79-117.
- Brooks, Christopher, "Apprenticeship and social mobility", in Jonathan Barry & Christopher Brooks (eds.), *The Middling Sort of People: Culture, Society and Politics, 1550-1800*, (Basingstoke, 1994), pp.52-83.
- Brophy, Elizabeth Brogan, *Women's Lives in the Eighteenth Century Novel*, (Tampa, Florida, 1991).
- Brown, A.E.F., *Essex People 1750-1900*, (Chelmsford, 1972).
- Buer, M.C., *Health, Wealth and Population in the Early Days of the Industrial Revolution*, 2nd edn., (New York, 1968), (first published London, 1928).
- Burnby, Juanita G.L., *A study of an English Apothecary from 1660-1760*, (London, 1983).
- Burnby, Juanita G.L., "An examined and free apothecary", in Vivian Nutton & Roy Porter (eds.), *The History of Medical Education in Britain*, (Amsterdam, 1995), pp.16-36.
- Bynum, Jwilliam F., Lock, Stephen & Porter, Roy (eds.), *Medical Journals and Medical Knowledge*, (London, 1992).
- Bynum, William, "Health, disease and medical care", in G.S. Rousseau & Roy Porter (eds.), *The Ferment of Knowledge - Studies in the Historiography of Eighteenth Century Science*, (Cambridge, 1980), pp.211-254.
- Bynum, William, "Treating the wages of sin: venereal disease and specialism in eighteenth century Britain", in William Bynum & Roy Porter (eds.), *Medical Fringe and Medical Orthodoxy 1750-1850*, (London 1987), pp.5-28.
- Bynum, William, *Science and the Practice of Medicine in the Nineteenth Century*, (Cambridge, 1994).
- Bynum, William F. & Porter, Roy (eds.), *William Hunter and the Eighteenth Century Medical World*, (Cambridge, 1985).
- Bynum, William F. & Porter, Roy (eds.), *Medical Fringe and Medical Orthodoxy 1750-1850*, (London, 1987).
- Bynum, William F. & Porter, Roy (eds.), *Companion Encyclopaedia of the History of Medicine*, (London, 1997).

- Bynum, William F., Porter, Roy & Shepherd, Michael (eds.), *Anatomy of Madness*, (London, 1985).
- Bynum, William, Jacyna, Stephen, Lawrence, Christopher, Hardy, Anne & Tansey, E.M. (eds.), *The Western Medical Tradition 1800 to 2000*, (Cambridge, 2006).
- Cameron, Hector S., *Mr Guy's Hospital 1726-1948*, (London, 1954).
- Chadburn, Paul, "Crabbe's Aldeburgh", *East Anglian Magazine*, 3, (1937-8), pp.15-18.
- Chambers, Jonathan D., *Population, Economy and Society in Pre-industrialised England*, (Oxford, 1972).
- Cherry, Steven, "General practitioners, hospitals and medical services in rural England: the East Anglia Region, 1800-1948", in Steven Cherry & J. Barona (eds.), *Health and Medicine in Rural Europe 1850-1945*, (Valencia, 2005), pp.171-192.
- Cherry, Steven, "Responses to sickness: medical and health care provision in modern Norwich", in Carole Rawcliffe & Richard G. Wilson (eds.) *Norwich Since 1550*, (London, 2004), pp.271-294.
- Cherry, Steven, "The role of a provincial hospital - the Norfolk and Norwich", *Population Studies*, 26, (1972), 2, pp.291-306.
- Clark, Alice, *Working Life of Women in the Seventeenth Century*, (London, 1919).
- Clark, Sir George, *A History of the Royal College of Physicians*, (Oxford, 1964).
- Clark, Peter, *British Clubs and Societies 1580-1800 - the Origins of the Associational World*, (Oxford, 2000).
- Clark-Kennedy, Archibald E., *The London*, Vol.1, 1740-1840, (London, 1962).
- Clegg, M.E., "Some eighteenth century Suffolk schools", *The Suffolk Review*, 1, (1957), 3, pp.55-58.
- Cockayne, E. & Stow, N., "Misfortunes of John Steggall 1789-1881", *Journal of the Royal Society of Medicine*, 82, (1999).
- Cockayne, E. & Stow, N., *Stutter's Casebook*, (Ipswich, 2005).
- Collingwood, Frances, "John Taylor - the gentleman quack", *East Anglian Magazine*, 10, (1950-51), pp.239-244.
- Comrie, John, *Selected Works of Thomas Sydenham*, (London, 1922).
- Cook, Harold A.L., "Good advice and little medicine: the professional authority of early modern English physicians", *Journal of British Studies*, 33, (1994), pp.1-31.

- Cook, James W. & Cook, Barbara, *Man Midwife, Male Feminist: the Life and Times of George Macaulay*, (Michigan, 2004).
- Cooter, Roger (ed.), *Studies in the History of Alternative Medicine*, (Basingstoke, 1988).
- Cooter, Roger, "Bones of contention? Orthodox medicine and the mystery of the bonesetter's craft", in William F. Bynum & Roy Porter (eds.), *Medical Fringe and Medical Orthodoxy 1750-1850*, (London, 1987), pp.158-173.
- Cope, Sir Zachery, "The history of the dispensary movement", in Frederick Noel Lawrence Poynter (ed.), *Evolution of Medical Education in Britain*, (London, 1966), pp.89-110.
- Cope, Sir Zachery, "The Influence of free dispensaries upon medical education in Britain", *Medical History*, 13, (1969), pp.29-36.
- Copeman, William Sydney Charles, *The Worshipful Company of Apothecaries of London - a History 1617-1967*, (London, 1967).
- Corfield, Penelope J., *Power and the Professions in Britain 1700-1850*, (London, 1995).
- Corlett, Helen, "'No small uncertainty' - eye treatments in eighteenth century England and France", *Medical History*, 42, (1998), 2, pp.217-234.
- Cory, J.W.E., *A Short History of Suffolk General Hospital*, (Bury St. Edmunds, 1973).
- Coxens-Hardy, Basil (ed.), *The Diary of Syllas Neville 1767-1788*, (London, 1950).
- Crosse, V. Mary, *A Surgeon in the Nineteenth Century - the Life and Times of John Green Crosse*, (London, 1968).
- Crowfoot, A.E, *The Crowfoots of Beccles*, (Beccles, 1959).
- Crowther, M. Anne, "Paupers or patients? Obstacles to professionalisation in the poor law medical service before 1914", *Journal of the History of Medicine and Allied Sciences*, 39,(1984), pp.33-54.
- Croxson, Bronwyn, "The public and private faces of eighteenth century London dispensary charity", *Medical History*, 41, (1997), 2, pp.127-149.
- Crumplin, Michael, *Men of Steel*, (London, 2007).
- Cunningham, Andrew & French, Roger, *The Medical Enlightenment of the Eighteenth Century*, (Cambridge, 1990).
- D.R., "Freston Tower", *East Anglian Magazine*, 1, (1956), 12, pp.654-655.

- Daiches, David, "George Eliot's Dr Lydgate", *Proceedings of the Royal Society of Medicine*, 64, (1971), 7, pp.723-724.
- Davidoff, Leonore & Hall, Catherine, *Family Fortunes - Men and Women of the English Middle Class 1780-1850*, (London, 1987).
- Davis, Celia (ed.), *Rewriting Nursing History*, (London, 1981).
- Davies, Owen, "Charmers and charming in England and Wales", *Folklore*, 109, (1998), pp.41-52.
- D'Cruze, S, "The middling sort in Eighteenth Century Colchester", in J. Barry & C. Brooks (eds.), *The Middling Sort of People: Culture, Society and Politics in England 1550-1800*, (Basingstoke, 1994), pp.181-207.
- Deane, Phyllis & Cole, William A., *British Economic Growth, 1688-1959 - Trends and Structures*, (Cambridge, 1993).
- Delf, Charles, *Yoxford: a Lively Suffolk Village*, (Yoxford, 1971).
- Dictionary of National Biography*, (Oxford, 1997).
- Dewes, Simon, "Life of Crabbe", *East Anglian Magazine*, 24, (1973), pp.40-43.
- Digby, Anne, "Change in the asylum - the case of York, 1777-1815", *English History Review*, 2nd Series, 36, (1996), 2, pp.218-239.
- Digby, Anne, *Evolution of British General Practice 1850-1948*, (Oxford, 1999).
- Digby, Anne, *Making a Medical Living: Doctors and Patients in the English Market for Medicine 1720-1911*, (Cambridge, 1994).
- Dingwall, Helen M, "General practice in seventeenth century Edinburgh", *Social History of Medicine*, 6, (1993), pp.1-29.
- Donnison, Jean, *Midwives and Medical Men - a History of Inter-professional Rivalries and Women's Rights*, (London, 1977).
- Durey, Michael, "Medical elites, the general practitioner and patient power in Britain during the cholera epidemic of 1831-32", in Ian Inkster & Jack Morrell (eds.), *Metropolis and Provinces*, (London, 1983), pp.257-278.
- Dymond, David & Martin, Edward (eds.), *An Historical Atlas of Suffolk*, 3rd edn., (Ipswich, 1999).
- Dymond, David & Northeast, Peter, *A History of Suffolk*, (Chichester, 1985).
- Earle, Peter, "The female market in London in the late seventeenth century and early eighteenth centuries", in Pamela Sharpe, *Women's Work: the English Experience 1650-1914*, (London, 1998), pp.121-149.

- Earle, Peter, "The middling sort in London", in Jonathan Barry & Christopher Brooks (eds.), *The Middling Sort of People: Culture, Society and politics in England 1550-1800*, (Basingstoke, 1994), pp.141-158.
- Ehrenreich, Barbara & English, Deirdre, D., *Witches, Midwives and Nurses: A History of Women Healers*, (London, 1974).
- Elliott, C.W., *King Edward School, Bury*, (Bury St. Edmunds, 1963).
- Ellis, Frank, "The background of the London dispensary", *Journal of History and Medicine and Allied Sciences*, 20, (1968), 3, pp.197-216.
- Elme, Peter & Grell, Ole, *Health, Disease and Society in Europe 1500-1800*, (Manchester, 2004).
- Emrys-Roberts, R. Mayrick, "On the tracks of the woozles: where was the first cottage hospital?", in Roger Rolls, John Guy & Jean Guy (eds.), *A Pox on the Provinces*, (Bath, 1990), pp.29-38.
- Evenden, Doreen Nagy, "Gender differences in the licensing and practising of female and male surgeons in early modern England", *Medical History*, 42, (1998), pp.194-216.
- Evenden, Doreen Nagy, *Popular Medicine in Seventeenth Century England*, (Ohio, 1988).
- Evenden, Doreen Nagy, *The Midwives of the Seventeenth Century*, (Cambridge, 2000).
- Everitt, Alan, "Social mobility in early modern England", *Past and Present*, 33, (1966), pp.56-73.
- Faulkner, Thomas C. (ed.), with the assistance of Blair, Rhonda L., *Selected Letters and Journals of George Crabbe*, (Oxford, 1985).
- Fee, E. & Porter, D., "Public health, proxy medicine and professionalisation: England and America in the nineteenth century", in Andrew Wear (ed.), *Medicine in Society: Historical Essays*, (Cambridge, 1992), pp.249-276.
- Fiske, Jane (ed.), *The Oakes Diaries - Business, Politics and the Family, Bury St. Edmunds 1778-1827*, (Bury St. Edmunds, 1990).
- Fissell, Mary, *Patients, Power and the Poor in Eighteenth Century Bristol*, (Cambridge, 1991).
- Ford, John M., *A Medical Student at St. Thomas' Hospital, 1801-1802, The Weekes Family Letters*, (London, 1987).
- French, Roger & Wear, Andrew (eds.), *British Medicine in the Age of Reform*, (London, 1991).

- French, Roger & Wear, Andrew (eds.), *The Medical Revolution of the Eighteenth Century*, (Cambridge, 1989).
- Fry, J., Hunt, J. of Fawley & Pinsent, R., *A History of the Royal College of General Practitioners - the First 25 Years*, (Lancaster, 1983).
- Fussell, George E., "Earl Soham Fair in George III's reign", *The Suffolk Review Bulletin*, 8, (1956), pp.3-5.
- Fussell, George E., "English countryside and population in the eighteenth century", *Economic Geography*, 3, (1936), pp.294-310.
- George, Mary, *A History of Nayland Schools 1707-2004*, (Nayland, 2005).
- Gelfand, Thomas, "The history of the medical profession", in William F. Bynum & Roy Porter (eds.), *Companion Encyclopaedia of the History of Medicine*, Vol. 2 (London, 1997), pp.1119-1150.
- Gittings, Robert, *A Life of John Keats*, (London, 1968).
- Goodwyn, Edwin Alvis, *A Century of a Suffolk Town - Beccles 1760-1860. Part 1. 1760-1815*, (Ipswich, 1968).
- Goodwyn, Edwin Alvis, *Beccles and Bungay - A Georgian Miscellany*, (Beccles, 1969).
- Goodwyn, Edwin Alvis, *Elegance and Poverty in Bungay & Beccles*, (Beccles, 1989).
- Goodwyn, Edwin Alvis, *George Crabbe and Beccles*, (Beccles, 1986).
- Goodwyn, Edwin Alvis, *The Fauconberge School, Beccles 1770-1926*, (Beccles, 1980).
- Gosden, P.H.J.H., *The Friendly Societies in England 1815-1875*, (London, 1963).
- Goss, Brian with Cane, L.H., *Three Centuries of Bungay Doctors 1662-1978*, (Bungay, 1978).
- Grace, Frank, "The population of East Bergholt, Suffolk, 1653-1836: an analysis of parish registers", *The Suffolk Review*, 3, (1970), 8, pp.260-268.
- Grace, Frank, "Food riots in Suffolk in the eighteenth century", *The Suffolk Review*, 5, (1980), pp.32-46.
- Grace, Frank, *Rags and Bones - Nineteenth Century Ipswich*, (Ipswich, 2005).
- Gray, Irvine E. & Potter, William. E., *Ipswich School 1400-1950*, (Ipswich, 1950).
- Granshaw, Lindsay, "The rise of the modern hospital in Britain", in Andrew Wear (ed.), *Medicine in Society: historical essays*, (Cambridge, 1992), pp.197-218.

- Granshaw, Lindsay, "Fame and fortune by means of bricks and mortar", in Lindsay Granshaw & Roy Porter (eds.), *The Hospital in History*, (London, 1989), pp.199-221.
- Granshaw, Lindsay & Porter, Roy (eds.), *The Hospital in History*, (London, 1989).
- Green, Monica, H., "Gendering the history of women's healthcare", in Alexandra Shepard & Garthine Walker (eds.), *Gender and Change: Agency, Chronology and Periodisation*, (Chichester, 2009), pp.43-82.
- Grell, Ole, "The medical profession - a study guide" in Open University, A 433 *The Early History of the Professions*, (Milton Keynes, 2001), pp.15-31.
- Groves, James, "Crabbe as a botanist", *Suffolk Institute of Archaeology and Natural History*, (1906), pp.223-232.
- Guy, John H., "Episcopal licensing", *Bulletin of History of Medicine*, 56, (1982), 4, pp.528-542.
- Halliday, D.J., *Nayland: Suffolk Town and Village*, (Nayland, 1991).
- Hamilton, Bernice, "The medical profession in the eighteenth century", *Economic History Review*, Second Series, 4, (1951), 2, pp.141-149.
- Hamlin, Christopher, *Public Health and Social Justice in the Age of Chadwick Britain 1800-1854*, (Cambridge, 1998).
- Hans, Nicholas, *New Trends in Education in the Eighteenth Century*, (London, 1951)
- Hardman, P. & Saunders, M., *The Book of Beccles and its Hospital*, (Tiverton, 2004).
- Harley, David, "Ignorant midwives - a persistent stereotype", *Society for the Social History of Medicine Bulletin*, 29, (1981), pp.6-9.
- Hele, Desmond King (ed.), *The Letters of Erasmus Darwin*, (Cambridge, 1989).
- Hervey, S., *King Edward VI School, Bury*, (Suffolk Green Books No. 13, 1908).
- Hill, Alfred W., *John Wesley Among the Physicians: a Study of Eighteenth Century Medicine*, (London, 1958).
- Hill, Alfred W., "Provincial medical practice in England 1730-1815", *Journal of History of Medicine*, (1964), pp.165-236.
- Hitchcock, Tim, "Redefining sex in eighteenth century England", *History Workshop* 41, (1996), pp.73-90.
- Holloway, Sydney, "Apothecaries Act - a re-interpretation", *History* 10, (1966), pp.107-129.

- Holmes, Geoffrey, *Augustan England: Professions, State and Society 1680 -1730*, (London, 1982).
- Houghton, Richard R., *Bungay Grammar School 1565-1965*, (Bungay, 1965).
- Houlbrooke, Ralph, *Death, Religion and the Family in England, 1480-1750*, (Oxford, 1998).
- Houlbrooke, Ralph (ed.), *Death, Ritual and Bereavement*, (London, 1989).
- Hughes, Edward, "The professions in the eighteenth century", in Daniel Bauer, *Aristocratic Government and Society in Eighteenth Century England*. (New York, 1975), pp.183-203.
- Illych, Ivan, *Limits to Medicine*, (London, 1976).
- Innes Smith, R.W., *Students of Medicine at Leyden*, (London, 1932).
- Jackson, D.M., "Bach, Handel and the Chevalier Taylor", *Medical History*, 12, (1968), 4, pp.385-394.
- Jackson, Frederick J. Foakes, *Social Life in England - Chiefly East Anglia, 1750-1850*, (New York, 1916.) Lovel Lectures delivered in Boston in March 1916.
- Jacyna, Stephen, "Medicine in transformation 1800-1849", in William F. Bynum, Stephen Jacyna, Christopher Lawrence, Anne Hardy & E.M. Tansy (eds.), *The Western Medical Tradition 1800-2000*, (Cambridge, 2006), pp.11-110.
- Jarvis, William, "Who was John Lyford?", *Reports of the Jane Austen Society*, (Bristol, 1962), pp.215-218.
- Jenner, Mark S.R. & Wallis, Patrick (eds.), *Medicine and the Medical Marketplace in England and its Colonies c.1450-c.1850*, (Basingstoke, 2007).
- Jewson, Nicholas, "Medical knowledge and the patronage system in the eighteenth century", *Sociology*, 131, (1974), pp.369-385.
- Johnston, Kenneth, R., *The Hidden Wordsworth - Poet, Lover, Rebel, Spy*, (London, 1988).
- Johnston, Leslie, "The Friends School in Ipswich 1790-1800", *The Suffolk Review*, 1, (1957), 4, pp.69-72.
- Johnston, William, *Roll of Commissioned Officers in the Medical Services of the British Army, 1727-1898*, (Aberdeen, 1917).
- Jones, A.G.S., "Suffolk bankruptcies in the eighteenth century", *The Suffolk Review*, 2, (1959), 1, pp.4-10.
- Jones, W.A., *Hadleigh Through the Ages*, (Ipswich, 1977).

- Kett, J.F., "Provincial medical practice in England 1730-1815", *Journal of History of Medicine*, 29, (1964), 1, pp.17-29.
- Kilpatrick, Robert, "'Living the light': dispensaries, philanthropy, and medical reform in late eighteenth century London", in Andrew Cunningham & Roger French (eds.), *The Medical Enlightenment of the Eighteenth Century*, (Cambridge, 1990), pp.254-281.
- King, Steven & Weaver, Alan, "Lives in their hands: the medical landscape in Lancashire 1700-1820", *Medical History*, 45, (2000), pp.173-200.
- Klein, Jo, "Closely observed pains", *British Medical Journal*, Vol. 292, December, pp.20-27.
- Knowlson, Thomas Sharper, *The Origins of Popular Superstitions*, (London, n.d.).
- Koss-Chino, Joan, *Women as Healers, Women as Patients - Mental Health Care and Traditional Healing in Puerto Rico*, (Oxford, 1992).
- Lane, Joan, *Apprenticeship in England 1600-1914*, (London, 1996).
- Lane, Joan (ed.), *Coventry Apprentices and their Masters, 1781-1806*, (Stratford-upon-Avon, 1983).
- Lane, Joan, *The Making of the English Patient - a Guide to Sources*, (Stroud, 2000).
- Lane, Joan, *A Social History of Medicine: Health, Healing and Disease in England 1750-1950*, (London, 2001).
- Lane, Joan, *Worcester Infirmary in the Eighteenth Century*, (Worcester, 1992).
- Lane, Joan, "Medical apprentices in the eighteenth century", in Roger Rolls, Jean Guy & John R. Guy (eds.), *A Pox on the Provinces*, (Bath, 1990), pp.119-128.
- Lane, Joan, "The medical practitioners of provincial England in 1783", *Medical History*, 28, (1984), pp.353-371.
- Lane, Joan, "The provincial practitioner and his services to the poor 1750-1800", *Bulletin for the Society for the Social History of Medicine*, 28, (1981), pp.10-13.
- Lane, Joan, "The role of apprenticeship in eighteenth century medical education", in William Bynum & Roy Porter (eds.), *William Hunter and the Eighteenth Century Medical World*, (Cambridge, 1985), pp.57-104.
- Larnder, Leslie, *The Smyths of Peasenhall - a Suffolk Dynasty*, (Lavenham, 2002).
- Larner, Andrew J., "Caleb Hillier Parry (1755-1822): clinician, scientist, friend of Edward Jenner (1749-1823)", *Journal of Medical Biography*, 2005, 13, pp.189-194.

- Laugham, George, *Eminent East Anglians*, (London, 1904).
- Lawrence, Christopher, *Medicine in the Making of Modern Britain*, (London, 1994).
- Lawrence, Christopher, *Medical Theory, Surgical Practice: Studies in the History of Surgery*, (London, 1992).
- Lawrence, Christopher, "The concept of family doctoring", *Bulletin of Medical History*, 58, pp.348-362.
- Lawrence, Christopher, "Democratic, divine and heroic: the history and historiography of surgery", in C. Lawrence (ed.), *Medical Theory, Surgical Practice: Studies in the History of Surgery*, (London, 1992), pp.1-36.
- Lawrence, Susan C., "Anatomy and address: creating medical gentlemen in eighteenth century London", in Vivian Nutton & Roy Porter (eds.), *A History of Medical Education in Britain*, (Amsterdam, 1995), pp.199-228.
- Lawrence, Susan C., "Private enterprise and public interest - medical education and the Apothecaries Act 1815", in Roger French & Andrew Wear, *British Medicine in an Age of Reform*, (London, 1991), pp.45-73.
- Lefanu, William J., *A Bibliography of Edward Jenner*, (London, 1951).
- Lefanu, William J., *British Periodicals of Medicine 1640-1899: a Chronological List*, (Oxford, 1984).
- Le Faye, Deirdre (ed.), *Jane Austen's Letters*, (London, 2003).
- Le Vay, David, "British bonesetters", *History of Medicine*, 3,(1971) 2, pp.13-15.
- Lindert, Peter H. & Williamson, Jeffrey G., "English workers' living standards during the Industrial Revolution: a new look", *Economic History Review*, 2nd Series, 36, (1983), pp.1-25.
- Lindemann, Mary, *Medicine and Society in Early Modern Europe*, (Cambridge, 1999).
- Lieske, Pam (ed.), *Eighteenth Century British Midwifery*, (London, 2007).
- Linnell, C.D. (ed.), *The Diary of Benjamin Rogers, Rector of Carlton 1720-1771*, (Bedford, 1949).
- Lloyd, Christopher & Coulter, Jack L.S., *Medicine and the Navy 1220-1900*, (London, 1961).
- Loudon, Irvine, *Medical Care and the General Practitioner 1750-1850*, (Oxford, 1986).
- Loudon, Irvine, "The concept of the family doctor", *Bulletin of the History of Medicine*, 58, (1984), pp.342-362.

- Loudon, Irvine, "Medical education and medical reform" in Vivian Nutton & Roy Porter (eds.), *The History of Medical Education in Britain*, (Amsterdam, 1995), pp.229-249.
- Loudon, Irvine, "Medical practitioners and the period of medical reform in Britain, 1750-1850", in Andrew Wear (ed.), *Medicine in Society: Historical Essays*, (Cambridge, 1992), pp.219-248.
- Loudon, Irvine, "The nature of provincial medical practice in eighteenth century England", *Medical History*, 29, (1985), 1, pp.1-32.
- Loudon, Irvine, "Origin and growth of the dispensary movement in England", *Bulletin of the History of Medicine*, 55, (1981), pp.322-342.
- Loudon, Irvine, "Vile race of quacks with which this country is infested", in William F. Bynum & Roy Porter (eds.), *Medical Fringe and Medical Orthodoxy 1750-1850*, (London, 1987), pp.106-128.
- MacNalty, Sir Arthur Salusbury, "Prevention of smallpox: from Edward Jenner to Monckton Copeman", *Medical History*, 12, (1968), pp.1-19.
- Malster, Robert, "The Foundation of the Suffolk Royal Humane Society", *The Suffolk Review*, New Series, 48, (2007), pp.2-6.
- Mann, Ethel (ed.), *Scott, B. An Englishman at home and Abroad, 1792-1828*, (London 1930).
- Marland, Hilary, *The Doncaster Dispensary 1792-1867*, (Doncaster, c.1989).
- Marland, Hilary, "'Stately and dignified, kindly and God-fearing' - midwives, age and status in the Netherlands in the eighteenth century", in Hilary Marland & Margaret Pelling (eds.), *The Task of Healing: Medicine, Religion and Gender in England and the Netherlands 1450-1800* (Rotterdam, 1996), pp.271-305.
- Marland, Hilary & Pelling, Margaret (eds.), *The Task of Healing: Medicine, Religion and Gender in England and the Netherlands 1450-1800*, (Rotterdam, 1996).
- Marland, Hilary & Rafferty, Anne Marie, "Midwives, society and childbirth: debates and controversies", in Hilary Marland and Anne Marie Rafferty (eds.), *Midwives, Society and Childbirth*, (London, 1997), pp.1-13.
- May, Maisie, "Inoculating the urban poor in the late eighteenth century", *British Journal for the History of Science* 30, (1997), 3, pp.291-306.
- McClure, Ruth K., *Coram's Children: The London Foundling Hospital in the Eighteenth Century*, (London, 1981).
- McKeown, Thomas & Brown, R.G., "Medical evidence related to English population changes in the eighteenth century", *Population Studies*, Vol. IX, No. 2, pp.119-141.

- McKeown, Thomas & Brown, R.G., "Reasons for the decline of mortality in England and Wales during the nineteenth century", *Population Studies*, 16, (1962), 2, pp.94-122.
- McMenemey, William H., "Medical education and medical reform movement in Britain", in Frederick Noel Lawrence Poynter (ed.), *The Evolution of Medical Education in Britain*, (London, 1966), pp.135-154.
- Mead, Kate Campbell Hurd, *A History of Women in Medicine*, (Haddam, Connecticut, 1938).
- Meek, Margaret, "The hempen cloth industry in Suffolk", *The Suffolk Review*, 2, (1960), pp.82-84.
- Meggs, Nancy, "Suffolk's poet, physician and parson", *Suffolk Fair*, (July 1985), pp.25-26.
- Miles, Phillip, "Men midwives of the past", *British Medical Chirurgical Journal*, December 1986, pp.101-102.
- Mitchell, Brian R. with Deane, Phyllis, *Abstract of British Historical Statistics*, (Cambridge, 1962).
- Morfeý, W.M. (compiler), *Ipswich School: an Alphabetical list of Ipswichians Known to have been Educated at the School from its Earliest Days Until the end of the Headmastership of the Rev. S.J. Rigaud in 1857*, (Ipswich, 1976).
- Morrison, Kathryn, *The Workhouse - a Study of Poor Law Buildings in England*, (Swindon, 1999).
- Mortimer, Ian, "The triumph of doctors: medical assistance to the dying c1570-1770", *Transactions of the Royal Historical Society*, 15, (2005), pp.97-116.
- Mortimer, Ian, "The rural medical marketplace 1570-1720", in Mark Jenner and Patrick Wallis, *Medicine and the Market in England and its Colonies c.1450-c.1850*, (London, 2007), pp.69-87.
- Neve, Michael, "Orthodoxy and fringe: medicine in late Georgian Bristol", in William F. Bynum & Roy Porter (eds.), *Medical Fringe and Medical Orthodoxy 1750-1850*, (London, 1987), pp.40-55.
- Newman, Charles, *The Evolution of Medical Education in the Nineteenth Century*, (London, 1957).
- Nutton, Vivian & Porter, Roy (eds.), *The History of Medical Education in Britain*, (Amsterdam, 1995).
- O'Day, Rosemary, *The Professions in Early Modern England, 1450-1800: Servants of the Commonweal*, (Harlow, 2000).

- Moscucci, Ornella, *The Science of Woman*, (Cambridge, 1990).
- Paget, Stephen (ed.), *Memoirs and Letters of Sir James Paget*, (London, 1901).
- Paine, Clive, *A History of Eye*, (Diss, 1993).
- Peachey, George Charles, *A Memoir of William and John Hunter*, (Plymouth, 1924).
- Pelling, Margaret, *The Common Lot - Sickness, Medical Occupations, and the Urban Poor in Early Modern England*, (London, 1998).
- Pelling, Margaret, "Compromised by gender: the role of the male practitioners in early modern England", in H. Marland & M. Pelling (eds.), *The Task of Healing: Medicine, Religion and Gender in England and the Netherlands 1450-1800*, (Rotterdam, 1996), pp.101-133.
- Pelling, Margaret, "Healing the sick poor: social policy and disability in Norwich 1550-1640", *Medical History*, 29, pp.115-137.
- Pelling, Margaret, "Knowledge command acquired: the education of unlicensed medical practitioners in early modern Britain", in Vivian Nutton & Roy Porter (eds.), *History of Medical Education in Britain*. (Amsterdam, 1995), pp.150-179.
- Pelling, Margaret, "Politics, medicine and masculinity: physicians and office-bearing in early modern England", in Margaret Pelling & S. Mandelbrote (eds.), *The Practice of Reform in Health, Medicine and Science 1500-2000 - Essays for Charles Webster*, (Aldershot, 2005), pp.81-105.
- Pelling, Margaret & Mandelbrote, S. (eds.), *The Practice of Reform in Health, Medicine and Science 1500-2000 - Essays for Charles Webster*, (Aldershot, 2005).
- Pelling, Margaret & Webster, Charles (eds.), "Medical practitioners", in Charles Webster, *Health, Medicine and Mortality in the Sixteenth Century*, (Cambridge, 1979), pp.165-236.
- Penfold, John, *The History of the Essex County Hospital (Colchester) (Previously the Essex and Colchester Hospital) 1820-1948*, (Colchester, 1924).
- Perkins, Harold, *The Origins of Modern English Society*, (1st published 1969, 2nd edn., London, 2002).
- Peterson, Jeanne M., "Gentlemen and medical men: the problem of professional recruitment", *Bulletin of History of Medicine*, 58, (1984), pp.457-473.
- Peterson, Jeanne M., *The Medical Profession in Mid-Victorian London*, (London, 1978).

- Pfeiffer, Carl J., *The Art and Practice of Western Medicine in the Early Nineteenth Century*, (Jefferson, N.C., 1974).
- Pickstone, John V., *Health, Disease and Medicine in Lancashire 1750-1950*, (Manchester, 1980).
- Pickstone, John V., *Medicine and Industrial Society - a History of Hospital Development in Manchester and its Regions 1752-1946*, (Manchester, 1985).
- Pickstone, John V., "Fever epidemics and British public health 1780-1850", in Terence Ranger & Paul Slack (eds.), *Epidemics and Ideas: Essays on the Historical Perspective of Pestilence*, (Cambridge, 1992), pp.125-148.
- Pinchbeck, Ivy, *Women Workers and the Industrial Revolution*, (London, 1930).
- Porter, Dorothy & Porter, Roy, *Patients Progress - Doctors and Doctoring in Eighteenth Century England*, (Oxford, 1989).
- Porter, Dorothy & Porter, Roy, *In Sickness and in Health - The British Experience, 1650-1850*, (London, 1988).
- Porter, Roy, *Bodies Politic - Disease, Death and Doctors, 1650-1900*, (London, 2001).
- Porter, Roy, *Disease, Medicine and Society in England, 1550-1860*, (Basingstoke, 1987).
- Porter, Roy, *The Greatest Benefit to Mankind - A Medical History of Humanity from Antiquity to the Present*, (London, 1999).
- Porter, Roy, *Health for Sale - Quackery in England, 1660-1850*, (Manchester, 1989).
- Porter, Roy, *Patients and Practitioners - Lay Perceptions of Medicine in Pre-industrial Society*, (Cambridge, 1986).
- Porter, Roy, *Popularisation of Medicine*, (London, 1992).
- Porter, Roy (ed.), *Cambridge Illustrated History of Medicine*, (Cambridge, 2006).
- Porter, Roy, "Death and doctors in Georgian England", in Ralph Houlbrooke (ed.), *Death, Ritual and Bereavement*, (London, 1989), pp.77-94.
- Porter, Roy, "The gift relationship: philanthropy and provincial hospitals in eighteenth century England", in L. Granshaw & Roy Porter (eds.), *The Hospital in History*, (London, 1989), pp.149-178.
- Porter, Roy, "'I think ye both be quacks': the controversy between Dr Theodore Myersbeck and Dr John Coakley Lettsom", in William Bynum & Roy Porter (eds.), *Medical Fringe and Medical Orthodoxy, 1750-1850*, (London, 1987), pp.56-78.

- Porter, Roy, "Lay medical knowledge in the eighteenth century: the evidence of the gentleman's magazine", *Medical History*, 29, (1985), pp.148-165.
- Porter, Roy, "The patient in England c.1660-1800", in Andrew Wear (ed.), *Medicine in Society: Historical Essays*, (Cambridge, 1992), pp.91-118.
- Porter, Roy, "Thomas Gisborne: physicians, Christians and gentlemen", in Andrew Wear, Joanna Geyer-Kordesch & Roger French (eds.), *Doctors and Ethics - the Earlier Historical Setting of Professional Ethics*, (Amsterdam, 1993), pp.252-273.
- Porter, Roy, "William Hunter - a surgeon and a gentleman", in William F. Bynum & Roy Porter (eds.), *William Hunter and the Eighteenth Century Medical World*, (Cambridge, 1985).
- Porter Roy & Wear, Andrew (eds.), *Problems and Methods in the History of Medicine*, (London, 1987).
- Powell, Neil, *George Crabbe: An English Life 1754-1832*, (London, 2004).
- Power, Sir D'Arcy, *British Medical Societies*, (London, 1939).
- Poynter, Frederick Noel Lawrence (ed.), *The Evolution of Hospitals in Britain*, (London, 1964).
- Poynter, Frederick Noel Lawrence (ed.), *The Evolution of Medical Education in Britain*, (London, 1966).
- Poynter, Frederick Noel Lawrence (ed.), *Medical Education In England Since 1600*, (London, 1964).
- Poynter, Frederick Noel Lawrence (ed.), "Medical education in England since 1600", University of California School of Medicine, 1968-1970, pp.231-240.
- Raach, John, *A Directory of English Country Physicians 1603-1643*, (London, 1962).
- Ranger, Terence & Slack, Paul (eds.), *Epidemics and Ideas: Essays on the Historical Perception of Pestilence*, (Cambridge, 1992).
- Rawcliffe, Carole & Wilson, Richard G. (eds.), *Norwich Since 1550*, (London, 2004).
- Razzell, Peter, *The Conquest of Smallpox: the Impact of Inoculation on Smallpox Mortality in Eighteenth Century Britain*, (Firle, Sussex, 1977).
- Razzell, Peter, *Population and Disease: Transforming English Society, 1550-1850*, (London, 2007).
- Razzell, Peter, "Population change in eighteenth century England - a reinterpretation", *Economic History Review*, 8, (1965), 2, pp.312-332.

- Reader, William, *Professional Men - the Rise of the Professional Classes in Nineteenth Century England*, (London, 1966).
- Redstone, Lilian J., *Our East Anglian Heritage*, (London, 1939).
- Rimmer, W.G., "William Hey of Leeds", *Leeds Philosophical and Literary Society*, IX, 1961, pp.199-209.
- Risse, Gunter, "Medicine in the age of the enlightenment" in Andrew Wear (ed.), *Medicine in Society*, (Cambridge, 1992), pp.149-195.
- Robb-Smith, Alastair H.T., "Medical education at Oxford and Cambridge prior to 1850", in Frederick Noel Lawrence Poynter (ed.), *The Evolution of Medical Education in Britain*, (London, 1966), pp.19-52.
- Richardson, Ruth, *Death, Dissection and the Destitute*, (London, 1987).
- Roberts, Shirley, *James Parkinson 1755-1824, from Apothecary to General Practitioner*, (London, 1997).
- Roberts, Shirley, *Medical Education in England Since 1600*, (London, 1964).
- Rolls, Roger, Guy, John & Guy, Jean (eds.), *A Pox on the Provinces*, (Bath, 1990).
- Rook, Arthur, Carlon, Margaret & Graham-Cannon, W., *A History of Addenbrooke's Hospital, Cambridge*, (Cambridge, 1991).
- Rosenberg, Albert, "London dispensary for the sick poor", *Journal of the History of Medicine*, 14, (1959), 1, pp.41-56.
- Rothery, Joanna, *William Goodwyn's Diaries 1785-1810*, (Ipswich, 2004).
- Rothery, Joanna, "William Goodwin's diaries 1785-1810", *The Suffolk Review*, 42, (2004), pp.2-17.
- Rousseau, G.S. & Porter, Roy (eds.), *A Ferment of Knowledge: Studies in the Historiography of Eighteenth Century Science*, (Cambridge, 1980).
- Rowlands, John, "Annals of a Teeside practice 1793-1969", *Medical History*, (2000), 16, 3, pp.387-403.
- Rubenstein, W.D., "The Victorian middle classes: wealth, occupation and geography", *Economic History Review*, 2nd Series, 30, (1977) 2, pp.602-623.
- Ryder, R. Stephen, "Population figures for Great Bradley in the eighteenth and nineteenth centuries", *The Suffolk Review Bulletin*, 4, (1954), p.6.
- Sharpe, Pamela (ed.) *Women's Work: the English Experience, 1650-1914*, (London, 1998).

- Sharpe, Pamela, "Continuity and change: women's history and the economic history of Britain", in Pamela Sharpe (ed.), *Women's Work : the English Experience 1650-1915*, (London, 1998), pp.23-42.
- Shapin, Steven & Thackray, Arnold, "Prosopography as a research tool in the history of science: the British scientific community 1700-1900", *History of Science*, 12, (1974), pp.1-28.
- Shaw, A. Batty, "Benjamin Gooch: eighteenth century Norfolk surgeon", *Medical History*, 16, (1972), 1, pp.40-50.
- Shaw, A. Batty, "The oldest medical school in Great Britain", *Medical History*, 12, (1968), 3, pp.232-244.
- Shaw, A. Batty, "The Norfolk school of lithotomy", *Medical History*, 6, (1970), 3, pp.221-259.
- Shepard, Alexandra & Walker, Garthine, *Gender and Change: Agency, Chronology and Periodisation*, (Chichester, 2009).
- Shepherd, John, "William Jeaffreson 1790-1865: surgical pioneer", *Brit. Med. J.*, 2, (1965), pp.1119-1120.
- Shoemaker, Robert E., *Gender in English Society 1650-1850*, (London, 1998).
- Shorter, Edward, "Primary care", in Roy Porter (ed.), *Cambridge History of Medicine*, (Cambridge, 2006), pp.103-135.
- Singer, Charles, "Early medical education in England in relation to the pre-history of London university", *Medical History*, 4, (1960), pp.1-18.
- Skultans, Vieda, *Madness and Morals - Ideas on Insanity in the Nineteenth Century*, (London, 1975).
- Smith, J.R., *The Speckled Monster - Smallpox in England 1670-1970 with Particular Reference to Essex*, (Chelmsford, 1987).
- Stow, N.J., "An aristocratic surgeon - Thomas Gery Cullum", *Pharmaceutical Historian*, 19, (1989), 1, pp.2-4.
- Summers, Anne, *Female Lives, Moral States: Women, Religion and Public Life in Britain 1800-1930*, (Newbury, 2000).
- Thomas, Keith, *Man and the Natural World: Changing Attitudes in England 1500-1800*, (London, 1983).
- Towler, Jean & Bramall, Joan, *Midwives in History and Society*, (London, 1986).

- Trohler, Ulrich, "The doctor as naturalist: the idea of clinical teaching and research 1770-1850", in H. Beukers & J. Molls (eds.), *Clinical Teaching: Past and Present*, (Amsterdam, 1987-8), pp.21-34.
- Ulph, Eugene A. & McCarthy, Muriel, *The Sir John Leman School, Beccles, 1631-1969*, (Beccles, 1970).
- Ulrich, Laurel Thatcher, *A Midwives Tale: The Life of Martha Ballard, Based on her Diary 1785-1812*, (New York, 1990).
- van Zwanenberg, David, "A singular calamity", *Medical History*, 17, (1973), 2, pp.204-207.
- van Zwanenberg, David, "The Suttons and the business of inoculation", *Medical History*, 22, (1978), pp.71-82.
- van Zwanenberg, David, "Interesting GPs of the past - George Stebbing of Ipswich 1749-1825", *Brit. Med. J.*, 283, (1981), pp.1517-1518.
- van Zwanenberg, David, "The training and careers of those apprenticed to apothecaries in Suffolk 1815-1858", *Medical History*, 27, (1983), pp.139-150.
- Vickery, Amanda, *The Gentleman's Daughter: Women's Lives in Georgian England*, (London, 1998).
- Vincent, William Alfred Leslie, *The Grammar Schools: Their Continuing Tradition 1660-1714*, (London, 1969).
- Waddington, Ivan, *The Medical Profession in the Industrial Revolution*, (Dublin, 1984).
- Waller, Phillip J., *Town, City and Nation - England 1850-1914*, (Oxford, 1983).
- Wallis, Peter J. & Wallis, R.V., (with Juanita Burnby & Thomas D. Whittet), *Eighteenth Century Medics - Subscriptions, Licences, Apprenticeships*, (Newcastle Upon Tyne, 1985).
- Warsop, David, "Social aspects of Nacton workhouse in its early years", *The Suffolk Review*, 4, (1973), 2, pp.27-31.
- Watson, Winifred, "The Austens' London doctor", *Reports of the Jane Austen Society*, (1961), pp.194-197.
- Wear, Andrew (ed.) *Medicine in Society: Historical Essays*, (Cambridge, 1992).
- Wear, Andrew, "Medical practice in the late seventeenth and early eighteenth century England - continuity and union", in R. French & Andrew Wear (eds.), *The Medical Revolution of the Eighteenth Century*, (Cambridge, 1989), pp.294-320.

- Wear, Andrew, Geyer-Kordesch, Joanna & French, Roger, *Doctors and Ethics - the Historical Setting of Professional Ethics*, (Amsterdam, 1993).
- Weber, Max, *Wirtschaft unde Gesellschaft* (Turbingen, 1922), translated as “*The Theory of Social and Economic Organisations*” by T. Pearson, (New York, 1964).
- Webster, Charles, *Caring for Health - History and Diversity*, (Buckingham, 1993).
- Webster, Charles (ed.), *Health, Medicine and Mortality in the Sixteenth Century*, (Cambridge, 1979).
- Whitehand, Ray, *At the Overseers’ Door: the Story of Suffolk’s Parish Workhouses*, (Saxmundham, 2007).
- Williams, David Innes, “The Obstetric Society of 1825”, *Medical History*, 42, (1998), 7, pp.235-245.
- Wilson, Adrian, *Childbirth in Seventeenth and Eighteenth Century England*, (Brighton, 1984).
- Wilson, Adrian, *The Making of Man-Midwifery - Childbirth in England 1660-1770*, (Cambridge, Mass, 1995).
- Wilson, Adrian, “Midwifery in the ‘medical marketplace’”, in Mark S.R. Jenner & Patrick Wallis (eds.), *Medicine and the Medical Marketplace in England and its Colonies c. 1450-c. 1850*, (Basingstoke, 2007), pp.153-174.
- Wilson, Adrian, “William Hunter and the varieties of man midwifery”, in William Bynum & Roy Porter (eds.), *William Hunter and the Eighteenth Century Medical World*, (Cambridge, 1985), pp.323-343.
- Winn, Arthur T., *Records of the Borough of Aldeburgh - the Church*, (Hertford, 1926).
- Witz, Anne, *Professions and Patriarchy*, (London, 1992).
- Woodforde, James, *A Country Parson: James Woodforde’s Diary 1759-1802*, (London, 1985).
- Wright, Pip & Wright, Joy, *The Amazing Story of John Heigham Steggall, ‘The Suffolk Gypsy’*, (Stowmarket, 2004).
- Wrigley, Edward A., “A simple model of London’s importance in changing English society and economy 1650-1750”, in D.A. Baugh (ed.), *Aristocratic Government and Society in the Eighteenth Century*, (New York, 1975), pp.62-95.
- Wyman, A.L. “The surgeoness: the female practitioner of surgery, 1400-1800”, *Medical History*, 28,(1984), pp.22-41.

Yeatman, J.C., "The origins of the general practitioner", *Journal of the Royal College of General Practitioners*, 33, (1999), pp.13-18.

2. Dissertations and Unpublished Works

Denyer, Amy, *The Body, Science and the Emergence of Separate Spheres*. Unpublished MA, University of East Anglia, 2004.

Gallard, Rita, *Correspondence of Elizabeth Leathes*. Research Progress Report, University of East Anglia, 2008.

Lawrence, Susan C., *Science and Medicine in the London Hospitals, 1750-1815*. Unpublished PhD, University of Toronto, 1985.

Muncaster, Michael J., *Medical Services and the Medical Profession in Norfolk 1815-1911*. Unpublished PhD, University of East Anglia, 1976.

Northeast, P., *The Population of Suffolk Parish by Parish, Compiled from Government Census Returns*, SRO (Ipswich, 312.0942), unpublished.

Patten, J., *Population Distribution in Norfolk and Suffolk*. SRO (Ipswich), unpublished.

Sellar, Amy, *Eighteenth and Nineteenth Century Midwives*. Unpublished MA, University of East Anglia, 2001.

van Zwanenberg, David, *Suffolk Medical Biographies*. Unpublished but edited onto the World Wide Web in 2004 by Eric Cockayne.

3. Web Sites

www.britishhistpry.ac.uk//reportwickhammarketschoolandAnneRoberts Wickham Market (January 2008).

www.oup.com/oxforddnb/info/quickguide (January 2008)

www.suffolkmedicalbiographies Suffolk Medical Biographies (SMB) (2006).

www.thomasmills.suffolk.schools.uk (Thomas Mills High School, Framlingham), (January 2008).

www.woodbridge.suffolk.sch.uk (Woodbridge School), (January 2008).