Scarlatina and Sewer Smells: Metropolitan Public Health Records 1855–1920

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The peculiarities of the history of public health in London have been the subject of several studies in the last twenty years, most notably by Anne Hardy, Bill Luckin, Lara Marks, Graham Mooney, John Davies and David Owen.[1] The purpose of this contribution is not to add to the canon, but rather to make a plea for a re-examination of some of the original sources for this field, in particular the surviving reports of the metropolitan Medical Officers of Health (MOHs), which provide a unique insight, not solely into the development of public health policy and practice in the capital, but into many aspects of London life.

London tended to be excluded from the provisions of much of the reforming legislation of the nineteenth century. It alone was left out of the 1835 Corporations Act, and the 1848 Public Health Act. This second Act decreed that, where a registration district recorded a death rate of over 23 per 1,000, the undertaking of remedial measures and the appointment of a Medical Officer of Health (MOH) became compulsory. In certain parts of London, most notably the East End, a death rate of

1 J. Davies, *The London Government Problem* (Oxford, 1988); A. Hardy, *The Epidemic Streets: infectious disease and the rise of preventive medicine 1856–1900* (Oxford, 1993); 'Public Health and the Expert: the London Medical Officers of Health, 1856–1900' in R. MacLeod, ed., *Government and Expertise: Specialists, Administrators and Professionals* (Cambridge, 1988); W. Luckin and G. Mooney, 'Did London Pass the "Sanitary Test"? Seasonal Infant Mortality in London, 1870–1914', *Journal of Historical Geography* 20 (1994); L. Marks, *Metropolitan Maternity* (Amsterdam, 1997); G. Mooney, 'Professionalization in Public Health and the Measurement of Sanitary Progress in Nineteenth-Century England & Wales', *Social History of Medicine* 10 (1997); D. Owen, *The Government of Victorian London 1855–1889* (Cambridge, Massachusetts & London, 1982).

23 per 1,000 would have been seen at that time as an unattainable improvement on the *status quo*. Although the health of London had long been considered of prime national importance, it took another seven years before it was dealt with by parliamentary legislation. Under the Metropolis Management Act of 1855, the larger London parishes were formed into vestries, and the smaller ones grouped into district boards of works, 'for the purpose of the better sanitary administration of the capital'. The appointment of a Medical Officer of Health in each of these 48 sanitary districts was henceforth mandatory, although the position could be part-time, and many MOHs combined their work for the vestry or district board with either other public appointments, or with private practice. Under the Act, a new medical elite was created, which would have a great impact on the health of London.

Although they were local government employees, and not granted security of tenure until 1891, the metropolitan MOHs quickly formed themselves into an association to promote the interests of both the public health of London, and of the MOHs themselves.[2] By January 1857, they had negotiated special transfers of information from the office of the Registrar General, which enabled them to gauge the new cases of illness coming under treatment weekly in pauper practice and public institutions of the Metropolis, and publish the district meteorology of London. It was planned that a central repository would keep a general register of the present condition of the Metropolis, with regard to drainage, removal of dust etc., and of new building and sanitary works. It was thus expected that, with the cooperation of private practitioners, a public health profile of London would be produced at regular intervals, and that this information would both direct local strategies for dealing with problems, and guide the legislators to frame new laws to handle specific public health issues. Unfortunately, the Treasury refused to pay for this initiative, which is why today the historian is faced, not with a wonderfully comprehensive set of records, but with the partial survivors of the written record of a piecemeal system.

One of the most daunting, and deterrent, aspects of research is the large network of different authorities with responsibility for administering metropolitan public health. At least three government departments, six metropolitan-wide authorities and dozens of different types of purely local bodies, including Paving and Burial Boards, were entrusted with different aspects of metropolitan public health administration. The 1855 Act, and much subsequent legislation, did not replace old administrative structures, but rather added more layers of government to what was already an almost

2 *Public Health* (Journal of the Society of Medical Officers of Health), jubilee number, 1906; D. Porter, 'Stratification and its discontents: professionalization and conflict in the British public health service, 1848–1914', in E. Fee & R. M. Acheson, eds., *A History of Public Health* (Oxford, 1991); and J. L. Brand, *Doctors and the State: the British Medical Profession & Government Action in Public Health, 1870–1912* (Baltimore, 1965).

incomprehensible system. The multiplication of authorities responsible for the different geographical areas, and functions of public health legislation, and the absence of an effective metropolitan central government, even after the creation of the London County Council in 1889, means that the researcher must look in many places in order to see the whole picture. The Local Government Board, the heir to the Poor Law Commission and the Poor Law Board, had overall supervisory control over most of the public health authorities of the metropolis, until the formation of the Ministry of Health in 1919, and the abolition of the Poor Law in 1929.[3] Its main functions were in authorizing loans, inspecting the administrations under its wing, and reporting on aspects of public health administration to Parliament. It authorized the appointment of Poor Law Medical Officers, and was, after 1891, able to pay a portion of the salaries of certain local public health staff.

Neither the main Home Office papers, nor those of the Privy Council, are likely to be of great interest to the metropolitan historian, but it is important to note that these two central government departments were responsible for bodies whose records are of some importance. The Privy Council's Medical Department reported on public health matters that were deemed to be of national significance. Their first chief Medical Officer was Sir John Simon, sometime MOH to the Corporation of the City of London, whose published reports were given extensive coverage in the national press.[4] The Home Office was the department responsible for the Metropolitan Police and the London School Board, both of which had public health responsibilities. The role of vagrants in transmitting infectious diseases was a matter of prime concern to the sanitary authorities, but until 1894 it was the Metropolitan Police which had the task of overseeing and inspecting common lodging houses (what we might term dos houses today).[5] Metropolitan Police records are held at the Public Record Office (PRO) and at Scotland Yard, although it is easier to track their reports on lodging houses through the local sanitary departments' holdings, most particularly the MOH reports. This last statement may be applied to most of the larger organizations described above.

Schools were a focus for the transmission of childhood diseases, and the records of the London School Board (LSB) are excellent, not just for those wishing to track outbreaks of measles or whooping cough in a particular area, but also for details of vaccinated and non-vaccinated children. London state schools pioneered the school dinner movement, which was begun as a charitable enterprise under the London School Dinners Association in 1890 before becoming part of the educational budget of the capital, and it is possible to trace the history of this, as well as chart the

3 C. Bellamy, *Administering central-local relations 1871–1919; the LGB in its fiscal and cultural context* (Manchester, 1988).

4 R. Lambart, *Sir John Simon, 1816–1904, and English Social Administration* (London, 1963).

5 See L. Rose, *Rogues and vagabonds* (London, 1988), 56–63.

development of the schools' medical service, and its enduring emblem, 'Norah the Nit Nurse', through the records of the LSB, which was subsumed to the London County Council in 1904.

The Corporation of the City of London was, and is, a separate entity, and a law unto itself. It ran the Thames Conservancy Board, and its reports are vital to an understanding of the importance of the river as a source of drinking water and the conduit for the waste of the capital. It also ran the Port of London Health Authority, which was an essential part of the state effort to block imported disease from entering the country – in particular, rabies, cholera and plague. The Corporation had its own Sewers Commission, and its Police Force, just like the Metropolitan Police, supervised doss-houses within the Square Mile. The published annual reports of the various departments were given wide coverage in the local newspapers, most notably *The City Press* and *The Weekly Despatch*.

The middle tier of public health government is complicated. Most notably it contained the Metropolitan Asylums Board (MAB), which was created under the Metropolis Poor Act of 1867 to set up and run fever hospitals and lunatic asylums. By 1929, it ran a network of training establishments for pauper children, fever hospitals and camps, lunatic asylums, and an ambulance service for infectious cases.[6] Its surviving records are held at the London Metropolitan Archives (LMA). The Metropolitan Board of Works (MBW), created in 1855 and disbanded in 1888 after a decade of scandal, was the body which built the main drainage system of London and the Thames embankments, in addition to carving out several thoroughfares, such as Charing Cross Road and Queen Victoria Street. It also began the movement to preserve parkland and open spaces for the people of London.[7] Its records are also at the LMA, as are its published reports, although its correspondence with the various local sanitary authorities can be found among the records of the latter.

Its successor, the London County Council (LCC), was intended to become the voice of London, but, in Sydney Webb's inimitable phrase, it 'was born in chains'. It was not granted control over the vestries and their successors, and was kept under parliamentary control by its dependence on an annually-determined budget. It never attained control over London's water, or its gas or electricity services, but its role in the public health history of London is nevertheless vital, especially after the passing of the 1891 Public Health (London) Act. By the end of the Great War, the LCC was responsible for London state schools, for housing the working classes, for many of the capital's parks and gardens, for ferry services across the Thames, for co-ordinating the capital's fight against pulmonary tuberculosis and much, much more. It had its own MOHs, who reported on matters of metropolitan concern, and who conducted

6 G. M. Ayers, *England's First State Hospitals and the Metropolitan Asylums Board, 1867–1930* (London, 1971).

7 G. Clifton, *Professionalism, Patronage and Public Service in Victorian London* (London, 1992).

many investigations into the public health deficiencies of the capital.[8] Housed at the LMA, the archive of the Public Health department of the LCC is a much undervalued source, not least for the evidence of just how much was expected of it by the local MOHs.

The Metropolitan Water Board, which in 1902 took over (at vast expense) the management of London water from eight private companies, reported on the distribution and quality of the water supply. Its financial records are of immense complexity. Other bodies involved in public health included the Sick Asylum Districts, which were amalgamated Poor Law medical provision in parts of London, and the School Districts, which ran the pauper schools. Their records are at the LMA, and the correspondence with their parent body, the Poor Law Board, and its successor, the Local Government Board, is housed at the PRO.

The third layer – the bottom tranche – was not only responsible for implementing the ever-increasing level of public health legislation after 1855, but also had to pay for it. Almost the whole of the Victorian advancement in terms of sanitation and public health was paid for out of local rates, and this dependence on the individual ratepayer is a very important factor in any consideration of metropolitan public health. The published annual reports of the vestries and district boards, their successors the metropolitan borough councils, and their various departments, do not survive in one place in an unbroken run, but the majority are to be found in the library of the LMA. The local London archives also have copies of their own departmental reports, in addition to the vestry and council minutes, and the papers of the various committees and local government departments. As a general rule, the original notebooks of the sanitary officials and the original correspondence files have NOT survived.

Between 1856 and 1870, the metropolitan vestries and district boards of works spent nearly £6.5 million on paving, lighting and improvement works. Under the 1855 Act, and the 1866 Sanitary Act, they had powers to condemn and close unsanitary dwellings, purchase and demolish condemned houses, acquire land and provide accommodation for the poor, establish public libraries, baths, washhouses, mortuaries and open spaces. Note that, while they had the *power* to undertake such actions, in reality political and financial interests meant that most of these powers lay underused until the advent of the LCC in 1889. Among those who pressed the sanitary authorities to undertake their responsibilities with greater zeal were the MOHs, whose duties, as required by law, were to inspect and report from time to time on the sanitary condition of their district, to enquire into the existence of disease and into increases in the death rate, to explain the likely causes of disease in their area and to recommend measures to counteract ill-health. The Metropolitan MOH has passed into mythology as at best undervalued and at worst abused. He

8 For example, W. H. Hamer, *Report on the Sanitary Condition of Kensington*, LCC official publication no. 454, 10 November 1899.

was in effect the conscience of his employers, and, as such, was kept in his place.

Illness was a fact of life for the majority of the city's inhabitants, and premature death was the lot of the working classes. The records, published and in manuscript, contain a microscopic account of life and death in London from the mid-Victorian period onwards. It is possible, not just to see the numbers in a given district who were dying from specific diseases, but actually in which streets they were dying. One can chart infant mortality rising in the heat of summer, measles breaking out as soon as the school holidays are ended, and, as winter sets in, the great increase in deaths from chest infections among the elderly, particularly those in institutions. The public health records can reveal not only the growth of a particular district, but the nature of its housing, the state of the streets and the sewers and drains underneath them, the impact of increased population density and the development of recreational space, the weather and how it affected the inhabitants, and the water supply, not only how clean it was, but who had access to it. They can show how bad sanitary arrangements caused typhoid, no respecter of persons, in the 1860s and 1870s, and how the disease came back in the early years of the twentieth century to kill hop-pickers, watercress-eaters, and Londoners who had gone to the seaside. By 1918, the metropolitan public health records deal not only with disease and death, but with a gamut of concerns. Infant mortality and measures to educate first-time mothers, the control of tuberculosis in the community, adult male unemployment, factory and workshop conditions, smoke nuisances, food adulteration, overcrowding, disinfection of buildings, clothes and people, public baths, housing of the working classes, water supply, slaughter houses and dairies, bakehouses and rubbish. The local public health departments operated quite literally at street level, and beyond – they were among the few bodies to penetrate the living spaces of the local inhabitants and, as such, can tell us more about their lives than almost any other resource.

Changes in legislation and the demands of epidemic crises had a profound effect on the job of the MOH and on the nature and extent of the reports he produced. In the beginning most MOHs worked under the supervision of a sanitary committee. They may (or may not) have directed the work of the inspectors of nuisances, whose job it was to ensure that the vestry's statutory obligations under the 1855 Act were fulfilled. The earliest reports are, at best, sketchy, although not without interest. They contain mission statements of what the MOH expected to achieve, or follow the particular interests of the appointee. Francis Godrich, MOH for Kensington from 1856 until 1870, was interested in the occupational profile of mortality in his district, and thus provides tables of the trades of those adults who died, including women. Details of local improvements, of the objections of individual householders to the actions of the vestries, and of the work undertaken by the sanitary departments is best found in the minute books of the vestry and of its committees. Alternatively, the letters pages of the local press and the editorials give a balancing slant on how well each authority was doing, at least in the eyes of the local literate population.

The metropolitan MOH was employed primarily to investigate and control the spread of the most fatal conditions of early Victorian London – infectious diseases. He was an intrepid seeker after dirt, disease – and smells. The olfactory element of his work cannot be underestimated, for the miasmic theory of infectious disease, whereby it was believed that bad smells could infect the individual, took many years to be overtaken by the arguments of the bacteriologists. The MOH was a servant of the vestry, which was the servant of the ratepayers, who objected loud and long to any unpleasant whiff emanating from the street drains or from the sanitary arrangements within their own homes. The minutes of the vestries and the sanitary committees hold vast detail of the nuisances occurring within each district and at that time perceived as dangers to human life. It is possible to chart the building of the main sewerage system, not just through the records and reports of the MBW, but through the vestries. Street by street, one sees houses being connected to the main drains and the results of shoddy workmanship and house building on unsuitable sites. There you can find the record of the numerous attempts to banish the smell of sewerage from the city streets – by putting charcoal and disinfectant down the drains or trapping and covering the offending sewer. There also can be found the history of local residents taking matters into their own hands and blocking the drains themselves, which, in the words of one MOH was

> ...a course to be regretted, as it is better to have stench here and there in the roadway than the escape of sewer gases into houses...sewers must be ventilated, and if this is not provided for artificially the resistance of almost any drain will be overcome by the pressure of the contained gases and foul effluvia, with all their injurious consequences, find their way into our houses.

The smell of the sick themselves is vividly evoked by the MOH for St George in the East, in his description of fever patients:

> the odour of such persons, so peculiar, depressing, and nauseating, is really very much due to the decomposition of their own dried up perspiration, and unctuous secretions of the skin, which saturates their rarely washed or changed clothing. These effete matters from their bodies yield an effluvium, as your Sanitary Officer expressed it, very like a pig pound, and when their places are visited, the windows and doors are usually found closed, often, I believe, that the condition of the place may not be seen by others. This shows that filthiness is not unrecognized by such inmates, but nevertheless they manifest a powerful disinclination to remedy it.

Smells did not just emanate from sewers and the sick. One can find out what servants did with the rubbish produced by their employers, chart how they, and indeed the rubbish collectors, during the building boom could make money by selling the contents of the grate or the sweepings from the floor, and the difficulties of disposing refuse after the 1880s. The correspondence registers of the sanitary committees and the letters pages of the local newspapers are filled with the howls of complaint from householders whose refuse had been left lying for weeks at a time. Trades were pursued in London which those familiar with Mayhew will know about only too well. Every part of the metropolis boasted its slaughterhouses, its cowsheds, and its fat-rendering factories. One particular business was the inoffensively-named marine stores, the lowest form of rag and bone merchant, with the emphasis on the bone. Anything that was not wanted, in whatever state of putrefaction, ended up in the marine stores.

Rubbish is a fertile area of study for the archaeologist and also for the historian. For example, here is the MOH for St George in the East describing the attractions and dangers of refuse in his district in 1879:

> The tenants in spite of our parochial receptacle much prefer to throw their dust on the ground. 1 person told me she thought her little girl's fever was contracted by her fondness for playing in the dustbin before breakfast. The courts in this scheduled area are the close playgrounds of these children inhabiting them, and it is no wonder that infectious diseases rapidly spread. A doctor visiting a house, even, is a source of some attraction to the playmates of a child ill, and its funeral is most alluring.

In the early days the metropolitan MOH had to deal not only with the human population, but with the pigs and other animals which had to be rooted out and removed from dwellings, and the MOH for St George in the East discovered a donkey living in a tenement on his patch. This exercise was not without its difficulties – Thomas Orme Dudfield, MOH for Kensington from 1870 to his death in 1908, had to have a police escort while making his pig inspections, as the customary greeting of the inhabitants of Notting Dale to all officials involved liberal gifts of bricks and mud, the latter almost certainly made out of the by-product of the porcine population.

All these factors have a bearing on public health, of course, but the prime concern of the local MOH was to reduce the mortality levels of his district, to as near 17 per 1000 inhabitants, which was the figure considered as perfection by the Registrar General. Before 1900, this meant that the work of the MOH was directed towards the control of infectious diseases. In 1870, vaccination against smallpox was made compulsory for children, but the job of keeping the registers was not given to the MOH, but to the local public vaccinator, who was invariably a Poor Law Medical

Officer and directly answerable to the Vaccination Department of the Local Government Board. From 1872 local registrars of births, marriage and deaths in London sent details of local birth registration up to three times a week to the vaccinators, so that they could visit the homes of the parents and arrange for the child to be vaccinated when it was three months old. The registers are to be found among the Poor Law union collections at the LMA, and are very detailed.

In the same year the first of the MAB fever hospitals was opened, to which were sent paupers suffering from smallpox. These hospitals were built in what were then outlying parts of London–Hampstead, Fulham, Stockwell and Homerton – and treated thousands of patients during the smallpox epidemic of 1871–1872. Theoretically, treatment at an MAB hospital pauperised the patient, which was a powerful disincentive for Londoners suffering from the disease to be open about it. In theory, smallpox patients could only be sent to an MAB hospital by order of the Poor Law Relieving Officer. In practice, MOHs and general practitioners sent patients to the hospitals directly, by-passing the Relieving Officer, in the interests of controlling the spread of the dread disease. When smallpox was not rife, scarlet fever, typhoid, typhus, diphtheria and whooping cough patients, many of them children, were sent to the MAB hospitals. While it is relatively simple to examine the surviving hospital registers, it is also possible to chart outbreaks of infectious disease, via the MOH reports. Smallpox outbreaks spread by laundresses or milkmen are meticulously recorded with all the contacts of the carriers, across London and beyond, listed. Cases of hidden infectious disease are similarly followed, and, after the Elementary Education Act of 1870, so are outbreaks of disease, most notably measles, in schools throughout the Metropolis.

Several MOHs made monthly and quarterly reports, or looked at specific local problems in special reports. Water was of prime concern; the first MOHs were uniform in condemning the quality of London water, both from the wells, which the Lambeth MOH described as representing '...the drainage of a great manure bed', and from the water companies. The latter hid behind their statutes to justify supplying water from a single standpoint in some areas for less than an hour a day, and often not at all on a Sunday, the one day when it was most needed. The Metropolis Water Act of 1852, which decreed that all companies had to give a constant water supply by 1857, was largely ineffective. There was also the problem of cutting off–if the landlord failed to pay the water company charges, they were entitled to cut off all supply to the house without notice. After the 1854 cholera outbreak, most companies had moved their intakes of water further up the Thames, but this did nothing to remedy the fact that large towns further up the river still discharged their sewage, untreated, into the river. It could have been no consolation to the Londoner that his lightly filtered drinking water contained the waste products of Reading and Oxford, but not of Hampton and Wandsworth.

As the century progressed, housing conditions became increasingly highlighted as a major contributory factor to high mortality rates in London. Clearance of slums for commercial buildings or railways put great pressure on the diminishing housing stock, resulting in high rents and poor conditions. The 1866 Sanitary Act, for the first time, classed overcrowding as a nuisance, and, as such, it came into the realm of the local sanitary authorities. One particular problem in London was 'houses let as lodgings', which were large dwellings built for one family which had been sub-divided to accommodate several families in furnished rooms. Although the vestries could register and control the numbers and the condition of such houses from 1866, the majority of them did not bother. Capital was sacrosanct, and the vestrymen were not prepared to interfere with the profits of the rentiers. It was not until after the shocking evidence and report of the Royal Commission on the Housing of the Working Classes in 1884–85 that action was taken. For the researcher, the lists of these houses, proceedings taken against the owners and the disease profiles of the tenants can all be gauged from the monthly and annual reports of the sanitary departments.

The working conditions of Londoners in factories and workshops became the concern of the vestries in 1867, but, none of them at this time was prepared to employ more staff to carry out inspections, and the researcher must wait until after the advent of the LCC for any systematic record of metropolitan working conditions. From 1893 onwards, several local authorities employed female sanitary inspectors, initially to enforce legislation with regard to the industrial working environment of women and young adults.[9] The reports of these women make fascinating reading, as they play a cat and mouse game with employers unwilling to bear the expense of extra ventilation or toilet facilities.[10] Within a decade, national concerns regarding the degeneration of the race, and a sustained high level of infant mortality in the metropolis, meant that these women inspectors were specifically charged with investigating the working conditions of mothers in London, and were joined, after 1907, by a small army of female health visitors, whose job it was to support and report on the living conditions of families whose babies were at risk of premature death.

As the nineteenth century progressed, progressive legislation changed the functions of the local public health department. The professionals saw the importance of infectious disease in their work diminish. After 1891, MOHs and their staff were

9 This was pioneered by Kensington, under pressure from its long-standing MOH, Thomas Orme Dudfield. T.O. Dudfield, *Women's Place in Sanitary Administration* (London, 1904); A. Tanner, 'Thomas Orme Dudfield: the model medical officer of health', *Journal of Medical Biography* 6 (1998).

10 One of the first women sanitary inspector's experiences is given in R. Squire, *Thirty Years in Public Service, an Industrial Retrospect* (London, 1927).

more concerned with factories and workshops, the inspection of houses, the adulteration of food, and the regulation of refuse collection and disposal in the metropolis. These were all important, but did little to affect the death rate from those conditions that had become most fatal, namely, tuberculosis and respiratory diseases, cancer, and diseases of infancy. In London, consideration of the 'new' killer conditions leads inevitably to the role of the voluntary sector in public health. It was a significant one, but one that is difficult to quantify. Numerous religious organizations had developed domestic visiting systems over long years, and these became transformed into crèches, infant welfare centres, mothers' dinner clubs. While these were primarily philanthropic and religious in character, they enjoyed a close relationship with the local authority services, and this alliance was confirmed throughout London during the First World War, when the mother and baby welfare services of the capital were officially recognized as being delivered by the voluntary sector. The numerous bodies attracted local authority grants from 1916, and joint committees of the voluntary and public sector were set up throughout the capital. Some of the new metropolitan borough councils had set up their own municipal provision for maternal and infant welfare – Battersea ran a municipal milk depot for a few years after 1902, and St Pancras established an internationally-renowned School for Mothers in 1908, the archives of which are to be found in the Camden local studies collection. The vital role played by the voluntary organizations, however, means that any student of metropolitan public health must look at their records as carefully as those of the local public health departments or the LCC. Locating these records is much simpler, thanks to the Wellcome Institute Library, and a search through their catalogues, or on the National Register of Archives website, will be of immense value to the researcher.

The end of the period under review is marked by several important developments in public health, most notably the formation of the Ministry of Health in 1919. This department would increasingly remove responsibility for the range of public health provision from the local authorities, and impose a national standard of services. Central government files, housed at the PRO, become vital adjuncts to the records of the local public health departments, but that is another story… .