

**Edwin Chadwick and John Simon:
Power, Politics and Public Health in Victorian Britain
1848-1876**

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The sanitary rights of the public are but very imperfectly secured.

John Simon

Introduction

The tenure of London's first (and Britain's second) Medical Health Officer, Sir John Simon, spanned several decades and saw momentous changes in the way the British government managed the public's health during some of the most challenging years of industrial expansion. Simon's dogged determination to systematize an alarmingly haphazard patchwork of legislation and policies in an era of extreme social transformation laid much of the groundwork for modern public health management.

Simon's career intersected with that of another great pioneer of sanitary reform, barrister Edwin Chadwick, one of the chief architects of the Poor Law Amendment Act of 1834¹, whose influence grew with the passing of the first Public Health Act of 1848.² Chadwick's ouster from the General Board of Health several years later created an opportunity for Simon, then an ambitious young surgeon working at St. Thomas's Hospital. His subsequent appointment as Chief Medical Health Officer for England and Wales opened the way for direct ministerial access with a prestigious connection to the Privy Council.³ Chadwick's departure also created tensions between lay administrators and the medical profession which became more apparent during a major bureaucratic restructuring in 1871.

Beginning with an overview of how these two very different individuals worked in parallel (Chadwick at the national level and Simon within the square mile of The City of London) to establish their respective public health administrations in 1848, this paper

¹ Christopher Hamlin, *Public Health and Social Justice in the Age of Chadwick: Britain, 1800-1854*, (Cambridge University Press: 1998), pp. 88-89.

² *Ibid.*, p. 246

³ John Simon, *English Sanitary Institutions Reviewed in Their Course of Development, and in Some of Their Political and Social Relations*, (London: Smith, Elder & Co. 1897), p. 258.

will summarize the achievements of both, and attempt an analysis of how the trajectory of Simon's career departed from its origins, and how subsequent changes to the hierarchy in 1871 impacted his department's work.

It is useful to frame this discussion around the recurrent cholera epidemics during this period, as the government's reaction to the disease was a major factor in shaping attitudes toward public health management (and the relevant powers accorded to government therein), within both the medical profession and society at large. The monumental task of managing epidemic disease and implementing sanitary improvements in the new industrial environment posed seemingly insurmountable problems which called for a departure from tradition and a trend toward systematic centralization which ultimately challenged ancient models of local government. This paper will explore the power dynamics of nineteenth-century public health administration and how it functioned within a constantly shifting and often challenging political landscape.

Primary sources include Chadwick's 1842 *Report on the Sanitary Condition of the Labouring Population of Great Britain* and Simon's *English Sanitary Institutions Reviewed in Their Course of Development, and in Some of Their Political and Social Relations*, published in 1897, as well as his annual reports to Parliament. Also pivotal are contemporary accounts of urban living conditions in the 1860s from John Hollingshead, later works such as G.R. Sims' *The Bitter Cry of Outcast London*, Joseph Rogers' *Reminiscences of a Workhouse Medical Officer*, the 1871 reports of the Royal Sanitary Commission, Henry Jephson's later work on *The Sanitary Evolution of London*, and selections from *The Times* and *Hansard*.

Much of the material on Simon comes from Royston Lambert's excellent biography published in 1963. Other secondary sources include Christopher Hamlin's various exhaustive works on Chadwick and Anthony Wohl's comprehensive *Endangered*

Lives: Public Health in Victorian Britain, which contribute much useful material on the origins of the schism between Poor Law administration and the medical profession. Margaret Pelling and Peter Baldwin provide much detail regarding government reaction to the cholera epidemics, which frames much of the discussion around public health in Britain in this era. Also referenced for this paper are Francis Smith's *The People's Health 1830 to 1910*, Gareth Stedman Jones' *Outcast London: A Study in the Relationship Between Classes in Victorian Society*, and Stephen Halliday's *The Great Filth and The Great Stink*, complemented by journal articles from Hamlin, Steven Novak, Jeanne Brand, Graham Mooney, Roy MacLeod, John Eyler and Michelle Allan which explore various aspects of Victorian society and government in the public health context.

There can be no question that, aside from large-scale epidemics, the unintended consequences of the new industrial economy created conditions which forced governments to focus on public health. Simon focused his energies on building systems of inspection and reporting that would gradually improve living conditions for all. Chadwick's sanitarian agenda, on the other hand, was driven by how these conditions adversely affected productivity of the labour force within the machinery of capitalism, which Christopher Hamlin characterizes as "an ongoing experiment to find the minimum conditions of human survival."⁴ The new way of working, and the migration of thousands of workers from town to cities in search of it, created squalid environments which changed social relations in a profound way.

Working Class Living Conditions in the Victorian Era

There can be no doubt that life for nineteenth-century working-class folk in Britain was one of extremes: of poverty and general want; of overcrowding; of hunger; of violence, drunkenness, disease and despair; of a general lack of the niceties that comprise

⁴ Hamlin, *Public Health*, p. 33.

what is generally accepted as the earmarks of a civilized existence. The people were, as Engels observed in 1845, not very many years removed from a time when “workers vegetated throughout a passably comfortable existence” in towns and villages, far from the stresses of the metropolis. Engels marks the beginnings of industrial capitalism, with its rapid shift from manual to machine-driven labour, as having the effect of transforming social relations into something utterly unrecognizable to previous generations.⁵

E.P. Thompson notes that, during the first half of the century, economic and political instability kept the standard of living for the average worker “at the point of subsistency”.⁶ Migrating to centres of production, whose aging urban infrastructures simply could not cope with the influx, new arrivals found a dearth of housing; in most industrial towns there were far more bodies than could reasonably be accommodated, and most accommodation lacked a readily available water supply.⁷ During this period of industrial expansion, the sheer weight of the human population on the urban environment was exacerbated by the presence of millions of dogs, cats, cows, sheep, pigs and poultry living in close proximity, as those blessed with the resources to possess livestock often had no choice but to share quarters with them.⁸ In many communities, abattoirs far outnumbered available privies, and the offal and effluvia from animal slaughter mingled with human waste, creating a foul and extremely unhealthful atmosphere ideal for the incubation of numerous epidemic diseases.⁹ One of the most frightening – cholera – entered the picture in 1831.

⁵ Friedrich Engels, *Condition of the Working Class in England*, (London: 1891), pp. 1-9.

⁶ E.P. Thompson, *The Making of the English Working Class*, (London: Penguin Books Ltd., 1991), p. 229.

⁷ Engels, p. 5. Engels notes that the population of Leeds more than doubled between 1801 and 1831. See also Anthony S. Wohl, *Endangered Lives: Public Health in Victorian Britain*, (London: J.M. Dent & Sons Ltd., 1983), p. 3.

⁸ Edwin Chadwick, *Report on the Sanitary Condition of the Labouring Population of Great Britain 1842*, reprinted, M.W. Flinn, ed., (Edinburgh, 1965), p. 23.

⁹ Francis B. Smith, *The People's Health 1830-1910*, (Canberra Australian National University Press, 1979), p. 198. Wohl, *Endangered Lives*, p. 84. “As late as 1892 well over 13,000 cows, calves, sheep, lambs and pigs were slaughtered *each week* in London's abattoirs. ... The slaughtering of cattle was one of the free spectacles that made town living exciting, but it augmented the filth and stench of the town.”

Cholera: 1831-32

Cholera's trajectory originated in India, making its way northwest via commercial trade routes into Russia in the 1820s. A decade later it began appearing in northern Europe.¹⁰ When the disease first arrived in Britain in 1831, the country was without any formal system of health organization or laws other than the Quarantine Act of 1825.¹¹ As news reports from the continent became more alarming, a Central Board of Health was convened by Royal Proclamation for the purpose of establishing a regulatory framework. While it is certainly believable that such a public health threat could drive government to take action,¹² Margaret Pelling argues that "cholera was a distraction rather than an impetus to reform,"¹³ as it exacerbated the deep divide between contagionist and anti-contagionist schools of medical thought. While it is important not to over-simplify the two concepts (there are many hybrid variations), we can safely assume, as Hamlin does, that Chadwick's "dogmatic anti-contagionism"¹⁴ was at the root of his view that cholera was merely a result of local conditions:¹⁵ quarantine was not a viable option, as it represented an unwarranted restriction of personal freedoms.¹⁶ Contagionists, on the other hand (Pelling calls Simon a "contingent contagionist"),¹⁷ proposed quarantine as the best option in an emergency like the one the country was facing in 1831. The Board, in

¹⁰ Peter Baldwin, *Contagion and the State in Europe, 1830-1930*, (Cambridge University Press, 1999), p. 37.

¹¹ Royston Lambert, *Sir John Simon 1816-1904 and English Social Administration*, (London: MacGibbon & Kee, 1963), p. 60.

¹² Jeanne L. Brand, *Doctors and the State: The British Medical Profession and Government Action in Public Health, 1870-1912*, (Baltimore: The John Hopkins Press 1965), p. 40.

¹³ Margaret Pelling, *Cholera, Fever and English Medicine, 1825-1865*, (Oxford University Press, 1978), p. 6.

¹⁴ Hamlin, "Predisposing Causes and Public Health in Early Nineteenth-Century Medical Thought," *Social History of Medicine*, Vol. 5, Issue 1, 1992, p. 44.

¹⁵ Pelling, *Cholera, Fever and English Medicine*, p. 57.

¹⁶ Baldwin, p. 95.

¹⁷ Pelling, *Cholera, Fever and English Medicine*, p. 293.

consultation with the Royal College of Physicians, initially chose to follow suit with the rest of Europe, taking a staunchly quarantinist stance based on epidemiology dating back to the plague years, “locked fast at the level of knowledge current a century earlier.”¹⁸

In the absence of any real scientific knowledge about the physical causes of disease, the Board could only take action based on “conjecture informed by despair.”¹⁹ The Privy Council, initially hobbled by the Quarantine Act – which prohibited taking any action until disease was first documented and disallowed the use of the rates to pay for public health measures – quickly acted to circumvent it.²⁰ The Board issued a set of *Rules and Regulations* which contemplated the creation of local Boards of Health to implement quarantine to restrict civil liberties should the need arise. Special instructions were issued to deal with purification of the abodes of the stricken and the burial of the dead. The rules also speculated on the possibility of calling in troops or police “so as utterly to exclude the inhabitants from all intercourse with the country.”²¹ Thus the country prepared for the imminent medical emergency.

There followed much dithering within the medical profession regarding possible causes of the cholera,²² which the government used as a reason for not imposing the types of draconian quarantine measures taken on the continent, perceived as immoral on the one hand²³ and having the potential for inciting political unrest on the other.²⁴ Cholera swiftly drew the country’s attention to the dangers of poverty, as it was perceived to

¹⁸ Baldwin, p. 106.

¹⁹ G.R. Sims, *The Bitter Cry of Outcast London: An Inquiry into the Condition of the Abject Poor*, (Boston: Cupples, Upham & Co., 1883) p. 10.

²⁰ Baldwin, p. 117.

²¹ Simon, *English Sanitary Institutions*, pp. 170-71.

²² George Davey Smith, “Commentary: Behind the Broad Street Pump: Aetiology, Epidemiology and Prevention of Cholera in mid-19th century Britain,” *International Journal of Epidemiology*, 2002:31, pp. 920-921.

²³ Baldwin, p. 95.

²⁴ Thompson, 888-909: The first epidemic occurred amid rising tensions and mass working-class demonstrations over the Reform Bill.

strike most ferociously among those “who are of drunken irregular life, and ... districts which are unclean, ill-ventilated and crowded.”²⁵ Soon after the initial emergency, the temporary Board was disbanded by the Privy Council and replaced with a more experienced team who abandoned strict quarantine in favour of a less coercive – and less intrusive – approach.²⁶

Poverty, then, was beginning to be perceived as a threat to social order,²⁷ a “disquieting alien presence”²⁸ which existed at the edges of polite Victorian society. As the population shift from rural areas to the industrial centres accelerated, pressure on existing housing stocks resulted in severe levels of overcrowding and, for many, town life soon became intolerably stressful.²⁹ With the lens focused with such intensity on paupers and the working poor, the door opened for Benthamite utilitarians³⁰ like Chadwick – many of whom firmly placed sanitationism at the heart of moral improvement and the divine order of the universe³¹ – to put forth the nation’s first real public health agenda. The utilitarian philosophy followed the doctrine of *laissez faire*, and its gospel was low taxation. Stephen Halliday remarks upon the “strange philosophical gymnastics”³² that Chadwick and his colleagues had to perform in order to justify the expenditure of considerable amounts of public money on raising the living standards of the poor. Seen through the utilitarian lens, a sick pauper was an unproductive one, a situation which

²⁵ Simon, *English Sanitary Institutions*, pp. 171.

²⁶ Baldwin, pp. 115-116.

²⁷ Rex Pope, Alan Pratt, Bernard Hoyle, eds., *Social Welfare in Britain, 1885-1985*, (London, Croom Helm Ltd. 1986), p. 1.

²⁸ Sims, *Bitter Cry*, p. 14.

²⁹ Wohl, p. 3. See also *Hansard*, House of Commons Debates, February 4, 1840, which notes an alarming increase in the annual per capita consumption of gin.

³⁰ Kenneth O. Morgan, ed., *The Oxford Illustrated History of Britain*, (Oxford University Press: 1984), pp. 436-437: The followers of Jeremy Bentham “who believed, more or less, that society could be governed through a set of self-evident principles analogous to those of economics.”

³¹ Hamlin, *Public Health*, p. 151; Baldwin, p. 128.

³² Stephen Halliday, *The Great Filth: The War Against Disease in Victorian England*, (Stroud, Gloucestershire: Sutton, 2007), p. 217

benefited no-one. The remedy was to get the poor healthy again by eradicating the filth in which they lived. The work required, although expensive, was considered a safe bet to yield a good return on investment by increasing productivity. Chadwick's efforts would result in a grand experiment in the management of human suffering.

Chadwick: the Poor Law Commission and the Sanitary Report of 1842

In the aftermath of the first cholera epidemic, a Royal Commission was convened to overhaul the Poor Law, which had been in place since 1795. The old model – in which ratepayers subsidized workers when wages fell below subsistence level – did little to discourage employers from paying as low a wage as possible, since the parish could be relied upon to provide a supplement. The Poor Law Amendment Act of 1834 introduced a model designed to drastically reduce pauperism's burden on the rates and make entry into the workhouse system so unattractive as to become the desperate last resort of the truly indigent.³³ Chadwick, as secretary of the Commission, advised the authors of this new legislation and, combined with his involvement as advisor to the Health of Towns Commission, subsequently found himself in a position to launch his sanitarian agenda.³⁴

In 1842 Chadwick published his *Report on the Sanitary Condition of the Labouring Population and on the Means of Its Improvement*. Historian Christopher Hamlin considers the *Sanitary Report* “a systematic attempt to dehumanize the poor,” a political document designed to advance its author's career and extend the life of the Poor Law Commission:

³³ Halliday, *The Great Filth*, pp. 128-29.

³⁴ Hamlin, *Public Health*, p. 244.

The initial claim of fever preventable by "sanitary reform" diverted attention from the charges ... that the new poor law itself bore responsibility for the fever. In sanitary reform the commission found a new and positive field of endeavour, and a way to emasculate the threatening medical profession as well as other rival authorities in engineering and public administration.³⁵

The report, which received favourable reviews in the press as a groundbreaking work on public health, was nonetheless considered controversial enough for the Poor Law Commissioners to allow Chadwick to take all the credit and leave their names out of it.³⁶

Rather than address the problem of poverty as a cause of disease (the lack of the essentials of life caused by the vagaries of political economy), Chadwick chose to promote sewer pipes as a cure-all for the physical and moral defects of the poor. His thesis was clear: disease caused poverty.³⁷ Making communities responsible for sweeping away their own disease-causing muck was surely a far less vexing solution than tackling the conditions that created poverty in the first place. His proof, however, was highly suspect,³⁸ and regardless of the supposed empiricism of his approach, Chadwick's reportage has since been perceived as being designed to satisfy his political masters at a time when fiscal constraint was being pursued with religious zeal.³⁹ He thus succeeded in promulgating his sanitarian agenda while simultaneously sidestepping the prickly political and social upheavals that would likely have resulted from pursuing the more humanitarian solution of increasing aid to the poor.⁴⁰

³⁵ Hamlin, *Public Health*, p. 157. Pp. 164-65: Hamlin notes that Chadwick's language objectifies the poor, accounting for their wretched condition as being of their own making through their "recklessness" and their predilection for "the use of ardent spirits."

³⁶ Halliday, *The Great Filth*, pp. 130-131.

³⁷ John M. Eyler, "Poverty, Disease, Responsibility: Arthur Newsholme and the Public Health Dilemmas of British Liberalism," *The Milbank Quarterly*, Vol. 67, (1989), , Supplement 1. Framing Disease: The Creation and Negotiation of Explanatory Schemes (1989), p. 111: "Environmental reforms, especially sanitation, would reduce disease and mortality and thus indirectly and economically address the problem of poverty without compromising individual responsibility or challenging personal liberty."

³⁸ Hamlin, *Public Health*, p. 163.

³⁹ Halliday, *The Great Filth*, p. 130.

⁴⁰ Christopher Hamlin, "Edwin Chadwick and the Engineers, 1842-1854: Systems and Anti-Systems in the Pipe-and-Brick Sewers War," *Technology and Culture*, Vol. 33, No. 4 (Oct., 1992), p. 683.

To Chadwick, the "hydraulic thinker," lack of water was the most immediate problem, and the provision of it the ultimate solution. He reasoned that time spent by workers searching for and fetching water was a waste of valuable human capital and a threat to morality and political stability.⁴¹ If water could be more readily piped into homes, valuable human resources could be redirected toward more salubrious pursuits that would potentially lift the individual from poverty. Sluicing away the foul detritus and sending it to fertilize the fields was considered the ultimate efficiently scientific solution.⁴² The chief obstacle lay in convincing local authorities to raise the rates to pay for the works required for the task. As subsequent public health administrators were to discover to their dismay, the costs could be astronomical, and ratepayers' resistance to tax increases often prevailed.⁴³ Mind-numbing complications often ensued when public welfare became mired within a maze of confounding regulations and conflicting jurisdictions.⁴⁴ General resistance to reform was compounded by additional pressures on rates, generated by the needs of ever-increasing numbers of destitute people who tended to migrate between parishes within the major urban centres in the hopes of achieving some sort of upward mobility.⁴⁵

In the summer of 1843, *Lancet* published an item on longevity which strongly inferred that rural life was considerably healthier than that in the metropolis. Its tabulations, which compared the life span of the gentry and professional classes with that of labourers and artisans in half a dozen districts, indicated that the working-class

⁴¹ Hamlin, *Public Health and Social Justice*, p. 298: "In queues assignments were made; children learned bad language."

⁴² Hamlin, "Edwin Chadwick and the Engineers," p. 4.

⁴³ Smith, *The People's Health*, p. 216. At Middleton in 1848 ratepayers opposed a petition for the creation of a local Board of Health as the first step to receiving a water supply. Wohl, p. 101: "To some the sewer was a symbol of sanitary progress; to others it was simply a costly and dangerous fad."

⁴⁴ Hamlin, *Public Health and Social Justice*, p. 289.

⁴⁵ Geoffrey Rivett, *The Development of the London Hospital System 1823 - 1982*, (London, Oxford University Press 1986), p. 21.

residents of Bath lived ten years longer than those in Liverpool, while its upper classes could expect to enjoy an additional twenty years.⁴⁶ It was not only want of food and clean water which affected the quality of life: the unrelenting regimen of factory work, and an almost complete absence of viable sanitation, made conditions in the “pestilential human rookeries”⁴⁷ of industrial towns and cities positively life-threatening. Progress was being made, but it was painfully slow, and the question of water use resulted in unintended consequences as Chadwick’s plan began to take hold.

Regardless of the ongoing overcrowding and general misery among the lower classes, water consumption increased dramatically between 1840 and 1850, as the upper classes began to enjoy the conveniences of the private bath and water closet (for which some paid a special rate).⁴⁸ As neighbourhoods were connected to the mains, the popularity of the water closet increased, resulting in copious outflows of sewage. Chadwick’s sewerage scheme created a whole new set of problems as the fertilization component of his plan failed to make much headway⁴⁹ – the importation of guano, which began in 1842, made nightsoil considerably less profitable⁵⁰ – and entire river systems were assaulted with effluent from the new ceramic pipes.⁵¹ Despite the Chadwickian view that the negatives of the system were outweighed by the benefits,⁵² to many alarmed

⁴⁶ *Lancet*, August 1843, p. 661. Wohl, *Endangered Lives*, p. 5.

⁴⁷ Sims, *The Bitter Cry*, p. 10.

⁴⁸ Smith, *The People’s Health*, pp. 217-18. There was, however, no extra rate for these in Glasgow: ‘even working men ... installed WCs.’

⁴⁹ Gareth Stedman Jones, *Outcast London: A Study in the Relationship Between Classes in Victorian Society* (Oxford, Clarendon Press 1961), p. 213.

⁵⁰ Halliday, *The Great Filth*, p. 53.

⁵¹ Smith, *The People’s Health*, p. 219. By 1857, an estimated 250 tons of metropolitan effluvia were being poured into the Thames each day.

⁵² Christopher Hamlin, “Muddling in Bumbledom: On the Enormity of Large Sanitary Improvements in Four Towns, 1855-1885,” *Victorian Studies*, Vol. 32, No. 1 (Autumn, 1988), p. 62.

citizens, the cesspit continued to represent the preferred, if flawed, method of dealing with the mountains of ordure.⁵³

Water supply continued to be the most vexing issue: with the miasma theory of disease still prevalent, and Snow's theory of water-borne disease yet to be proven,⁵⁴ water companies continued feeding what was essentially raw sewage to town pumps with impunity.⁵⁵ This occurred despite the implementation of the Metropolis Water Act of 1852, which required water companies to cover their reservoirs, filter their water, and ensure that Thames water be taken from a source above the worst of the sewage outfalls. The Act was thought to be "a considerable step in the right direction,"⁵⁶ one of many pieces of legislation enacted during Chadwick's tenure following the landmark Public Health Act of 1848. With the passage of the Health of Towns Act the same year, Chadwick and his supporters in Parliament charted a new course of public health governance which put him firmly in the driver's seat on the General Board of Health.

General Board of Health Under Chadwick

Jeanne Brand describes the establishment of the General Board of Health as "a six-year experiment"⁵⁷ in governance. With the *Sanitary Report* fresh on the public mind and a second wave of cholera in the news again in 1847, Chadwick and Dr. Thomas Southwood Smith acted quickly to put a Public Health Bill before Parliament.⁵⁸ The Public Health Act (and the Health of Towns Act) paved the way for communities to deal

⁵³ Stephen Halliday, *The Great Stink of London: Sir Joseph Bazalgette and the Cleansing of the Victorian Metropolis*, (Stroud: Sutton Publishing, 2009), p. 45

⁵⁴ Smith, *The People's Health*, p. 235. "Official opinion only accepted in 1866 after his death his view of the ingestion of a specific micro-organism." *Edinburgh Medical Journal*, Vol. I, (1855-6), pp. 481-3, 670, 944; *Lancet*, January 5, 1867, p. 18.

⁵⁵ Halliday, *The Great Stink*, pp. 137-40. This was brought into harsh relief with an outbreak of cholera among customers of the East London Water Company in 1866.

⁵⁶ Henry Jephson, *The Sanitary Evolution of London*, (Brooklyn, N.Y., A. Wessels Co., 1907), p. 71.

⁵⁷ Brand, *Doctors and the State*, p. 3.

⁵⁸ Pelling, p. 46.

with local sanitation nuisances without having to resort to parliamentary approval. Under the guidance of the central Board, a Local Board could take action against nuisances on the petition of one-tenth of the ratepayers or upon a spike in the rate of mortality at a given threshold.⁵⁹ The Health of Towns Act enabled local authorities to use the rates for drainage schemes and water-supply systems.⁶⁰

Chadwick installed himself into one of three positions on the General Board; to the ire of the medical profession, there was initially no provision to appoint a doctor, but this deficiency was remedied when his friend and colleague Southwood Smith – who had spent a number of years working at the London Fever Hospital – was provisionally appointed to a fourth position. Southwood Smith was a safe choice, as he could be relied upon to follow Chadwick's lead,⁶¹ and his relatively insignificant position on the board exemplified Chadwick's view that doctors ought to play only a secondary role in the administration of public health. *Engineers* were to be the key players in Chadwick's master plan.⁶²

Chadwick's anti-medical bias is evident in his *Sanitary Report*: his sanitation solutions were to spring from "operations for which aid must be sought from the science of the civil engineer, not from the physician."⁶³ Doctors, he thought, had already done the work of discerning the presence of disease; it was not their job to involve themselves in fixing the surrounding issues of poverty, bad housing and immorality. Far better that they should play a subordinate role within an administrative framework – modelled after existing sewer commissions – having all the efficient "executive machinery"⁶⁴ capable of

⁵⁹ Lambert, p. 71.

⁶⁰ Smith, *The People's Health*, p. 198.

⁶¹ Pelling, p. 301: The two men were "advocates of state interference, a position which was then compatible with a belief in the freedom of capital."

⁶² Hamlin, *Public Health*, p. 183: "...fever prevention required institutions in which engineers could act."

⁶³ Chadwick, *Sanitary Report*, p. 188.

⁶⁴ *Ibid.*, p. 203.

bringing the full force of sanitary law down upon legions of offenders. Chadwick believed that the ultimate efficiency would result from creating a comprehensive administrative template of inspection and reporting and applying it uniformly throughout the country in each district.

The doctors, however unsuited they might be to administration in Chadwick's view, clearly had a role on the front lines in fighting the filth diseases. Cholera enhanced his sanitarian agenda again in 1848, as it gave his Board a mandate that few could argue against. *The Times* reported that the impending epidemic gave it license "in the present emergency" to endow its Poor Law medical inspectors with

...discretionary powers, because the rapidity of the course of cholera will not allow them to wait for directions from the guardians at their weekly meetings.

The news item also mentioned that the good doctors could do with a raise, especially given the invaluable (and unpaid) role they had played in the previous epidemic:

...and seeing the many and arduous duties that devolve upon the medical officers, the General Board of Health cannot but express a hope that the remuneration of these officers will be more proportionate to the value of the services required than it was upon the former occasion.⁶⁵

With the new rules in place, between 1848 and 1854 legions of sanitary inspectors, drafted from the ranks of civil engineers,⁶⁶ ranged far and wide to take Chadwick's "totalizing utopian sanitary vision"⁶⁷ to the people. Curiously – due to the language of the legislation which left it up to the community itself to decide whether or not to act on a sanitary strategy – they often found themselves with "nothing to enforce"⁶⁸ in communities which often balked at the cost of the works involved. Many towns did, however, embrace the new powers accorded to them by the Act and saw the advantage of

⁶⁵ *The Times*, November 8, 1848, p. 8.

⁶⁶ Hamlin, *Public Health*, p. 283.

⁶⁷ Baldwin, p. 7.

⁶⁸ Hamlin, *Public Health*, pp. 279 - 280: "The General Board might well be a stableful of experts eager to sewer and water every town in the land, but they were part-timers, in work only when towns petitioned the board to adopt the act or to approve a loan request."

reforming local government as a means of taking control of a plethora of confusing and overlapping jurisdictional divisions.⁶⁹

In summarizing Chadwick's legacy, Simon's biographer notes that the General Board of Health, and the administrative structure it was to oversee, exemplified "the anti-representative, anti-medical and 'centralizing' propensities" that were Chadwick's hallmark.⁷⁰ Quite apart from the hostility of the medical profession,⁷¹ the backlash against centralization was key to his demise: as the cholera crisis faded once again into memory, the country was simply not prepared to break with tradition and take orders from the metropolis, and the anti-centralists who had been resisting that trend since 1848 eventually prevailed.⁷²

Despite the fact that his efforts set the stage for the development of efficient municipal government in matters of sanitation and nuisance control, by 1854 Chadwick had become one of the most reviled public figures in the country due to his authoritarian methods and uncompromising nature.⁷³ Pressured to resign from all his positions of influence, the Poor Law Commission, the General Board of Health and the Metropolitan Sewers Commission, Chadwick retired from the scene, "a victim of old vested interests and opponents of centralized government."⁷⁴ The Public Health Act was ultimately applied only to England and Wales and excluded the City of London, a fact which was to prove instrumental in launching John Simon's career, the early years of which ran parallel to Chadwick's six-year experiment.

⁶⁹ Hamlin, *Public Health*, pp. 289-290: The local governments were perceived as "... so much silly English tradition that might be swept away by authoritative enactment as easily as one swept filth from the streets with a high-pressure jet."

⁷⁰ Lambert, p. 72. Pelling, p. 13: "...his dismissal of medical therapeutics was characteristic of the context of the 1820s and 1830s."

⁷¹ Steven J. Novak, "Professionalism and Bureaucracy: English Doctors and the Victorian Public Health Administration," *Journal of Social History*, Vol. 6, No. 4 (Summer, 1973), p. 448.

⁷² Simon, *English Sanitary Institutions*, p. 205.

⁷³ Halliday, *The Great Filth*, p. 134.

⁷⁴ Hamlin, "Edwin Chadwick and the Engineers," p. 683.

John Simon: Medical Health Officer to the City of London

In 1848 the City of London was undertaking its own sanitary agenda with the passing of the Sewers Act, a comprehensive package of legislation to be applied to its public works. The Act swept away outdated laws and set out, among other concerns such as paving and lighting, specific regulations pertaining to drainage and sewerage of new buildings, giving the Commission of Sewers unprecedented powers “to supervise the *condition and cleanliness* of house interiors.”⁷⁵ Of specific interest is its recommendation that a Medical Officer of Health be appointed: the language of clause 80 of the Act was fairly loose in this regard, in that it “allowed” rather than *compelled* the Commission to create this new appointment.⁷⁶ Divisions within the Commission were behind this compromise – the drive to increase state intervention in sanitary and medical matters was undertaken in an atmosphere of caution; it behooved the government to take care not to appear too Chadwickian in its infringements upon the private sphere or to be seen to be dictating policy to the medical profession. This was in keeping with the general mood of the time regarding the delicate balance between “domestic autonomy” and the greater good.⁷⁷

The Times, reporting on the meeting of the Commission, conveyed a sense of urgency,

as ... the cholera was making rapid advances towards this country, it was desirable that there should be no delay in the matter.⁷⁸

The commissioners were divided as to whether or not the new officer should be a doctor — they were looking for someone “who could distinguish causes of disease in this case

⁷⁵ Lambert, pp. 88-95. Emphasis in the original.

⁷⁶ *Ibid.*, p. 92.

⁷⁷ Michelle Allan, “From Cesspool to Sewer: Sanitary Reform and the Rhetoric of Resistance, 1848-1880,” *Victorian Literature and Culture*, Vol. 30, No. 2 (2002), p. 388.

⁷⁸ *The Times*, October 4, 1848, p. 8.

rather than a man who could supply a remedy after an epidemic had made its appearance” — and what his remuneration should be: when a figure of £400 to £500 per annum was put on the table, Mr. Taylor opined that “it ought to be ten times that amount.”⁷⁹ Others pointed out that Poor Law medical health officers had provided their services free of charge during the last epidemic, so they saw no reason why matters should be different this time around.

With the matter adjourned to the Court of Common Council, the discussion continued. There were expressions of concern over departing from Chadwick’s model, which considered simultaneous engagement in private practice to be a conflict of interest (an argument the Chadwickians did not win on the grounds that in opting for a working doctor, the Commission could avail itself of men of experience). In the interests of wanting to “reconcile cheapness with quality of appointment,”⁸⁰ it was agreed that the post urgently needed to be filled and that it would ultimately give a prestigious leg up to any young medical man in the early stages of his career. Despite the vocal misgivings of the anti-sanitarians who, wary of “jobbery,” maintained that “nothing could be more unwise than to choose a person whose object it would be to make a situation for himself,” the motion was carried:

That the Court do agree with the Commissioners of Sewers, that it is highly necessary that a medical officer of health be forthwith appointed, and that a sum for that purpose (not exceeding £150) be paid out of the city’s cash: and that the Court of Sewers be requested to nominate two fit and proper persons, of whom this Court will appoint one to be the medical officer of health for this city and liberties.⁸¹

Simon’s qualifications were considered alongside those of a small field of other applicants. Although eminently qualified as a surgeon, he was seen by some to be rather ambitiously intruding upon a role thought to be more suited to the physician. Simon won

⁷⁹ Ibid.

⁸⁰ Lambert, p. 99.

⁸¹ *The Times*, October 7, 1848, p. 7.

the post, however, thanks in no small degree to a bit of nepotism (his father, a prominent and successful City businessman, wielded a considerable degree of influence among his colleagues on the selection committee) and fervent expressions of support from the upper echelons of the medical establishment.⁸² The only other frontrunner was passed over on the basis of his activities within the unpopular Health of Towns Association, which had been publicly critical of the City's sanitary administration in the past.⁸³ In choosing Simon over a man with more specific sanitary reform experience, it could be said that the Commission was settling an old score with the Chadwick camp.⁸⁴

So what kind of man did the Commission get in October of 1848? Someone, it appears, who was perfectly suited to the job of facing the impending cholera crisis and tackling what would prove to be an endless series of seemingly unsolvable problems. Despite the initial similarities in their sanitarian strategies,⁸⁵ Simon – the man – was nearly the polar opposite of Chadwick. Apart from his medical duties which kept him in touch with developments in medical research and the sciences, Simon, just thirty years old upon his appointment, was already a well-rounded critical thinker who immersed himself in literature and the arts – he indulged in painting to relax his inquisitive mind and maintained deep friendships with artists and writers – and who considered medicine to be something which lived at the crossroads of art and science.⁸⁶ One outcome of his pursuits in the arts was that he cultivated an eloquent writing style, a talent which would garner notice outside medical circles when he began publishing his immensely popular

⁸² Lambert, pp. 101-103.

⁸³ *The Times*, October 17, 1848: Simon was also a member of the Association, but publicly denied being involved with its political machinations against the City.

⁸⁴ Lambert, p. 106.

⁸⁵ *Ibid.*, p. 112.

⁸⁶ *Ibid.*, p. 32.

annual reports. His formidable energy and integrity drew the respect of his contemporaries from the outset and would serve him well in the years to come.⁸⁷

Given the fact that his appointment was among the first of its kind, Simon's position was really quite extraordinary: here was an opportunity to apply emerging sanitarian strategies to a much smaller area, the square mile of the City of London;⁸⁸ despite the excitement of being given license to conduct his own public health experiment *in situ*, constructing the framework upon which to hang his work must surely have been a bit daunting. His only true colleague, Dr. Duncan of Liverpool, barely a year into his own appointment, had very little practical experience to share with the newcomer,⁸⁹ and so, like the proverbial blind man attempting to ascertain the size of a very large proverbial elephant, he simply had to get on with it. In November, just a few weeks after his appointment, cholera was again drawing the public's alarmed attention to the notorious "fever nests" of the metropolis, as the first case was noted to have occurred "as early as the 2d of October".⁹⁰ With all eyes on the medical establishment, Simon's position in London thus assumed a discomfiting degree of celebrity as he went to work "abating the local conditions of unwholesomeness."⁹¹

Wasting little time, he set about organizing his office. Although not a proponent of Chadwick's philosophy, Simon followed his lead in some respects: at the core of his *modus operandi* was the collection of reliable statistics. (The trend towards data collection, then in its infancy under William Farr, would be more fully articulated toward

⁸⁷ Brand, "John Simon and the Local Government Board Bureaucrats 1871-1876," *Bulletin of the History of Medicine*, XXXVII 2 (March-April 1963), p. 184; Lambert, pp. 144-145.

⁸⁸ Jephson, *Sanitary Evolution of London*, p. 51. The teeming masses of the Metropolis were excluded from the legislation enacted in 1848.

⁸⁹ Lambert, pp. 112-113. See also p. 109: Dr. W.H. Duncan was appointed a Britain's first Medical Health Officer in 1847.

⁹⁰ *The Times*, November 8, 1848, p. 8.

⁹¹ Simon, *English Sanitary Institutions*, p. 248.

the end of the century in the work of Charles Booth.)⁹² Simon immediately identified a problem with the mortality reports issued by the Registrar General. His intention was to take the temperature of his square mile, identifying which diseases prevailed in which neighbourhoods *before* people died from them, not after. What he needed was a consistently reliable instrument, and he sought to enlist the assistance of the Poor Law Medical Officers to conduct weekly inspections of their respective areas.⁹³ The already overburdened (and, as we have seen, poorly paid) doctors revolted against Simon's proposal and it was only the spectre of cholera that allowed him to work around them and access the needed returns from their employers.⁹⁴ (Infectious disease reporting protocols finally become reality in 1889, but even then they were only compulsory in London.)⁹⁵

Applying the template set down by the General Board of Health, Simon soon established a system of weekly reporting and repeated inspections which tackled sanitary nuisances ranging from bad drainage to the "noxious and offensive trades."⁹⁶ His main areas of concern were egregious overcrowding;⁹⁷ the absence of a viable water supply; the presence of hundreds of cellar slaughterhouses (which he found particularly appalling); and churchyard burial grounds, which had clearly begun to exceed capacity,⁹⁸ all of which he attributed not to administrative neglect, but rather to "absence or insufficiency of law."⁹⁹

⁹² Charles Booth, "Enumeration and Classification of Paupers, and State Pensions for the Aged," *Journal of the Royal Statistical Society*, Vol. 54, No. 4 (Dec., 1891), pp. 600-643.

⁹³ Simon, *English Sanitary Institutions*, pp. 250-251.

⁹⁴ Lambert, pp. 115-117. Simon eventually won their support as the cholera crisis forced all parties into collaboration. p. 139. For interesting insight into the tension between Medical Health Officers and statisticians, see Graham Mooney, "Professionalization in Public Health and the Measurement of Sanitary Progress in Nineteenth-Century England and Wales," *Social History of Medicine*, 10:01, (1997), pp. 53-78.

⁹⁵ Walter W. Holland and Susie Stewart, *Public Health: The Vision and the Challenge*, (London: The Nuffield Trust, 1998), p. 21.

⁹⁶ Jephson, p. 53.

⁹⁷ Smith, *The People's Health*, p. 223. Mortality rates in the worst areas reached nearly fifty percent by 1858.

⁹⁸ Lambert, pp. 145-148.

⁹⁹ Simon, *English Sanitary Institutions*, p. 255.

During his first year in office, he was able to use the cholera emergency to goad his superiors into giving him more staff to address the increasing workload of inspection, reporting and nuisance removal. With the death toll mounting in the summer of 1849, an emergency meeting of the Health Committee and Common Council drafted a resolution authorizing house-to-house inspections and the provision of medical relief, which Simon implemented immediately.¹⁰⁰ By late fall the epidemic had waned, but Simon's method of repeat inspections (the "sanitary rotas") proved to be such an effective weapon against sanitary evils that it survived the epidemic response phase and became a permanent part of his administrative toolkit.¹⁰¹

Simon's first reports to his superiors after the crisis had abated served to shine a spotlight on the persistent problems in the worst parts of his jurisdiction, which remained on his mind later in life:

... I rejoice to remember that, even in those early days, I did my best to make clear to the Commission, what sufferings and degradation were incurred by the masses of the labouring population through the conditions under which they were so generally housed in the courts and alleys they inhabited: not only how unwholesome were those conditions, but how shamefully inconsistent with reasonable standards of civilisation; and how vain it must be to expect good social fruits from human life running its course under such conditions.¹⁰²

From the outset, Simon's concern for the living conditions of the pauper and working classes lay at the heart of everything he did. Unlike Chadwick, who was more obsessed with systems and economics than humanity, Simon's popularity grew exponentially. As he settled into his work with the City, his reports and clinical lectures were widely published and well received by a public increasingly interested in health matters.

Simon's office was initially subject to annual review, but in 1853, as he divided his time between his City duties and his medical practice, he was hired permanently with

¹⁰⁰ Lambert, pp. 130-131.

¹⁰¹ Baldwin, p. 240.

¹⁰² Simon, *English Sanitary Institutions*, p. 253.

increased remuneration and was also given leave to hire more staff. That same year he also joined a Royal Commission investigating a third outbreak of cholera and was appointed as an advisor to Sir Benjamin Hall's Medical Council.¹⁰³ These two events (and his friendship with Tom Taylor, Secretary of the Board of Health)¹⁰⁴ placed Simon in a favourable position when Chadwick resigned from the Board in 1854. Seeing opportunity in the impending sea change, by this time Simon had begun to call for ministerial control of public health matters in his annual reports. The connection with Hall brought parliamentary attention to his department's excellent record in dealing with sanitary matters in the City (particularly in light of the latest cholera epidemic, which had devastated the metropolis but left Simon's square mile relatively unscathed),¹⁰⁵ and, as Hall was instrumental in bringing forth the bill to appoint a new temporary Board, Simon was considered a natural candidate for the position of Medical Health Officer.¹⁰⁶ By now a seasoned, respected and popular civil servant, he was more than ready to apply his expertise to a broader stage.

Medical Health Officer: 1855-71

Simon's first years in his new position were tenuous, as political machinations in Parliament favoured the anti-sanitarian camp,¹⁰⁷ the result, according to his memoir, of festering resentment against Chadwick's Board of Health:

...each year, when the estimates of the establishment were before the House of Commons, the old escutcheon of the board was still a target; and we, who by no particular fault of our own were under that sign, used to receive shots which had been in store for others.¹⁰⁸

¹⁰³ Simon, *English Sanitary Institutions*, pp. 256-257.

¹⁰⁴ Lambert, p. 199.

¹⁰⁵ *The Times*, "Report of the Medical Officer of Health on the Cholera Epidemic of 1854," December 20, 1854. p. 4.

¹⁰⁶ Lambert, p. 196-197.

¹⁰⁷ *Ibid.*, p. 240.

¹⁰⁸ Simon, *English Sanitary Institutions*, p. 259.

In the absence of any clearly defined statutory duties, it must have seemed as if he were starting all over again. Between 1855 and 1859, the appointment was provisional and subject to annual scrutiny; his department continued to forge ahead with its work despite the heavy weather, and Simon was able to propose legislative changes for the advancement of its endeavours.¹⁰⁹

The Board of Health continued to hang in the balance, buffeted by the political convulsions of yet another change in government, as anti-sanitarians held sway, even as the ripe and disgusting emanations from the sewage-saturated Thames wafted in the windows of Westminster.¹¹⁰ It was a serendipitous circumstance that brought the Palmerston government back into power in the summer of 1859, an event which reversed Simon's fortunes yet again and brought him a new ally in the form of Robert Lowe. A revised Public Health Act was finally passed by six votes, and Clause 4 assigned Simon to the Privy Council, again only provisionally. There would be another three years of uncertainty before he was given complete autonomy as Secretary of the new Medical Department, with "the right of constant and direct access to the responsible ministers."¹¹¹

By this time Simon's annual reports become increasingly available to a wide readership thanks to an amiable relationship with the press. He placed a great deal of emphasis on the importance of disseminating the information his department was collecting, much of it written in such a way as to engage a non-medical audience. Recurring themes were: qualifications of vaccinators; consistency of lymph supply; drainage; diptheria; scarlatina; typhoid; smallpox; lung diseases in certain noxious industries; water supply; instructions to vaccinators; excessive child mortality; diseases of livestock; housing of rural labourers; sanitary inquiries; comparative efficacy of various

¹⁰⁹ Lambert, p. 259.

¹¹⁰ Halliday, *The Great Stink*, pp. 71-72.

¹¹¹ Lambert, pp. 274-279, 328-329.

methods of excrement removal: dry earth; midden closets, pail closets and water closets; relapsing fever; water supply; excremental poisoning; cholera; constitution of the medical profession; and regulation of pharmaceuticals. After 1865, while continuing with his usual reporting, Simon branched out into research projects, including requisitioning "auxiliary science investigations" into the causes of epidemic disease (including the "intimate pathology of contagion"),¹¹² funded by small non-renewable annual grants.¹¹³

One of the first major crises the new department dealt with occurred in 1862 as the work of half a million cotton workers was interrupted in Lancashire and Cheshire by the disruption of trade in the American Civil War.¹¹⁴ Simon conducted personal inspections and marshalled thirty medical men to collect data from guardians, local boards and sanitary authorities in twelve towns. His report, published in 1863, ran to 456 pages and included several hundred tables of exhaustively researched dietary costs and detailed schematics for sixty-gallon steam boilers in which to cook soup.¹¹⁵

Simon's thorough reporting most certainly contributed to raising awareness in the 1860s of the plight of the poor and the inadequacy of sanitary laws in addressing the root causes of epidemic disease. While great strides were being made in the area of sanitary improvements, there was still a great deal to be done. Simon's ceaseless agitation for change was answered with the passage of the Sanitary Act of 1866. With its unprecedented compulsory clauses,¹¹⁶ this legislation made the powers of the Public Health Act "clumsily workable."¹¹⁷ Of all the reforms of the 1860s this (and the

¹¹² Simon, *Fifth Report of the Medical Officer of the Privy Council 1862*, PP 1863, vol. xxv., p. 229.

¹¹³ Roy M. MacLeod, "The Frustration of State Medicine 1880-1899," *Medical History*, January, 1967, 11(1): p. 21. These grants continued until 1919.

¹¹⁴ *Oxford Illustrated History of Britain*, pp. 472-473. See also *Fifth Report of the Medical Officer of the Privy Council, 1862*, PP xxv., p. 299, which notes that the welfare of an estimated two million people was impacted in some way.

¹¹⁵ Simon, *Fifth Report*, vol. xxv. Lambert, p. 341: "...a model of social-survey technique, unsurpassed for generations to come."

¹¹⁶ Wohl, *Endangered Lives*, p. 155.

¹¹⁷ Smith, *The People's Health*, p. 199.

Vaccination Act of 1867) validated the efforts of Simon and his department as no other. He reflected upon this landmark event in 1897:

All who had anything to do with the passing of that Act may rejoice to the end of their lives in contemplating the gains which it achieved. Among its many noteworthy features ... is that, under the Act, the grammar of common sanitary legislation acquired the novel virtue of an imperative mood.¹¹⁸

The language of the 1866 Act created the notion that local governments now had a *duty* to address sanitary deficiencies and expanded the definition of nuisances within their jurisdictions. In its final articulation, however, the critical notion of *compulsion* was conspicuously absent and, complicated by an already chaotic tangle of local/central relations, the legislation ultimately frustrated Simon's efforts to complete the task of building a cohesive system of public health governance.¹¹⁹

Royal Sanitary Commission 1869-71

In 1869, the Royal Sanitary Commission began a two-year inquiry into the health of the nation. Regarding the outcome, Simon writes:

With such large and varied experience as the Department had acquired, with such colleagues as I had, and with such completion of staff as I believed we were soon to have, I felt sure that the Department would be ready to meet any greater claims which Parliament might throw upon it in the more active times which apparently were about to come.¹²⁰

He was clearly optimistic that his role would continue relatively unchanged. His privileged position as Medical Officer of Health within the Privy Council afforded him a great deal of autonomy, which in turn had allowed him to accomplish a great deal, but by 1871 his position was in fact much less secure. For two years the Commission had studied in exhaustive detail every aspect of the country's public health administration in

¹¹⁸ Simon, *English Sanitary Institutions*, p. 300.

¹¹⁹ Lambert, p. 391: "... its lack of definition gave wide scope for evasion, and necessitated much later legislation."

¹²⁰ Simon, *English Sanitary Institutions*, p. 348.

light of the increasing burdens being placed upon it, and its reports outlined a plan to reorganize the chaotic administrative superstructure that had grown up around a shaky framework of piecemeal legislative efforts.

The time was clearly at hand to address the "marked absence of system" which Simon referred to as "a parquetry which was unsafe to walk upon."¹²¹ The most vexing problems arose around questions of jurisdiction, and he saw poor-law relief as a function apart. The crux of the matter was how to reconcile pauperism, sanitation and nuisances. The old Chadwick model proposed that the poor *were* the nuisance. Simon's approach was decidedly more humanitarian: he saw a major disconnect between the functions of local medical health officers, the Poor Law guardians and central sanitation authorities.¹²² Inefficiency abounded when authority over sewers fell to the vestries, the Poor Law guardians managed nuisances, and the central authority controlled the whole. The problem, as Simon saw it, was that there were simply too many cooks.¹²³ The Royal Commission was tasked with devising a solution to the "baffling and ludicrous complexity" of over 700 different entities barely functioning with "excess in some parts, insufficiency in others, duplication elsewhere and friction everywhere."¹²⁴

The Minutes of Evidence give us a great deal of insight into Simon's thoughts on the matter. It is quite clear that he was of the opinion that the Medical Office of the Privy Council and the Local Government Act Office should remain separate and autonomous, and that going back to the old way of doing things was simply not an option:

I do not see what machinery could be economized, for the two systems are essentially different.¹²⁵

¹²¹ Lambert, p. 501.

¹²² *Second Report of the Royal Sanitary Commission*, PP (1871), Vol. I, p. 31.

¹²³ Simon, *English Sanitary Institutions*, pp. 323-24: "...from 1868, in each such parish, the privies were under one authority, and the pigsties under another."

¹²⁴ Lambert, p. 502.

¹²⁵ *First Report of the Royal Sanitary Commission*, PP (1869), p. 103.

The Commission apparently agreed with him; it recommended the establishment of a Central Authority overseeing cascading levels of local and district authorities under a single minister, with six separate departments pertaining to local government: engineering; registration and statistics; poor relief; public health; and oversight of the medical profession. The system would include medical and nuisance inspectors operating in conjunction with expert consultants as required; local and district inspectors; special inspectors and experts; local and district boards and unions, each with its own local executive and medical health officers. The intention was to *harmonize* the functions of each office, not to eliminate any of them. With local authorities reporting back to the Central Office on all matters of district concern, the outcome was envisioned to be a comprehensive scheme of information-gathering, sharing of data between departments, and remediation from the top down.

On the matter of the role of Poor Law medical health officers, the commission noted that they should not be required "to discharge the duties of the police, the lawyer or the engineer" and concluded that "a reasonable number of subordinates *under the existing chiefs of departments* would effect all that can be desired."¹²⁶ This sentence must have given Simon the comfort he was seeking. He can be forgiven for assuming that his role was secure, but the outcome was to bring him, yet again, to the brink of uncertainty.

By this time Simon's influence on politicians had become undeniable, and he often succeeded in wielding it in the face of powerful opposition.¹²⁷ As a result, he became bolder and began to push for an expansion of his department and its powers. By 1870, with the Royal Commission report yet to appear, he was already promoting an overhaul of the entire administration, including placing the Local Government Act Office

¹²⁶ *Second Report of the Royal Sanitary Commission*, PP (1871), Vol. II, pp. 359-60. Emphasis added.

¹²⁷ Lambert, p. 410. The replacement of one his chief admirers on the Privy Council, the Duke of Buckingham, with the Duke of Marlborough resulted in a demotion in February of 1868 which removed his autonomy, but a subsequent change in government revived his popularity with his superiors.

(LGAO) in a subordinate position to his Medical Department. With the national sanitary agenda expanded by the 1866 Act, Simon wanted to clear away the ambiguities and duplication of effort between the two departments: he pushed for clear division of duties, with his department being the point of first contact for all sanitary and medical matters, and the LGAO responsible for engineering and legal matters under his direction. Given his favourable political connection with the Home Secretary at the time, parts of his proposal were written into the regulations and he became the *de facto* "Superintendent General for Health."¹²⁸ A smallpox epidemic the following year coincided with the implementation of the Vaccination Act, compelling each Local Board to appoint a vaccination officer to enforce it.¹²⁹ Again, Simon pressed for an expansion of his staff to coordinate these new efforts and, thanks to his political connections, was granted his request over the objections of the Treasury.

In 1871 the Royal Commission finally issued its report. Simon's old friend Tom Taylor had testified to the inefficiencies of the unwieldy relationship between the LGAO and the Medical Department which had become bogged down with unnecessary duplication of effort.¹³⁰ The intent of the Sanitary Commission regarding the continuance of Simon's position within the proposed new structure from 1871 onward was quite clear:

Mr. Simon ... is the medical referee for the Home Office, and is in correspondence with the Poor Law Board: with which latter he states that his "communications are immeasurably more frequent than with the Local Government Act Office." His severance from the Council Office, and concentrated superintendence of all public sanitary arrangements, whether those of Local Boards or Guardians, or any other Local Authorities, would greatly add to his usefulness and power.

¹²⁸ Lambert, pp. 421-423. The title was unofficial.

¹²⁹ *Ibid.*, pp. 446-447.

¹³⁰ *First Report of the Royal Sanitary Commission*, PP (1869), p. 10.

...at present the Poor Law Board has no authority over the Guardians in their sanitary capacity, and the communications of the medical officers of the Privy Council with Poor Law medical officers on sanitary matters are, however numerous, only indirect and occasional. ... The work of the whole staff needs to be made uniform and to be collected and digested under the guidance of one Central Authority.¹³¹

Simon obviously hoped to become that Central Authority, and all indications were that this would be the case.

Local Government Board: 1871-76

Despite the unequivocal recommendations of the Royal Commission, that the two departments remain as separate entities under one minister, the Local Government Board (LGB) which was brought into being in 1871 under James Stansfeld (who had little practical experience with, or knowledge of, local government) was a completely different animal.¹³² Stansfeld was instrumental in formulating the Public Health Act of 1872, a somewhat inadequate piece of legislation which left certain important issues in administrative limbo. Royston Lambert argues that this type of vague governance was typical of the era:

Still generally uninterested in health affairs and content to sanction the roughest outline of future administration, the legislators delegated creative decisions on principles of crucial practical importance to administrators. At fundamental points in the Acts concerning both central and local administration nothing had been done to ensure the fulfillment of the Royal Commission's plans: such matters were left entirely and without safeguard to the mercies of a weak Minister and his permanent officials.¹³³

The appointment of this particular politician as "virtual Minister of Health"¹³⁴ represented a defining moment.

¹³¹ *Second Report of the Royal Sanitary Commission*, PP (1871), Vol. I, p. 34.

¹³² Brand, "John Simon and the Local Government Board Bureaucrats," p. 188. Stansfeld's background was with the Admiralty and the Treasury.

¹³³ Lambert, p. 517.

¹³⁴ *Ibid.*, p. 521.

As the Board's business got under way, it became painfully clear that things were going to be run very differently from what Simon had envisioned. In the day-to-day operations of his office, Stansfeld relied heavily upon the Board's secretary, John Lambert, who took the reins thanks to a patronage appointment from Prime Minister William Gladstone. It soon became clear that Lambert, a member of the Royal Commission and longtime denizen of the Poor Law Board himself, was going to run the new Board, and that Simon would be shut out of the power-sharing arrangement proposed by the Commission.¹³⁵ Gone was the plan of separate autonomous departments operating under one minister. Gone too was Simon's vision of being the clearinghouse for all sanitary matters. He did retain his statutory rights as Medical Officer to the Privy Council, but the title no longer held sway with the new minister.¹³⁶

Simon's first report to the LGB, issued in 1874, gives a clear indication of what he thought about the new state of affairs:

I beg leave to submit to you that for the past two and a half years, and particularly during the last year, the circumstances of official and administrative transition ... have been such that no consistent scheme of report in general relation to sanitary interests ... has been possible to me; and the present report, which regards the year 1873, must necessarily ... illustrate the difficulty of the unsettled circumstances.¹³⁷

Lambert's position as Permanent Secretary gave him primary control over the Board's affairs and effectively severed Simon's access to Stansfeld. In addition, Lambert's connections enabled him to hand pick his executive from the old Poor Law Board and fashion the new arrangement along the lines of the old Chadwick model.¹³⁸

Coincidentally, Chadwick himself had the ear of the minister. Together with his old ally, Florence Nightingale – who also harboured an intense dislike of Simon and his methods –

¹³⁵ Brand, "John Simon and the Local Government Board Bureaucrats," p. 188.

¹³⁶ Lambert, pp. 531-533.

¹³⁷ Simon, *Reports of the Medical Officer of the Privy Council and Local Government Board*, New Series, No. I, 1874, p. 2.

¹³⁸ Lambert, pp. 522-23.

he went out of his way to garner favour with Stansfeld, even going so far as to air his anti-Simon views in the medical press. This turn of events effectively turned back the clock to "the closed mind and smug layman's arrogance" of the 1840s,¹³⁹ and the atmosphere must have been frosty.¹⁴⁰

The depth of the disconnection between the departments is evident in a contemporary account by Dr. Joseph Rogers in his memoir, *Reminiscences of a Workhouse Medical Officer*. Writing in 1889, he describes the restructuring as "a most disastrous act of policy" and describes an 1872 meeting to discuss Stansfeld's Public Health Bill:

I saw Mr. H. Fleming and Mr. Lambert sitting together with the President, while Mr. John Simon and his staff, who were the only intellectual element of the new Board, were relegated to distant seats in the corner of the room.¹⁴¹

Clearly a new era had begun, and Simon's position in it was tenuous indeed.

Conclusion

Without question, the Stansfeld years (1871-1874) had a negative impact on sanitary progress as Simon's staff were replaced in the field with lay inspectors either drawn from the Poor Law Board or trained on the job.¹⁴² (This must surely have been a slap in the face to the doctors, not to mention a blow to their professionalism.)¹⁴³ His reports, diminished in size and content, nevertheless remained focused on observation and reporting, particularly during a virulent smallpox epidemic of 1870-73.¹⁴⁴ A

¹³⁹ Brand, "John Simon and the Local Government Board Bureaucrats," p. 190.

¹⁴⁰ Wohl, p. 60: "Down to the end of the century the central agency responsible for preventive medicine had to operate in an unfriendly atmosphere fraught with the dangers of imminent budget cuts."

¹⁴¹ Joseph Rogers, *Reminiscences of a Workhouse Medical Officer*, (London: T. Fisher Unwin, 1889), p. 101.

¹⁴² Brand, "John Simon and the Local Government Board Bureaucrats," p. 192.

¹⁴³ Novak, p. 452.

¹⁴⁴ Simon, *Reports of the Medical Officer of the Privy Council and Local Government Board*, New Series, No. IV, 1875, p. 9.

seemingly endless catalogue of sanitary misery continued to appear in print whenever time and finances permitted.

The tensions between departments continued until his retirement in 1876, which *The Times* marked with a reverential retrospective of his career and a scathing indictment of the LGB:

There is obviously no place for Mr. Simon in a Department, or under a Government, by which science is held to be superfluous except when it is practically useless, or by which it is at best regarded as a reserve force for the rectification of blunders, or as a means of securing, in a dignified and imposing manner, the door of a stable from which the steed had already been stolen.

Mr. Simon, therefore, retires from service from the public. A day must come, either with the progress of education and the growth of knowledge, or else under the sharp teachings of pestilence, when the people of this country will learn the full value of this guide whom they have lost, and the extent of the gratitude which they should feel to those who have succeeded in displacing him.¹⁴⁵

And what of the years after Simon? A journal article published in 1898 characterizes the business of the public health administration since 1871 as “masterly inactivity” and claimed it was still “a thing of shreds and patches.”¹⁴⁶ A cholera survey in 1885 pointed to a general failure of local authorities to implement sanitary improvements recommended by a revised Public Health Act of 1875, and the Royal Commission on the Housing of the Working Classes that year drew attention to the fact that not much had changed in the sanitary state of many communities since Chadwick’s report of 1842.¹⁴⁷ But by the mid-1880s the Board had at least begun to consider the recommendations of its medical staff again as a new generation of medical men (now accorded professional

¹⁴⁵ *The Times*, September 7, 1876, p. 4.

¹⁴⁶ A. Campbell Munro, “Public Health Administration in England and Scotland,” *Public Health*, October, 1898, pp. 10-11. The article recommends the creation of a proper Ministry of Public Health, separate from the LGB.

¹⁴⁷ Holland and Stewart, *Public Health: The Vision and the Challenge*, p. 14.

public health designation) and engineers put the old Chadwickian vendetta behind them.¹⁴⁸

We can now step back and consider the post-Simon era within the context of the British civil service as a whole. The grand scheme envisioned by the Royal Sanitary Commission was, in reality, impossibly expensive and could not reasonably be realized in its entirety even in the best of economic times. Simon's troubled years in the 1870s, and the trials of his successors, in fact reflected a general contraction in government spending originating with an increasingly parsimonious Treasury which balked at the expense of expanding the Health Department.¹⁴⁹ This was a trend occurring across the board in all departments, so the LGB was not alone in having to make do with what little it could expect to receive.¹⁵⁰ We can extrapolate one outcome from the report of a Committee of Inquiry from 1898, which noted that the rota of inspections between 1872 and 1898 had been cut back to an average of less than one inspection per district over the entire period.¹⁵¹ (Simon's staff had inspected 259 districts in 1870 alone).¹⁵² New inspectors were appointed, but their compensation never matched Simon's. His successor, Dr. Seaton, unable to keep up with an ever-increasing workload, succumbed to illness and exhaustion and expired in 1881. There was no time for special studies or even much reporting, with subsequent officers and assistants working flat out six long days per week.¹⁵³

¹⁴⁸ Wohl, p. 195. Novak, p. 455: "In an 1886 amendment to the Medical Act they obtained official permission to grant diplomas in public health. ... Specialization was now officially recognized, as the result of a determined campaign by the profession."

¹⁴⁹ *Second Report of the Royal Sanitary Commission*, p. 68. The Treasury was responsible for fifty percent of the MHO salaries. Hiring lay inspectors was a much cheaper option.

¹⁵⁰ MacLeod, p. 16.

¹⁵¹ Wohl, p. 161.

¹⁵² Simon, *Thirteenth Report of the Medical Officer of the Privy Council 1870*, PP 1871, vol. xxxi., p. 25.

¹⁵³ MacLeod, p. 17-19.

There were other challenges facing the country in the 1880s: a severe economic depression, concurrent with the demise of older industries, which resulted in increased levels of unemployment; a critical shortage of working-class housing in urban areas¹⁵⁴ resulting in increased levels of overcrowding; rising labour unrest such as the dockworker's strike in London in 1889; and an overall contraction in luxury spending which trickled down to impact the servant class.¹⁵⁵

Considering the state of the Medical Department, it is not surprising that the sanitary situation in many towns remained untenable until well into the new century.¹⁵⁶ In 1891 cholera reappeared yet again as an instigator, approaching from the Middle East. Medical Officer Dr. Thorne-Thorne managed to convince the Treasury to loosen the purse strings for a temporary increase in his staff, but relations remained tense, "cordial acquiescence was rare," and the scheme for coordinating routine infectious disease control was sidelined indefinitely for lack of resources. Thorne-Thorne died in 1899, following Seaton's path to exhaustion due to overwork.¹⁵⁷

Over time, resistance to the idea of centralized government waned, and the work of the medical men played a large part in that trend. Wohl sums up the overall influence of the Medical Department, Privy Council and the LGB during this era quite nicely:

¹⁵⁴ C.J. Stewart, *The Housing Question in London*, (London, Jas. Truscott and Son, 1900), p. 73. See also Smith, p. 224: An estimated 10,000 houses were demolished to make way for railways and street improvements throughout the country, displacing an estimated 57,000 people in 1873 alone.

¹⁵⁵ Stedman Jones, pp. 281-282.

¹⁵⁶ Smith, p. 227.

¹⁵⁷ MacLeod, p. 31-39.

Above all the patient, evolutionary pace of the work of Simon and his successors did much to prevent the re-emergence of the fears and antagonisms that had been directed against Chadwick and his General Board of Work. Thus the medical departments ... must take much credit for the gradual acceptance, between 1860 and 1880, of the role of the central government as a supervisory power in public health. ... Given the nature both of the composition of the local sanitary administrations in those years and of the political and economic philosophies they espoused, direct control or aggressive use of compulsory legislative powers would have been disastrous.¹⁵⁸

Despite the troubled years after Simon's resignation and the upheavals and distress of the interim period, his legacy was never truly extinguished: the role of Chief Medical Health Officer would once again achieve direct access to the minister with the creation of a Ministry of Health in 1919.¹⁵⁹ The foundation he had so meticulously laid down continued to serve as a model for a public health infrastructure that included routine vaccination, infectious disease control, sanitary improvements and the standardization of medical training. The painful experience of Simon's demotion ultimately failed to diminish his reputation as one of the most important figures in the history of modern public health.¹⁶⁰

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¹⁵⁸ Wohl, p. 164.

¹⁵⁹ Lambert, p. 610.

¹⁶⁰ Brand, "John Simon and the Local Government Board Bureaucrats," p. 194.

BIBLIOGRAPHY

Primary Sources

- Edinburgh Medical Journal*, Vol. I, (1855-6).
- First Report of the Royal Sanitary Commission*, PP (1869).
- Hansard*, House of Commons Debates, February 4, 1840.
- Lancet*, August, 1843.
- Lancet*, January 5, 1867.
- Second Report of the Royal Sanitary Commission*, PP (1871), Vol. I.
- Second Report of the Royal Sanitary Commission*, PP (1871), Vol. II.
- The Times*, October 7, 1848.
- The Times*, October 4, 1848.
- The Times*, October 17, 1848.
- The Times*, November 8, 1848.
- The Times*, December 20, 1854.
- The Times*, September 7, 1876.
- Booth, Charles, "Enumeration and Classification of Paupers, and State Pensions for the Aged," *Journal of the Royal Statistical Society*, Vol. 54, No. 4 (Dec., 1891).
- Chadwick, Edwin, *Report on the Sanitary Condition of the Labouring Population of Great Britain 1842*, reprinted, M.W. Flinn, ed., (Edinburgh, 1965).
- Engels, Friedrich, *Condition of the Working Class in England*, (London: 1891).
- Jephson, Henry, *The Sanitary Evolution of London*, (Brooklyn, N.Y., A. Wessels Co., 1907).
- Munro, A. Campbell, "Public Health Administration in England and Scotland," *Public Health*, October, 1898, pp. 5-24.
- Rogers, Joseph, *Reminiscences of a Workhouse Medical Officer*, (London: T. Fisher Unwin, 1889).
- Simon, John, *English Sanitary Institutions Reviewed in Their Course of Development, and in Some of Their Political and Social Relations*, (London: Smith, Elder & Co. 1897).

Simon, John, *Fifth Report of the Medical Officer of the Privy Council 1862*, PP 1863, vol. xxv.

Simon, John, *Reports of the Medical Officer of the Privy Council and Local Government Board*, New Series, No. I, 1874.

Simon, John, *Reports of the Medical Officer of the Privy Council and Local Government Board*, New Series, No. IV, 1875.

Simon, John, *Thirteenth Report of the Medical Officer of the Privy Council 1870*, PP 1871, vol. xxxi.

Sims, G.R., *The Bitter Cry of Outcast London: An Inquiry into the Condition of the Abject Poor*, (Boston: Cupples, Upham & Co., 1883).

Stewart, C.J., *The Housing Question in London*, (London, Jas. Truscott and Son, 1900).

Secondary Sources

Allan, Michelle, "From Cesspool to Sewer: Sanitary Reform and the Rhetoric of Resistance, 1848-1880," *Victorian Literature and Culture*, Vol. 30, No. 2 (2002), pp. 383-402.

Baldwin, Peter, *Contagion and the State in Europe, 1830-1930*, (Cambridge University Press, 1999).

Brand, Jeanne L., "John Simon and the Local Government Board Bureaucrats 1871-1876," *Bulletin of the History of Medicine*, XXXVII 2 (March-April 1963), pp. 184-194.

Brand, Jeanne L., *Doctors and the State: The British Medical Profession and Government Action in Public Health, 1870-1912*, (Baltimore: The John Hopkins Press 1965).

Eyler, John M., "Poverty, Disease, Responsibility: Arthur Newsholme and the Public Health Dilemmas of British Liberalism," *The Milbank Quarterly*, Vol. 67, (1989), Supplement 1. Framing Disease: The Creation and Negotiation of Explanatory Schemes (1989), pp. 109-126.

Halliday, Stephen, *The Great Filth: The War Against Disease in Victorian England*, (Stroud, Gloucestershire: Sutton, 2007).

Halliday, Stephen, *The Great Stink of London: Sir Joseph Bazalgette and the Cleansing of the Victorian Metropolis*, (Stroud: Sutton Publishing, 2009).

Hamlin, Christopher, "Edwin Chadwick and the Engineers, 1842-1854: Systems and Anti-Systems in the Pipe-and-Brick Sewers War," *Technology and Culture*, Vol. 33, No. 4 (Oct., 1992), pp. 680-709.

- Hamlin, Christopher, "Muddling in Bumbledom: On the Enormity of Large Sanitary Improvements in Four Towns, 1855-1885," *Victorian Studies*, Vol. 32, No. 1 (Autumn, 1988), pp. 55-83.
- Hamlin, Christopher, "Predisposing Causes and Public Health in Early Nineteenth-Century Medical Thought," *Social History of Medicine*, Vol. 5, Issue 1, 1992, pp. 43-70.
- Hamlin, Christopher, *Public Health and Social Justice in the Age of Chadwick: Britain, 1800-1854*, (Cambridge University Press: 1998).
- Holland, Walter W. and Stewart, Susie, *Public Health: The Vision and the Challenge*, (London: The Nuffield Trust, 1998).
- Jones, Gareth Stedman, *Outcast London: A Study in the Relationship Between Classes in Victorian Society* (Oxford, Clarendon Press 1961).
- Lambert, Royston, *Sir John Simon 1816-1904 and English Social Administration*, (London: MacGibbon & Kee, 1963).
- MacLeod, Roy, "The Frustration of State Medicine 1880-1899," *Medical History*, January, 1967, 11(1): pp. 15-40.
- Mooney, Graham, "Professionalization in Public Health and the Measurement of Sanitary Progress in Nineteenth-Century England and Wales," *Social History of Medicine*, 10:01, (1997), pp. 53-78.
- Morgan, Kenneth O., ed., *The Oxford Illustrated History of Britain*, (Oxford University Press: 1984).
- Novak, Steven J., Steven J. Novak, "Professionalism and Bureaucracy: English Doctors and the Victorian Public Health Administration," *Journal of Social History*, Vol. 6, No. 4 (Summer, 1973), pp. 440-462.
- Pelling, Margaret, *Cholera, Fever and English Medicine, 1825-1865*, (Oxford University Press, 1978).
- Pope, Rex; Pratt, Alan; Hoyle, Bernard, eds., *Social Welfare in Britain, 1885-1985*, (London, Croom Helm Ltd. 1986).
- Rivett, Geoffrey, *The Development of the London Hospital System 1823 - 1982*, (London, Oxford University Press 1986).
- Smith, Francis B., *The People's Health 1830-1910*, (Canberra: Australian National University Press, 1979).
- Smith, George Davey, "Commentary: Behind the Broad Street Pump: Aetiology, Epidemiology and Prevention of Cholera in mid-19th Century Britain," *International Journal of Epidemiology*, 2002:31, pp. 920-932.
- Thompson, E.P., *The Making of the English Working Class*, (London: Penguin Books Ltd., 1991).

Wohl, Anthony S., *Endangered Lives: Public Health in Victorian Britain*, (London: J.M. Dent & Sons Ltd., 1983).