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FROM PHYSICANS' ENQUIRY TO DEWAR REPORT: A SURVEY OF MEDICAL SERVICES IN THE WEST HIGHLANDS AND ISLANDS OF SCOTLAND, 1852-1912: PART I

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> I must state that I know no class of men more extensively and actively charitable than medical practitioners in the highlands.

These words, addressed to Dr John Coldstream, a distinguished Fellow of the Royal College of Physicians of Edinburgh, were written by the Reverend Archibald Clerk, minister of Kilmalie in Argyllshire, in November 1850. The minister was more critical on the subject of his parishioners, the doctors' patients. 'The poverty of the people,' he observed, 'and especially the filth and wretchedness of their hovels, which in many cases are fearful, seem to me the chief causes of the continuance of many diseases ...'.[1]

The minister of this remote Highland parish was commenting on the physical, rather than on the spiritual wellbeing of his parish in response to a questionnaire sent to him and to other ministers by the Royal College, which was conducting an enquiry into the state of medical practice in the west Highlands and Islands of Scotland:

> ...to determine the proportion which the practitioners bear to the whole population, keeping in view the extent of country over which such practice extends, and to ascertain whether there be much complaint on the part of the people of the difficulty in getting medical aid.[2]

The investigative part of the project was carried out between 1850 and 1852, and was followed by a handwritten Report, published in shortened form a year later. No action seems to have been taken following its completion, and shortly after publication it was shelved and apparently forgotten.[3]

Although the only specifically medical source document for this period, the Physicians' Enquiry was one among a number of investigations into conditions in the western Highlands and Islands around the mid-nineteenth century, undertaken in response to the distress of the Highland population. The Royal Commission which led to the reform of the Scottish Poor Law in 1845 was the first to make destitution and the lack of medical aid matters of public concern. Other enquiries, carried out by Government and charitable agencies dealt with such matters as relief measures during the potato famine of the 1840s and the necessity for emigration from congested districts in the immediate aftermath. Later in the century other investigations were undertaken into particular social problems in the area such as land tenure and housing condition. Medical issues such as the treatment of mental illness and the standards of medical services provided by the Poor Law were also the subjects of national investigations, which included the crofting counties in their scope. The reports from all these studies extend the information available on Highland medical practice to the end of the century. In the years immediately before the First World War, a further crop of investigations, principally the Dewar Report of 1912, continued the process.[4]

Using these and other relevant sources, this essay examines the provision of medical services in the west Highlands and Islands between 1842, the year of the Royal Commission on the Scottish Poor Law, and 1912, the year when the Dewar Commission reported its findings. It is hoped that light will be thrown on such questions as how and why the status of the Highland medical practitioner altered during the period, what influences affected the perceptions of local communities and individuals towards health care and what measures were necessary to ensure a medical provision, adequate in the eyes of government and the profession, for the Highland population in the early twentieth century.

THE HIGHLANDS AND ISLANDS

The area of Scotland loosely referred to as the Highlands covers more than a third of the country and extends roughly north of a line stretching from Stonehaven, just south of Aberdeen on the east coast, to Helensburgh, just north of Glasgow on the west, excluding the low-lying coastal strip from Aberdeen to Easter Ross. In this large rugged area, there are wide variations in topography, soil fertility and even climate. By the early nineteenth century the traditional run-rig system of agriculture in most of the Highlands east of the Great Glen had been replaced by improved farming methods similar to those in use elsewhere in Britain, and English was rapidly replacing Gaelic as the language of the population.

West and north of the Great Glen lay a remote and sparsely populated area where Gaelic was still the predominant language of the peasantry, most of whom supported themselves by subsistence agriculture. The counties that make up the west Highlands and Islands, sometimes referred to as the 'crofting counties', include the islands of Orkney and Shetland, the mainland counties of Caithness, Sutherland, Ross and Cromarty, Inverness, and Argyll, and the island county of Bute. Of the mainland counties, Ross and Cromarty, Inverness and Argyll extend westwards to incorporate the Inner and Outer Hebrides including remote St Kilda, at that period an outpost of the parish of Harris in the county of Inverness.[5] Throughout this large area, isolation, a harsh terrain and, in most areas, a distinct language had resulted in common problems, but there were also pronounced differences among the different localities. In parts of southern Argyllshire, eastern Inverness-shire and Easter Ross, subsistence farming was declining and a new breed of tenants worked farms of up to 100 acres. On the north-east coast and in south-west Argyllshire, fishing was as important as agriculture and prosperous fishing villages had become established. The island groups of Orkney and Shetland were distinct from the rest of the crofting counties in having roots in Norse rather than Gaelic culture.

The heart of Gaeldom which lay north of Oban included all the scattered islands making up the Inner and Outer Hebrides, and it was here that subsistence agriculture on small plots or crofts, with the potato as chief food crop, was most firmly established. This part of Scotland had experienced most acutely the rise and subsequent collapse of the kelp industry in the early nineteenth century and, by the 1840s, was feeling the effect of the decline in the profitability of the traditional black cattle. Frequently agricultural plots had been subdivided to the point where they were no longer economically viable as smallholdings. Widespread destitution, and even starvation, in 1836-7, and again in 1846-8, resulted from the failure of the potato harvest. From the landlords' point of view, rents were difficult to collect, arrears built up, and in times of food shortage, they were expected to support their impoverished tenantry. Yet it was

here that the peasantry's attachment to the traditional social structure and patterns of landholding was strongest, and opposition to clearance and emigration most pronounced.[6]

Although the population of the crofting counties had increased in common with the rest of the British Isles, and peaked at 395,540 in 1851, it began to decline thereafter and by the 1911 census had fallen to 335,697, a drop of almost 60,000.[7] Most of this decline was due to emigration, either voluntary or enforced, as the more enterprising looked for a better life elsewhere or as landowners converted their estates to sheep farms and, later, deer forests. Those that stayed did so out of an attachment to the land, which went against prevailing beliefs in material improvement as a spur to self-help. When the crofting counties were badly hit by the economic depression in the 1870s and 80s, the determination of the population to remain was a strong element in the movement by crofters in some areas to recover by force land which they regarded as rightfully theirs. Although these attempts were unsuccessful, sufficient sympathy for the crofters in the nation at large induced the government to pass the Crofters Holdings (Scotland) Act in 1886 which, though inadequate as a solution to the land problem, at least recognised the special needs of the population living off the land in this remote area.[8]

In spite of its obvious differences from the rest of mainland Britain, it would be wrong to write off the Highlands as of no social significance in this period. Geographically, so large a portion of Scotland could not be ignored, particularly once fishing, large-scale sheep farming and later sporting estates gave a fiscal focus to the area. Many Highland landowners were prominent in the political and economic life of the nation, for example businessmen such as Sir James Matheson, who had made his fortune through the Hong Kong-based company Jardine, Matheson & Co., and politicians such as Edward Ellice of Glenquoich. The Queen herself had purchased an Aberdeenshire estate and maintained an abiding interest in the Highlands.

More significant was the unique place of the Highlands and Islands in the European Romantic movement. From the late eighteenth century when Romanticism first became a factor in European culture, the image of the Scottish Highlands as an unspoilt wilderness peopled by dignified if primitive peasants was very compelling. MacPherson's *Ossian* and the novels of Sir Walter Scott fed this Romantic image, and Scottish history, landscape and literature were the inspiration for writers, artists and musicians of such stature as Schiller, Mendelssohn, Schubert and even Beethoven. The Romantic notion of Scotland which flourished outside its own borders ensured that the west Highlands and Islands had a cultural importance out of all proportion to their economic position within the British Isles.

Not unconnected with this Romanticism, the image of the robust Highlander was a strong one in Scottish mythology. During the debate on the Poor Law in 1845, Sir James Graham, in opposing the proposal to make medical relief under the Poor Law compulsory in Scottish parishes, commented that it would be 'a nice question of health statistics to determine whether the Highland constitution, without a doctor, did not conduce more to longevity than to sickness'. He spoke of a small island in the Highlands 'within the experience of an Honourable Friend near him' without a medical attendant for the whole of it 'where persons live to a greater age and enjoy better health than where doctors abound'.[9] The longevity of the population was often remarked upon as an indication of the essential healthiness of the crofting way of life, in spite of its harshness and poverty. The minister of Kildonan in Sutherland described his parishioners, in the *New Statistical Account* of 1842, as being particularly healthy

with no distempers prevalent among them. His colleague at Farr commented on the number of very old people in his parish, 'a few vigorous and stout at 80 and 90', and similar observations occur throughout the *New Statistical Account* for Highland parishes.[10]

COMMON AILMENTS

In spite of these beliefs, evidence of disease abounds, even from the same source. Among the ailments many of the ministers listed as prevalent in their parishes featured rheumatism, scrofula, digestive disorders, 'dropsy' and fevers. Those parishes, which included Helmsdale, a seaport in Sutherland, and Stornoway on Lewis, were particularly vulnerable to imported infections; both ports suffered epidemics of cholera in 1832, 1848 and 1854. Larger ports such as Wick, which were important centres of the fishing industry, were in effect smaller versions of coastal cities such as Aberdeen and experienced similar problems. At the height of the herring fishing season, an additional ten thousand people crowded into Wick to gut and pack the fish, exacerbating an already serious problem in basic sanitation. In an extended report on the health of the parish of Wick, the minister listed fevers, pleuritis, catarrh and cough, inflammation of the throat and whooping cough as occurring frequently; rheumatism was becoming more common and was ascribed to the introduction of lighter, cotton clothes; and itch was very prevalent, a result he considered of insanitary housing and scanty, dirty clothing. Dysentery was never absent; Asiatic cholera had affected Wick in 1832 with 306 cases and 66 deaths; fatal cases of smallpox were frequent.

Throughout the west Highlands the regular smallpox outbreaks were popularly believed to be imported by Highlanders returning from the south. Vaccination often depended on local beliefs and prejudices. In Wick the people rejected the practice as 'tempting Providence', whereas in the remote Shetland parish of Unst, the population had encouraged vaccination ever since knowledge of the procedure had reached the parish, largely as a result of the indelible memory of two severe epidemics in the 1720s, known locally as 'the mortal pox'.

Particularly isolated communities usually were fairly free of infectious diseases, but should they be visited by outsiders suffering from even a minor infection, the result could be serious. An extreme example of this was St Kilda, where an epidemic of smallpox, the first and last recorded for the Islands, almost wiped out the population in 1724, and where severe forms of the common cold were usually the calling card left behind by visitors and were known to the islanders as the 'boat cough' or 'strangers' cold'. Sometimes the entire population was affected, a few deaths might even occur, and the life of the community would be thrown into confusion for weeks.[11] The threat of imported disease could cause panic. In one Mull parish a family affected by typhus in 1891 were thrown out of their lodgings and left without assistance to die by the roadside.[12]

As medical issues formed an important part of the debate on the reform of the Scottish Poor Law, it is not surprising that, following the appointment of a Royal Commission in 1842, the Poor Law Commissioners paid particular attention to the provision of medical relief to the destitute sick. Several of the questions on a questionnaire sent out to all ministers in Scotland were devoted to medical matters. The answers, which have been analysed by Ian Levitt and T.C. Smout in their book *The State of the Scottish Working Class in 1843*, indicated an almost total absence of any parochial medical aid throughout the crofting counties.[13] These findings coincide with evidence given directly to the Commissioners by doctors and ministers working in the west Highlands and Islands. Witnesses spoke

of districts too large to be adequately covered by a single medical practitioner, of the difficulty in making a living in areas where few paying private patients lived among a desperately poor population, and of hardships and dangers occurring daily in covering a medical practice which included exposed moorland and unpredictable sea crossings. These three aspects of Highland medical practice were insoluble problems and were to remain so throughout the nineteenth century. However, for Scotland as a whole, the availability of medical aid to the destitute sick was revealed to be glaringly inadequate, and to remedy this situation the reformed Scottish Poor Law included a compulsory, if crude, medical service in its provisions, to be discussed below.

Doctors did practise in the west Highlands and Islands before the nineteenth century. The main medical texts were translated into Gaelic in the medieval period, and physicians held a high place in Highland society. As in the Lowlands until the late eighteenth century, they were attached to aristocratic households and their art was handed down, in apprenticeship style, from father to son in many instances. The most famous of these medical dynasties was the Bethunes or Beatons, hereditary physicians to the MacLeods and to the Lord of the Isles, who received grants of land on the west coast of Argyll and maintained their tradition for several centuries. The Earls of Argyll were served by another medical family, the O'Connachers, who held land in Lovat. These physicians, however, were part of an intellectual culture distinct from that of the common people and rarely treated those not part of their chief's household. It was probably not until the eighteenth century that surgeon-apothecaries began to set up practice in the Highlands and attempt to gain patients from among the local population, and only in the nineteenth century that they settled in any numbers outside the major centres such as Inverness.

FOLK REMEDIES AND HEALERS

The Highland people themselves, however, recognised many paths to health and the cure of sickness, among which the qualified medical attendant was only an important, but expensive, option. At the opposite end in this medical marketplace were those cures linked to superstition and magic. Many of these were descended from far older, pre-Reformation rituals connected with holy wells and the healing powers of water. Among surviving rites were those performed at certain lochs in Sutherland and Caithness whose waters were only potent between midnight and dawn on the first Monday in May, August, November and February of the old calendar. Patients would gather at these times to walk around and bathe in the waters, and be out of sight of the loch by sunrise. According to one sceptical local minister, the patients were mainly hypochondriacs who professed to feel better for it, the more seriously ill being made worse and occasionally dying by the roadside as a result of their exertions.[14]

Although this may have been true, such folk cures obviously answered a deeply-felt need, and their very durability is an indication of the emotional relief they brought. The geologist Sir Archibald Geikie, writing in 1904, describes seeing a tree in Sutherland in the 1880s covered in blossom, which on closer inspection turned out to be rags tied to branches as votive offerings by patients seeking a cure from a nearby holy well.[15] Even in the 1990s the Cloutie Well in the Black Isle has a nearby tree from whose branches a macabre assortment of votive rags flutters.

An equally durable tradition is that of the healing powers of the seventh son of a seventh son. As late as 1912 the Dewar Commission heard first-hand, from a crofter

from the island of Rona, an account of a woman cured of scrofula by a seventh son, who gave her water in a box free of iron to wash her wound. The same witness described a cure for epilepsy which involved burying a black cock alive in the place where the first fit occurred. The witness, while admitting that such cures were scarcely credible, insisted that the scrofulous woman had been successfully healed; he also made clear that no payment was made to a seventh son for his services. This deep-seated belief that the healer should not profit from his gifts may hold a possible explanation for the persistent habit of accepting medical treatment without feeling obliged to pay the doctor.[16]

Many of the folk cures needed considerable effort: the cure for heart disease from Unst, Shetland, known as casting the heart, involved melting lead and pouring the molten metal through a key to counteract the wasting away of the heart by fairies or witches. Sprains were cured by tying a 'wresting thread', spun in black wool with nine knots and blessed in the name of the Father, Son and Holy Ghost, around the wrested or wrenched limb.

Scrofula was a common complaint throughout the Highlands and Islands, and one cure described by the minister of Mid and South Yell in Shetland in 1840 was based on a much wider tradition, that of curing by the 'King's touch'. Few families, he observed, 'do not have the constitutional taint of scrophula'. To cure it in the absence of the monarch to touch them, a few crowns and half-crowns from the time of Charles I, handed down carefully from father to son, were considered to be effective in every parish in Shetland, a procedure known as 'curing by the coin'.[17]

Life-threatening diseases might need rituals connected with death and burial. A cure for tuberculosis involved laying on the patient's chest mould from the grave of the last corpse buried, or alternatively drinking water from a burn over which bodies passed for burial. A variety of local medicines and potions were also available, such as a smallpox cure from Orkney consisting of sweet milk in which sheep droppings had been infused.[18] Childbirth was also surrounded by ritual. In the Western Isles the *bean-ghluine* or knee-woman, known as the med-woman in Orkney and Shetland, was present at every birth to perform rites upon the severed umbilical cord. This involved applying a rag, sometimes smeared with salt butter as in Barvas on Lewis, sometimes first held to the fire with tongs, to dress the cord. On St Kilda the 'sickness of eight days', or *tetanus neonatorum*, caused a very high death rate among new-born infants and was possibly due to the use by the knee-woman of infected fulmar oil for dressing the navel.[19]

Between these therapeutic relics surviving from an earlier tradition and the qualified doctor lay a large area of health practices loosely based on orthodox medicine. Those who could afford to do so sent to Aberdeen and other mainland cities for supplies of ready-made drugs. Already by the mid-nineteenth century tradesmen in remote areas stocked common medicines such as laxatives, and within the home itself self-medication was an important part of health maintenance. Family medicine chests and medical books were in every educated household and some basic drugs such as castor oil were probably in all but the poorest houses.

In addition the unqualified healers, regarded by the medical profession as quacks, abounded; the empirics, bone setters, bleeders, skilly women and well-meaning ministers, dispensing advice and medicines free to those who applied to them, all of whom feature to a greater or lesser extent in the questionnaires returned to the Royal College, and who provided a choice of treatment to the sick which stretched far beyond the narrow confines of regular medical practice.

THE RCPE ENQUIRY AND ITS FINDINGS

The method used by the Royal College for collecting the information they required involved sending out questionnaires to all the Established and Free Church ministers in the crofting counties. The questions were phrased to find out the number of doctors in practice, the size of their practices, whether suffering or even death ever resulted from the absence of medical aid, and who filled the breach if no doctor was available. On the basis of those returns giving the names and addresses of practitioners, the College were able to send out a further questionnaire to more than seventy doctors. In this instance they desired to know how long the doctor had been practising in the area, whether matters had improved or deteriorated in recent years and which hardships incident to his particular situation might be remedied by an Act of Parliament. Not all chose to reply, but those who did were frequently anxious to grab this opportunity to express their frustrations to their more fortunate colleagues in Edinburgh. The last question in particular provided a vehicle for stating their grievances, with little reference as to whether or not these could be remedied by legislation. Taken together, the returns from doctors and ministers contain a unique body of information on medical practice in the Highlands and Islands at the time.

The first question addressed to the ministers was designed to find out how many doctors were working in the area. The replies are too vague to give an accurate figure but the 1852 Medical Register names 84 qualified practitioners, and a further 27 with doubtful qualifications. Towns of any size such as Oban, Wick or Tobermory could expect to have more than one doctor, all of whom would visit the outlying parishes without much difficulty. For example, the minister of Kingarth on Bute reported that in 24 years he had never known cases of suffering or accidental injury where medical assistance was lacking, though if aid was required, householders were obliging in sending express to Rothesay, eight miles away. Dissatisfaction with the available medical services increased with distance from a doctor to become veritable apprehension when the nearest practitioner was many miles and perhaps a sea crossing away. The most vivid example of this comes from the return of the minister of Morven, a remote, rugged mainland parish with no resident doctor, whose inhabitants were forced to send to the island of Mull for medical aid when needed. He wrote:

> I have known an express sent by myself under circumstances of painful anxiety, for three days in quest of the laborious medical man who usually attends my family and I have experienced in the course of many afflictions with which God has visited me, miseries and anxieties arising from delays, uncertainties, and disappointments, in such cases which I cannot attempt to describe and which I cannot recall to recollection without deep sorrow.[20]

This minister, John MacLeod, was a churchman of distinction and a former Moderator of the General Assembly of the Church of Scotland. His sympathy with the sufferings of his sick parishioners was a personal one as he had obviously experienced some tragedy which he felt might have been avoided had medical help been available. But his lengthy reply highlights a problem which formed an apparently insuperable barrier to efficient medical practice at the period: the vast extent of many practices and the difficult nature of the terrain to be covered by a peripatetic doctor. MacLeod detailed the case of a landowner whose eye was blown out in a shooting accident and who had to wait for medical assistance until the surgeon could be fetched from Oban, more than 20 miles away by sea. Sir Archibald Geikie describes the case of an injured workman from Canna whose leg had been crushed when he was building a wall. His

companions rowed him first to Arisaig, 25 miles away across the sea and from there, as the doctor was away inland, to Tobermory on Mull. After a 36 hour journey in an open boat, a doctor was tracked down and an amputation was performed successfully.[21] The minister of North Ronaldsay described the case of a young man who fell from a cart and dislocated his hip, and from want of immediate medical attention, was disabled for life.

These and other similar stories were in response to the question as to whether the minister knew of cases of protracted suffering or of disability after accidental injury which might have been alleviated had medical aid been to hand. They thus dealt with the problem from the patient's point of view. But from the doctor's point of view, a summons to a distant patient might mean hours of discomfort, and even danger, while attempting to reach the house. Dr Ballenden of Stromness on Orkney, who frequently had to visit the islands of Walls, Hoy and Flotta, described the hazards of sea crossings in leaky boats:

> The boats they send are often bad, not being able to have good ones ... I have to land on the barren shore, far from houses, and remain until daylight, not being able to trust to the boat.

One of the Lewis practitioners described 'the great fatigues consequent on the long journeys to be travelled, the exposure to vicissitudes of weather, and sometimes to danger by sea, together with the discomforts from want of accommodation ...'. Many Highland doctors were accustomed to long hours in the saddle, to exposure to wet and stormy conditions when crossing arms of the sea, or to tramping miles over open moorland to reach their patients. Distances of 70 miles or more were not uncommon.

Foreseeing the problem caused by inaccessibility, which, according to their calculations affected some 120,000 people 'scattered over wide and rugged districts...[who were] at this moment most inadequately provided for in sickness', the physicians also wished to know whether the people complained of the absence of medical aid. In a few instances, for example Kilmelford in Argyllshire, 'custom made them silent' and medical aid was only sought in cases of malignant fever or serious accident, as distance added greatly to the expense. The people of North Ronaldsay apparently never complained because they considered themselves totally unable to support a physician and had never enjoyed the advantage of one.

COLLECTING FEES

A common complaint was not so much of the difficulties of obtaining medical assistance but of the inability to pay the doctor's fees, even when the matter was urgent. These could be as high as two or three pounds a visit where the hire of a horse or a ferry boat was involved, a sum quite beyond all but a handful of crofters and described as 'extravagant' by one outraged Shetland minister.

Extravagant or no, from the doctors' viewpoint the difficulties of collecting fees was a grievance that outweighed all others. As one Lewis doctor put it:

> the principal hardship here is, undoubtedly, the non-payment of fees ... The extent of non-remuneration may be estimated from the fact that, for the last two years and a half, my partner and myself have travelled in one parish, upwards of 2000 miles on express visits ... without obtaining any payment whatever, not even, in most cases, for the medicines given.

Another practitioner, whose potential patients numbered 5,000, could not raise more than £5 annually from private practice. Over half of the doctors who replied to the Royal College made non-payment of fees their chief complaint, which in turn gave rise to others. Dr Clark of Harris complained:

> Owing to the miserable and inadequate remuneration I cannot afford, after supporting a wife and ten of a family, even to insure my life, or make any provision for myself or them ... As my family increased, I was obliged to give up a medical periodical. I can scarcely afford to give my family the common rudiments of education.

Only one doctor, Roderick McLean of South Uist in the Outer Hebrides, honestly admitted refusing to attend patients he believed could not pay, adding apologetically '... I am sorry that I am under the necessity of such resolutions', but others certainly did likewise.

The ministers substantiated these claims, one Shetland minister stating he '...would not guarantee the best physician in Edinburgh realizing £20 from his practice ... in any parish in this County, Lerwick excepted'. The sympathetic John MacLeod of Morven described the medical practitioners of the Highlands as:

> ...usually humane and in every instance inadequately remunerated, but at the same time the difficulties of procuring their services and affording any remuneration for them are so great that it is only in very extreme cases that medical aid is sought...

Many practitioners were paid in kind, through a system of 'mutual assistance' as one doctor put it, and most treated the sick poor without expecting payment, even providing simple medicines out of their own pockets. Their apparent generosity won praise, which the Royal College set on record. 'I know of no class of men', wrote John MacLeod, 'more inadequately remunerated than the medical practitioners of the Highlands, or who obtain a livelihood at a greater sacrifice of time and of labour'. After gently criticising them for failing to keep up with advances in medicine, he continued:

> ...very generally they have been found to evince an untiring zeal and energy in prosecuting their professional duties under peculiar hardships and difficulties, which disinterested humanity, guided by sound and enlightened principles, could alone animate and sustain.

Humane and principled as many Highland doctors undoubtedly were, their actions in continuing to treat patients without much hope of collecting a fee were also dictated by self-interest. Had they not done so - 'in order to make themselves popular' as one doctor admitted - the secure base in the community which they were struggling to establish would have been seriously threatened by those other purveyors of medical aid who were already well entrenched.

OTHER PROVIDERS OF MEDICAL CARE

If the Royal College learnt anything from the investigation, it was the extent to which untrained, unlicensed medical aid was available to the Highland population. Among the most popular therapies was blood-letting. Ministers made reference to 'a few people [who] can use the lancet'; 'there are three midwives residing in the parish who let blood and apply a few simple remedies'; 'they generally prefer putting themselves under the hands of two uneducated men who make free use of the lancet and profess

skill in herbs'; 'there are two men who can bleed but they have very bad lancets. They have often done much good and I do not know of a case in which bleeding was resorted to where a medical man did not approve of bleeding', and so on. Of other traditional practitioners, one village enjoyed the services of 'what is called a bonesetter', in another 'an old farmer lends his feeble aid' to treat broken bones and dislocations. Unqualified midwives were to be found in every community, while at least one parish enjoyed the services of a midwife who had been sent for training by the Duchess of Argyll. Shetland seemed to be particularly affected by empirics 'who have extensive practices, but it may be questioned whether they make up the deficiency of qualified practitioners'.

By far the largest group of unqualified providers of medical aid, however, consisted of the ministers themselves. A few were at least partially medically qualified, the result of their undergraduate studies, or had been closely connected with a practitioner who had taught them basic procedures. Such a one was the minister of Farr in Sutherland who had learned medicine from 'much intercourse with an eminent professional man'. One or two seem to have developed considerable skill and to have been sought out by patients beyond the confines of their own parishes.[22] The majority probably dispensed advice and medicines to the poor of their parishes with no more than their Buchan or their Reece and common sense to guide them, trusting to God and the strong constitution of their patients to provide a successful outcome. 'We arrived in the island ignorant of the Medical Art', wrote the Free Church minister of North Ronaldsay:

> ...and with some popular books to study the cases briefly as they arose, which is sometimes attended with a great deal of anxiety and perplexity ... We cannot but gratefully acknowledge the success with which God has been pleased to crown our efforts in various instances.

This minister obviously had anticipated his role as irregular medical practitioner before arriving in his parish, and he suggested that ministers should be provided with surgical instruments and 'codes of direction' for their use.

Second only to the ministers in importance were the local proprietors, who regarded the care of the sick poor as part of the responsibilities inherent in their social position. The amount of aid donated ranged from a substantial subsidy to local surgeons expended by the Duke of Sutherland throughout his estates, to simple medicines from the household medicine chest. One or two areas had landowners who were medically qualified and who continued to give aid *gratis*. Taken together, the ministers and proprietors were the true providers of medical aid in the west Highlands and Islands.

From the point of view of the patients, the minister and his educated fellows were to be trusted as they held long-established positions as leaders of the community, whereas the general practitioner was a comparatively new addition to the small educated elite. 'The physician of the soul is presumed here to be *a fortiori* the best physician for the body. He must prescribe and administer medicine whether he will or not', wrote the minister of Nesting. He added 'no doubt sad mistakes do sometimes happen in consequence, for all professors are not Deacons at the trade'. This minister was obviously ill at ease about the advice he was compelled to provide, and he went on to demonstrate that so deep-rooted was the belief in the trustworthiness of their minister that parishioners prescribed medicines by others would first bring them to him for his approval before accepting they were safe to swallow. 'This ignorance, prejudice and gullibility on the one hand with the paucity of thoroughbred medical men on the other opens the door to the vast imposition of quackery' he concluded. However, only one of the doctors

who communicated with the Royal College of Physicians singled out the interference of ministers as among the difficulties with which he had to contend and, from other evidence, it is obvious his relationship with the clergy in his area was extremely bad.

Certainly earlier in the century, when medical men were establishing practices in the Highlands and Islands possibly for the first time, the doctors needed the benign influence of the clergy to give them the necessary respectability and trustworthiness in the eyes of the community. Mistrust of the medical profession by the Highland population was often a barrier to establishing a practice, particularly in Easter Ross and Sutherland. In the *New Statistical Account* the minister of Moy had noted 'the people have a strong prejudice against medical advice; and often require the sanction of their minister before they take such medicines as are prescribed', whisky being the preferred antidote whether for fever, a cold or consumption. These sentiments against doctors emerge again in the Report. 'The great body of the people entertain prejudices common to all Highlanders against medical men. They prefer the advice of quacks to that of the first medical man in Europe', wrote the Free Church minister of Resolis in the Black Isle. At this stage, when the doctor was not considered indispensable and his social behaviour was under constant scrutiny from a deeply religious population, he had to exercise extreme care in building up his practice and at all times exhibit respectability and Christian charity in public.

PAROCHIAL MEDICAL AID IN THE WEST HIGHLANDS AND ISLANDS

The returned questionnaires thus conveyed to the Royal College of Physicians an image of a desperately poor population living in scattered communities, frequently in need of medical attendance, but rarely able to pay the doctor's fees and therefore forced, or choosing, to look outside the regular profession for help when sick. Highland doctors had to be prepared to endure an exceptionally arduous working day, and often had to forego or postpone the collection of their fee. These conditions were almost unchanged from the time of the Royal Commission on the Poor Laws ten years earlier. The Royal College requested the ministers to suggest ways in which the situation might be improved. Their ideas included the stationing of half-pay military surgeons in remote areas, the training of local women as midwives and the use of steamboats to bring medical aid on a regular basis to scattered communities along the coastline, a measure probably suggested by their use to reach isolated populations during the potato famine in 1846. These and other imaginative ideas were incorporated by the Royal College into their Report.[23] However, the majority recognised that the only way to ensure that the population received medical assistance when they needed it, and that doctors were adequately compensated for their services, was for some agency to put up the money, whether this be the government, the Poor Law authorities, or the heritors through a levy on property. Without such intervention an improvement was unlikely, but it was also realised that any enactment to provide such funds would be vigorously opposed in Parliament as a misuse of public money and an unwarranted interference in the individual's obligation to provide for himself and his family in sickness and health.

In fact Parliament had unwittingly come to the aid of hard-pressed Highland doctors. The legislation which would alter their situation significantly was already on the statute book, although few people would have appreciated its potential when it first passed through the parliamentary process. The Poor Law Amendment (Scotland) Act became law in 1845 and, though largely concerned with ensuring that those entitled to poor relief were not refused it, a limited number of clauses provided a rudimentary medical

service for registered paupers. In brief, these laid down that medical attendance, medicines, medical appliances and cordials must be provided to sick and infirm paupers on the roll, and that poorhouses must appoint a properly qualified medical officer.[24] The latter requirement only became applicable in the Highland context later in the century, when the drive to establish poorhouses throughout Scotland was instrumental in bringing these institutions to the west Highlands and Islands. However, the statutory provision for some sort of medical attendance was of immediate consequence, particularly as the government followed up it up two years later by voting a grant of £10,000 to be spent on improving medical services, the money to be administered in Edinburgh by the Board of Supervision for the Relief of the Poor and to be divided up among the parochial boards according to the size of their population. Those wishing to receive a share of the medical grant were required to spend a sum on medical aid each year equal to their allotted share, and on accepting it, had to agree to certain conditions laid down by the Board which included the appointment of a properly qualified medical practitioner as parochial medical officer.[25]

To wealthier Lowland parishes with few paupers and healthy poor funds, the conditions attached to the medical grant represented an interference in their management of the poor and a substantial number ignored its existence for many years. To impoverished Highland parochial boards, coping almost immediately after their establishment with the crisis brought about by the potato famine, a grant of any sort had at least to be considered seriously. Sickness and infirmity were important causes of pauperism and some spending on a medical service was difficult to avoid. As a result, many Highland parishes welcomed the opportunity provided by the grant to obtain money towards the doctor's salary. Those who chose not to accept the grant at first, through indifference to their medical responsibilities, were soon forced to reconsider - although remote parishes such as Lochcarron in Wester Ross spent so little on medical relief that it did not pay them to accept the money for several years.[26] Where the medical grant was accepted, a local practitioner became a salaried officer of the parochial board. Even where the grant was not accepted, the paupers had a right to medical treatment and a local practitioner had to be engaged to attend them when necessary, the fee being paid from the poor rates. In both instances, however narrow the interpretation of 'adequate medical attendance' decided upon by the parochial authorities, and however miserly the remuneration, the doctor was an integral part of the relief system.

PAROCHIAL PATRONAGE

By the time the Royal College undertook their investigation in the early 1850s the parochial medical service had been in operation for five or six years. In spite of the shortness of this period, it was already evident to the respondents in several parishes that financial survival was linked to parochial patronage. Dr MacLean, who was medical officer to the parishes of Assynt and Edrachillis in Sutherland, was paid £25 by Assynt's and £15 by Edrachillis' parochial boards annually for attending a total of 240 registered paupers. This £40 formed over one third of his annual income of £100, the remainder being made up of a salary of £40 from the Duke of Sutherland for attending estate workers and fees of £20 from his private practice among local farmers. As the Duke also provided him with a house and grazing for a horse, he was far better off than many of his colleagues. Alexander Ross, surgeon of Invergordon, was parochial surgeon for three parishes for which he received sums of between £10 and £15 a year; John MacDonald, surgeon of North Uist, received two-thirds of his income from his parochial

duties.[27] At this stage in the development of the parochial medical service, when many parishes were still able to provide minimal medical assistance without employing a surgeon regularly, the few salaried situations which did become available were hotly competed for by doctors in the area.[28] Appointments seem often to have been made for political or social reasons which had little to do with medical qualifications or the priorities of care. On Arran, a populous island with only two doctors, one had been made parochial surgeon for both the island's parishes to the other's chagrin and the inconvenience of the paupers furthest away from his residence.

However welcome parochial subsidies might be to financially embarrassed doctors, unwelcome aspects are also to be considered. Parochial surgeons were expected to attend paupers day and night and frequently travelled long distances for very small returns. According to John MacKellar, surgeon of the extensive Argyllshire parish of Clachan, the parochial authorities had divided the adjacent parish into three, giving two portions to a non-resident doctor and paying MacKellar £4 to look after the remaining third. 'What do you think', he wrote to the Royal College, 'when the heritors and Parochial Board that lies next to this parish only give me 4 lousey pounds per annum for attending and giving medicines to their paupers, a parish 16 miles in length and containing near 100 paupers'.[29] Medical officers were appointed at the pleasure of parochial boards and had no security of tenure, although from 1895 their dismissal had to be approved by the Local Government Board for Scotland, successor to the Board of Supervision. Where the salary was inclusive of medicines, the profits must have been minimal unless cost-cutting was achieved through limiting the supply of drugs. Parochial boards made use of their position to pay as low a fee or salary as they could get away with, £5 per annum in some instances. Others made economies by conjoining the offices of inspector of the poor and of medical officer until this was made illegal, or sharing a medical officer with a neighbouring parish.

The unfortunate paupers of Lochcarron could rarely have seen the medical officer who held the position between 1859 and 1862 for he also attended the remote Applecross parish and lived in Fort William more than 100 miles away.[30] Midwifery duties were time consuming, yet the parochial medical officers had to attend pauper confinements for no extra charge. Again, acceptance of the post entailed frequently irksome, and occasionally acrimonious, relationships with the Chairman and salaried officials of the parochial boards who might pay little regard to the professional status of the medical officer. In the Highlands the Chairman of many parochial boards was elected from among the principal landowners and it took a courageous doctor to oppose him. One unfortunate young Shetland doctor who thwarted, on medical grounds, an attempt by the powerful landowner, John Bruce of Sumburgh, to evict an elderly pauper, was forced to withdraw all opposition and admit his mistake before the next attempt.[31]

Another pitfall to be avoided was the suggestion of negligence. Scandals, such as the death alone and unattended of an elderly bedridden pauper woman in Walls on Shetland, were widely publicised in the local and national press and the doctor's reputation inevitably suffered, even though under the Poor Law the inspector was officially to blame. As their rights under the Poor Law became better understood by the destitute, paupers who felt their medical officer's attentions were insufficient did not hesitate to say so. One Lochcarron medical officer, for example, was dismissed in 1870 'from the many complaints made against him for neglect of duty'.[32]

In spite of these limitations, the parochial medical service was crucial to the development of health care in the area. It provided the vital injection of money

which enabled Highland practitioners to remain in their practices. When positions fell vacant, those parishes involved in the medical grant were compelled to find another doctor as quickly as possible or face losing the money. Their need was often the means of bringing new practitioners into the Highlands, as many parishes preferred to appoint a resident medical officer rather than one already practising some miles away, thus in effect creating a new practice.

The steady extension of doctors throughout the west Highlands and Islands can be illustrated by Orkney's experience. In 1850 there were nine doctors practising in the Islands, all but two of them based in the county town of Kirkwall and the port of Stromness on Mainland. By the end of the century the number had risen to 20 and all but the smallest communities had direct access to regular medical aid.[33] The central authority for poor relief, the Board of Supervision, also played a part in maintaining the professional standards of its medical officers. From 1858 onwards, only properly qualified and registered practitioners were permitted to hold posts in those parishes accepting the medical grant, which in the west Highlands and Islands meant virtually every parish. The Board's insistence on each parish having a casual sick-house where vagrants or travellers falling ill could be cared for, although generally ignored, did ensure in a number of instances that facilities for sick strangers were available.[25]

Once the new parochial structure was in operation, the government made use of it to add other health responsibilities, some of which further augmented the doctor's income. Parochial medical officers became vaccination officers under the Vaccination (Scotland) Act of 1863. The 1867 Public Health (Scotland) Act and 1891 Local Government (Scotland) Act added public health duties to the official posts available to general practitioners. Not all the extra responsibilities thrust upon parochial medical officers were profitable however. In particular those which they had to perform under the Lunacy Laws generally carried no extra fees.

CARE OF THE MENTALLY ILL

Important changes in the laws governing the treatment of the mentally ill had come about as a result of a scandal in which the west Highlands and Islands had featured prominently. In 1857 the *Report of the Royal Commission on Lunacy in Scotland* was published, containing a damning indictment of the care of the mentally defective and insane throughout Scotland. Particular criticism was levelled at the Poor Law authorities who had been made responsible for the pauper insane under the 1845 Act. Grave cases of neglect and cruelty came to light, several of the most serious connected with Highland parishes. One which caused particular concern in Parliament was the case of Archibald MacLaren, a pauper lunatic from Lochcarron who had been chained up for 30 years, his movements restricted to a few yards around the miserable byre in which he was kept by his sister. Reaction to the case reveals graphically the unbridgeable gap in understanding between the Members of Parliament in Westminster and the members of the parochial board at Lochcarron. To the parochialists, accustomed as they were to the insanitary domestic conditions in their area, where cattle-housing was normal, restraining a madman from wandering at will, naked and filthy, through the countryside was only common sense in order to protect him and his neighbours.[34]

However, other cases revealed in the Report showed thoughtless cruelty and neglect towards unprotected patients, both private and pauper. The evident need for regulation ensured the Lunacy (Scotland) Act passed relatively smoothly through Parliament. This set up a new centralised authority, the Commissioners in Lunacy, who were

responsible for all cases of insanity and mental deficiency in Scotland. Under the terms of the Act, most lunacy cases were to be despatched to new district asylums, unless their families could afford a private mental institution. Many harmless mental defectives were removed from their communities and incarcerated in asylums under this law which caused particular distress in the west Highlands and Islands to families unable to visit them. It also added greatly to parochial medical expenses, as most Highland parishes had at least one inhabitant who fell within the terms of the Lunacy Laws. In later years the rules were relaxed to permit incurable or harmless patients to reside in the community under strict supervision of inspectors from the Board of Lunacy. The procedures for committal and supervision involved the parochial medical officers where pauper lunatics were concerned, since the parochial authorities were responsible for their maintenance either in an institution or at home. The same regulations applied to the comparatively few private mental patients who by law, once certified, had to be lodged in an asylum unless authorised by the lunacy inspectors to remain at home under the supervision of a medical practitioner. In the latter instance a local doctor might well benefit financially, although as parochial medical officer his salary usually covered duties under the Lunacy Laws.

Government legislation on poverty, public health and lunacy had important implications for the medical profession in the west Highlands and Islands. In thinly populated, scattered communities the majority of the inhabitants either had a member of the family or a neighbour who was a pauper; many could expect in old age to become one themselves. The inspector of the poor and the medical officer became, like the minister and schoolmaster, indispensable parts of the parochial structure and known to everyone. Whatever feelings communities may have had towards the Poor Law, its medical services were seen as an asset. The parochial medical officer was the avenue through which the paupers obtained free medicines and medical attendance, cordials and nutritious food, at parochial expense. In addition he was likely to be the only medical practitioner in the district and members of the non-pauper community were also his patients. His very presence was an advantage, particularly in cases of accident, even to those who could not afford his services normally. Although in individual instances a doctor might be inefficient and uncaring towards his pauper patients, in general the popularity of the parochial medical service from the 1860s onwards did more than the efforts of the profession itself to popularise orthodox medical treatment. Thus a very important, if unforeseen, outcome of the parochial medical service was its part in fighting the battle for patients on the medical profession's behalf.

Among the other external influences, the status of the medical profession in the Highlands and Islands, the scientific and technological advances which had revolutionised medical procedures raised standards, as also the determined attempts of the profession elsewhere in the British Isles, to establish orthodox medicine as the sole source of health care. However, the very isolation of the area meant such influences took longer than direct experience to affect the ingrained attitudes of the local population. Poor Law medicine was in everyone's experience. Although remnants of these attitudes persisted into the twentieth century, unorthodox practitioners increasingly became pushed to the margins of popular health care and orthodox medicine became the first choice, where possible, for the majority.

Nevertheless, it has to be emphasised that the parochial medical service in Scotland only applied to the registered poor and did not extend to the general population. However important a role it played in the west Highlands and Islands, it was not

designed to be comprehensive, nor could the parochial component of the doctor's income, though often a substantial percentage, be more than a part.

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