

MANAGING MADNESS

Discourse and day-to-day practice
in English public lunatic institutions
founded up to 1765

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Abstract

Published histories of madness have commonly cited inhumane practices in early English mental institutions as a negative baseline for judging subsequent management of lunacy, though adequate primary research on these institutions has been lacking. This raises the questions, pursued in this research project, as to how these institutions actually functioned, and what their governors saw as their role? The project examines the formation, maintenance, dissemination and practical expression of the ethos of the governors of early institutions for lunatics using material from the archives of all English public institutions for the mad founded up to 1765, supplemented by additional contextual information collected at the same time. The geographical and temporal limits of the sample were imposed because of the volume of material involved, and in order to focus on the period inadequately researched in published histories.

The thesis describes significant processes in the formation, maintenance and change of the governors' ethos, and its diffusion into the body of staff running the institutions. Its content is also described in the form of four discourses:

1. *The Discourse of Confinement*, concerning three institutional justifications for confining lunatics; public protection, care and cure. It is suggested that the initial justification of public protection, while remaining in use, was largely supplanted by what have been termed the "rhetorics" of care and cure which served to obfuscate the confining nature of the institutions.
2. *The Discourse of Control and Commerce*, concerning issues related to the appointment, monitoring and control of staff, and the financial, and other, management of the institutions.
3. *The Discourse of Care*, concerning elements of institutional practice which can be seen as directly caring. It describes care extended to inmates and staff, to their families, to tenants and to the institutions' neighbours.
4. *The Discourse of Piety* concerning the absence of supernatural explanations of madness which were expected in the sampled material, together with issues of religious observance, particularly the issue of whether the mad could benefit from divine service, and visits from the clergy.

The governors' ethos, particularly in its transmission downwards, was constantly challenged by unanticipated events, staff misconduct and inmate resistance. Examples of these, and the governors' handling of them, are detailed for each discourse and considered as catalysts for institutional change.

The influence of the institutions on each other, and those which came later, is then discussed, and they are considered within their broader social context. The major conclusions of the project are presented and its methods critically assessed. Finally, some future research directions are outlined.

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Chapter 9

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Declaration

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed R. J. Wycherley

Dated 22/10/2013

Abbreviations

Bethlem Hospital

Bridewell and Bethlem Court Minutes: BBCM
Bridewell and Bethlem General Committee Minutes: BBGCM
Bethlem Hospital Grand Committee Minutes: BethlemHGCM
Bethlem Committee Minutes: BethlemHCM
Bethlem Sub-Committee Minutes: BethlemHSCM

Bethel Hospital

Trustees'/Governors' Minute Book: BHTMB

French Hospital

Grand Livre No A: FPHGLA
Journal du Grand Livre No A: FPHJGLA
Livres des Délibérations des Assemblées Générales de la Corporation Française
(General Assembly Minutes.): FPHGAM
Journals des Commissaires de Quartier (Journals of the Commissaires de Quartier):
FPHJCQ

Guys Hospital

Receipt Books: GHRB
Court of Committees Minutes: GHCCM

St Luke's Hospital

General Court Book: SLGCB
General Committee Minutes: SLGCM
House Committee Minutes: SLHCM

Newcastle Lunatic Hospital

Common Council Order Book: NUTCCOB
Rules for the Hospital for Lunaticks for the Counties of Northumberland, Newcastle
upon Tyne and Durham. Undated but probably c. 1770. Newcastle Central Library
Class 362.2 LO42 Local Tracts 1 Miscellaneous No 11A: NUTRHL.

CHAPTER 1

THE ORIGIN, ORIENTATION AND ORGANISATION OF THE PROJECT.

1.1 The origin of the project

The project to be reported here developed from the author's clinical psychology training, and work, in a range of nineteenth-century lunatic asylums. This generated an interest in the English nineteenth-century county asylum network, and initial reading focused on accounts of this. However, pre-nineteenth-century English institutions for the mad also commonly featured in the historical literature, provoking the following observations:

- That coverage of these institutions was much scantier than that of nineteenth-century asylums.
- That, with some recent exceptions, coverage of them demonstrated a dearth of primary archival research so that the accounts were very external, taking little, or no, account of the internal practices of the institutions.
- That they were commonly presented as part of a "bad old days" from which the mad were progressively rescued through humanitarian and scientific progress, culminating in an enlightened pattern of modern mental health care.

These observations suggested two simple research questions. How did early English public institutions for the mad function, and what did their governors see as their role? They also led to a closer, historiographic, analysis of a selected sample of histories of madness, which will be introduced in section 1.3 and presented in section 1.4. This, in turn, led to the present project, an account of which forms the major part of this thesis. However, as some aspects of the account require preliminary discussion, the next section will be devoted to this.

1.2 Preliminary comments

1.2.1 The parameters of the project

Section 1.1 noted the two simple research questions which drove the project. How did early English public institutions for the mad function, and what did their governors see as their role?

The project intentionally focused on early institutions as, relative to later, nineteenth-century, institutions, they had received little attention in the literature on madness, and its management. However, the term “early” is rather vague and, as the major time frame for the project was from 1600 to 1815, a span of over two centuries, it could, perhaps, be seen as having achieved rather more than a consideration of the earliest institutions for the mad. While the project, naturally enough, began with the first of the English public institutions for the mad, Bethlem Hospital, the process of sampling and, particularly, the endpoint of 1815, requires some discussion.

Having begun at the beginning, with the first Bethlem Hospital, later institutions were examined sequentially, in order of their foundation dates. The total sample comprised the first two Bethlem Hospitals, St. Peter’s Hospital (Bristol), the Bethel Hospital (Norwich), Guy’s Hospital lunatic house, the two French Hospital lunatic houses, the first St. Luke’s Hospital, and the first two Newcastle-upon-Tyne Lunatic Hospitals. The latest of the institutions, the second Newcastle Hospital, dated from about 1765.

As far as possible the records of each sampled institution were examined to its closure. However, this was not possible for some institutions, which continued to function into the nineteenth century. It was felt that at least 50 years of records should be examined for each of them, unless closure occurred earlier, and this set a date of 1815 for the finish of data collection as the latest institutional foundation date was about 1765. 1815, fortuitously, also marked the establishment of the first comprehensive parliamentary inquiry into the management of madness, and a new phase in the management of the mad which accelerated the development of the nineteenth-century county asylum network.

A further brief comment on the first Bethlem Hospital is necessary as its records were not, strictly speaking, examined from its foundation date. This hospital, though founded as a priory in 1247 had, by the fifteenth-century, become an institution for the mad (see Appendix 1). However, it only had consistent records concerning this function after Bridewell Hospital assumed managerial control of it in 1557. These were scanty until the latter part of the century, but were drawn upon in the present project as they were thought to have important implications for the argument, pursued in chapter 4, that coercive confinement of the mad began, at an early stage, to be reconstructed into the conception that the institutions were specifically devoted to the care and cure of their inmates. Admissions and discharges to Bethlem were also recorded in the Acts of the Privy Council of England from somewhat earlier than the hospital's own records, and were included to augment these.¹ Thus, though the bulk of the material analysed dated from 1600 to 1815, a small amount of that for the first Bethlem Hospital dated from 1546. Consideration of the first Bethlem Hospital, in itself, covered a period of 130 years, to 1676, about half the total time-span of the project and, though it was the earliest of the institutions examined, its importance in establishing practices for the management of madness should not be underestimated.

The project was also confined to English institutions, as well as to those which were public, that is, not run by individuals for profit. These parameters also require brief comment.

The focus on English institutions, as noted in section 1.1, resulted from the writer's particular interest in them, their inadequate treatment in the secondary literature, and the need to keep the project within manageable bounds. These considerations also led to the exclusion of private madhouses from the project as these had already been adequately addressed by Parry Jones in his book *The Trade in Lunacy*,² and it was felt that investigation of public institutions for the mad was the most pressing need.

The account which will be presented is also an "internalist" one which is focused, almost entirely, on the world inside the institutions, and this aspect of it will now be discussed.

In section 1.1 three negative aspects of the treatment of early English public institutions for the mad in the secondary literature were noted. First there was a lack of primary archival research into their records, second a systematic account of their internal structures, relations and practices was lacking and third there was a tendency to depict them in a very negative light, often as part of a progressive narrative justifying present-day services for those with mental disorders. In relation to the latter aspect it seemed unlikely that their governors had set out to systematically abuse the mad, as was commonly suggested, but any accurate account of their intentions was lacking. The present project specifically set out to produce an account of the internal organisation, and practices, of the sampled institutions, and of their governors' conception of what they were doing, in order to fill these conspicuous gaps in the literature. This was to be achieved through in-depth research of their internal records. A further aim was to approach these records of in a way which was not influenced by the assumptions of the secondary literature. In particular, concepts of progress, which were typical of much of the literature, were avoided, and an attempt was made to explore the records in their own terms, from a position of neutrality. Thus, the aim of the project, from its outset, was to produce an "internalist" account of the institutions which would derive from their own records and allow a more balanced view of them, and their historical importance, to be reached. The account to be reported, it is suggested, has achieved this aim, and will demonstrate that the institutions were far more sophisticated in their internal organisation and practices than has previously been thought. Further, it will be shown that, although they coercively confined their inmates, their governors, at least in their own eyes, saw themselves as pursuing a worthy, if difficult, task in attempting to care for, and cure, them. In consequence, these institutions should be seen as having an important developmental role in the management of madness rather than simply functioning as a negative baseline from which narratives of scientific and humanitarian progress can be constructed.

1.2.2 The “model”

1.2.2.1 Introduction

At the outset of the project it was not known what material would be found, or what could be expected of it. However, although the research questions noted in section 1.1 were rather open they did imply the intention, as far as was possible, to produce a model of the day to day working of the institutions which flowed from the intentions of their governors. Certainly, it became progressively clearer, as more institutions were investigated, and particularly during the later phase of the analysis, which involved the amalgamation of material from the separate institutions, that it was possible to construct a generalised model of their social structure, practice and gubernatorial ethos. This was the final outcome of the project and was expressed in their systems of rules, in their day-to-day procedures, and in the prescriptions of the roles of those carrying them out. Additionally there were instances of individual actions, by those managing the institutions, by those they employed, by those who were confined and, very occasionally, by those external to the institutions, which could be seen as challenging institutional structure and practice, and forcing change on it. On occasion an account could also be given of the processes through which such change came about. In short, although it was not known at the outset whether the archival material would allow the construction of a generalised model, this was an implicit aim of the project from the start, and was fully achieved.

In the collection and interpretation of the material the intention was to avoid undue influence from the secondary literature, to proceed with very open research questions, and not to take any rigid theoretical stance. Nevertheless the model of institutional functioning which emerged clearly had an affinity with three specific theoretical and methodological approaches, notably Max Weber’s conception of the “ideal type”, Clifford Geertz’s anthropological approach, and, albeit on a micro level, Christopher Lloyd’s conception of “methodological structuralism.” These could be seen as having influenced the model and will now be briefly discussed.

1.2.2.2 Weber's ideal type

Max Weber's "ideal type" is a working construct which:

.....brings together certain relationships and events of historical life into a complex which is conceived as an internally consistent system.³

As such it is not a description of reality, but a heuristic device which can aid the construction of hypotheses and, particularly, the comparison of different "cases" of a particular phenomenon. It is, in effect, a model which, though informed by empirical research, stresses the essential elements of occurrences of a phenomenon while accepting that cases of it which are encountered in reality may differ in less significant details. It is a compromise between losing one's way in a welter of historical detail and losing contact with this detail in excessively abstract generalisations:

An ideal type is formed by the one-sided *accentuation* of one or more points of view and by the synthesis of a great many diffuse, discrete, more or less present and occasionally absent *concrete individual* phenomena, which are arranged according to those one-sidedly emphasized viewpoints into a unified *analytical* construct (*Gedankenbild*). In its conceptual purity, this mental construct (*Gedankenbild*) cannot be found empirically anywhere in reality. It is a *utopia*. Historical research faces the task of determining in each individual case, the extent to which this ideal-construct approximates to or diverges from reality.....⁴

Weber notes that the construction of "ideal types" does not evade the problem that different researchers have different viewpoints and that, consequently, a wide variety of ideal types relating to the same phenomenon could be constructed. Nevertheless, he sees the use of ideal type models as unavoidable:

Every conscientious examination of the conceptual elements of historical exposition shows however that the historian as soon as he attempts to go beyond the bare establishment of concrete relationships and to determine the *cultural* significance of even the simplest individual event in order to "characterize" it, *must* use concepts which are precise and unambiguously definable only in the form of ideal types.⁵

Weber's concept of the ideal type has been the subject of considerable debate, which cannot be dealt with here. However, Susan Heckman, following a detailed account of the differing viewpoints of its critics concluded that:

His methodology was formulated as an answer to a set of problems similar to those which confront present-day social theory. His ideal-typical methodology supplies a link in his work between interpretive and structural analysis. As such it is at least suggestive of the kind of synthesis required by contemporary social theory.⁶

Turning to the present project, the model which resulted from the analysis of the collected material was derived from the whole range of the sampled institutions. However, it largely ignores their less significant individual differences and could be seen as representing an “ideal type” focused on making their important commonalities salient. In this sense it could serve as a basis for future research on new institutions or more detailed, chronological, examination of those in the present sample.

1.2.2.3. *The ethnology of Clifford Geertz*

Clifford Geertz, in his essay “*Thick Description*,” argues that:

...this fact - that what we call our data are really our own constructions of other people's constructions of what they and their compatriots are up to - is obscured because most of what we need to comprehend a particular event, ritual, custom, idea, or whatever is insinuated as background information before the thing itself is directly examined.⁷

Here he emphasises that ethnology (and history) is, at base, an interpretative activity. It involves the researcher's interpretation of human actions, both in terms of the actors own interpretations of them, and in terms of the social context which has moulded these. Thick description, though Geertz does not give a very adequate definition of it, goes beyond the simple provision of detail and involves the interpretation of specific social actions within a complex of structures, circumstances, and shared understandings and intentions, which make them intelligible to the reader, as well as to the participants:

The claim to attention of an ethnographic account does not rest on its author's ability to capture primitive facts in faraway places and carry them home like a mask or a carving, but on the degree to which he is able to clarify what goes on in such places, to reduce the puzzlement - what manner of men are these? - to which unfamiliar acts emerging out of unknown backgrounds naturally give rise.⁸

Denzin, as part of a considerable elaboration of Geertz's use of the concept has provided a rather more adequate description. For Denzin thick description:

....does more than record what a person is doing. It goes beyond mere fact and surface appearances. It presents detail, context, emotion, and the webs of social relationships that join persons to one another. Thick description evokes emotionality and self-feelings. It inserts history into experience. It establishes the significance of an experience or sequence of events, for the person or persons in question. In thick description, the voices, feelings, actions, and meanings of interacting individuals are heard, made visible.⁹

Essentially Geertz's approach to ethnology leads to the construction of empirically derived models from the close study of activities and events. These models place human mentality, agency and power within social structures which are humanly constructed but also constraining of social action and understanding. He also emphasizes that ethnological studies are commonly microscopic, taking place in restricted settings, and involving prolonged acquaintance with the subject matter of the investigation. Nevertheless, these microscopic models form the base from which credible higher-level theoretical concepts and models may be constructed:

The important thing about the anthropologist's findings is their complex specificity, their circumstantiality. It is with the kind of material produced by long-term, mainly (though not exclusively) qualitative, highly participative and almost obsessively fine-comb field study in confined contexts that the mega-concepts with which contemporary social science is afflicted – legitimacy, modernization, integration, conflict, charisma, structure....meaning - can be given the sort of sensible actuality that makes it possible to think not only realistically and concretely *about* them, but what is more important, creatively and imaginatively *with* them.¹⁰

The model of institutional functioning which emerged from the present research was empirically constructed from close interpretive study of the inner worlds of a series of early English institutions for the mad. While it clearly did not involve participant observation it was derived largely from the records left by the governors who were responsible for running them, whose ethos was reflected in their rules, practices and specifications for the conduct of those who worked in them. Thus, the model attempts to throw light on the origin, stabilization and change of their ethos, its structural expression in the rules and role specifications which were designed to inform and control the activities of their staff, and in the practices which were designed to confine and, putatively, care for and cure their inmates. It also gives examples of events, often arising from the behaviour of staff and inmates, which illustrate clashes between the gubernatorial ethos and other imperatives which were

incompatible with them. These clashes expressed the agency of these non-gubernatorial groups, and their power to force change on the system, often in the direction of greater coercion. In these respects the model fits Geertz's conception of "thick-description" well.

1.2.2.4 Methodological structuralism

Finally, the model to be described is consistent with Lloyd's version of structuralism, which sees society as having a real existence separate from individual thought and action. Social structures, while created by human agency, are relatively autonomous of individual action and understanding, yet motivate, enable and constrain human action and thought. Nevertheless they are amenable to change over time through the intended, and unintended, consequences of human action.

....society exists in a dual sense as agential people and the institutional structures that constrain people, which are the products of people collectively. In other words, this is a general theory that is resolutely historical in that it refers to the dialectical process in which the structure of society's institutionalized system of rules, roles and relations is produced, reproduced, and transformed through human thought and action, which over time it enables and constrains.¹¹

Lloyd sees the basic cause of social change as lying in the failure of social institutions to co-exist without conflict and to satisfy the needs of individuals:

...institutions must together satisfy the physiological and psychological needs of many individuals and be mutually consistent. If they fail in either of these ways their existence is in jeopardy. Change thus comes about because sufficient numbers of individuals are dissatisfied or find themselves in stressful situations of conflict caused by the incompatibility of institutions and they are able to do something about altering their situation. People begin to evade their institutional responsibilities or reinterpret them in ways which result in institutional change. The rules, roles and relations governing choices and actions are ignored and altered.¹²

The model of institutional functioning which will be presented will encompass both enduring structural elements and the power of human agency to produce structural change. Lloyd sees the production of such models as one of the explanatory elements of methodological structuralism, accounts derived from which contain:

.....a complex web of reasoning that includes imaginative hypotheses, theories, models, metaphors, analogies, inductive empirical generalizations, and deductions. Their aim is neither to give a simple statistical or narrative account nor to give a logically justified account. Rather, their achievement of an increasing degree of plausibility comes from a combination of theoretical richness, empirical complexity, explanatory narrative, and methodological structurism. Structural history done in this way is at least potentially scientific because like other sciences it is based on a realist ontology of structures and a commitment to discovering the complex multi-level structural reality of the world.¹³

1.2.3 The atemporal nature of the account

This section will begin with a brief discussion of some general matters bearing on atemporal historical accounts, and will then discuss the present account in terms of its atemporality. This atemporality takes two forms, the first of which concerns the thematic structure of the account, which groups together related elements of the institutions' practice and organisation into a comprehensive model of their functioning, rather than presenting a chronological account of their development. The second type of atemporality concerns the absence of a consideration of the relationship between internal changes in the institutions and developments in the world outside them. While this could be seen as a result of the "internalist" nature of the account, which was discussed in section 1.2.1, this was not, in fact, the case and arose because external events were seldom referred to in the institutional records. Consequently the material necessary to make adequate links between institutional processes and external events was lacking. However, the account will not be entirely atemporal and some specific internal changes over time will be noted, as well as some references to events outside the institutions. Finally some more general observations on the concept, and origins, of historical change will be made.

Stone has suggested that the proper form for historical writing is the narrative, which he describes as:

.....the organization of material in a chronologically sequential order, and the focusing of the content into a single coherent story, albeit with subplots.¹⁴

However, his defence of narrative history admitted that, for half a century, historical accounts had taken a different path, one which saw story-telling and chronology as relatively unimportant matters:

For the last fifty years, however, this story-telling function has fallen into ill-repute among those who have regarded themselves as in the vanguard of the profession, the practitioners of so-called ‘new history’ of the post-Second-World-War era.¹⁵

Tosh, too, has suggested that the development of cultural history produced two types of historian, those interested in explaining social change in the past, and those interested in explaining past culture, with little interest in change:

This difference is crucially one of theory. For the first group of historians, the subject of their research usually holds interest because of its place in a social narrative, which in turn is interpreted by reference to a dynamic theory of social change, often Marxist. The second group, on the other hand, is essentially interested in contextualising – in making cultural connections within a single plane, as it were, often with scant attention to changes over time.¹⁶

The second group Tosh mentions could be seen as closer to anthropologists than traditional historians. Tosh, however, advises caution as the anthropologist in the present is a participant observer, with the ability to collect as much contextual evidence as is necessary for a correct interpretation of cultural phenomena, whereas the historian is completely dependent on available sources, and is unable to question the participants in historical events. Nevertheless, he sees the anthropological approach as valuable:

.....as much in its general orientation as in its handling of detail. It serves as a strong reminder that history is not just about trends and structures that can be observed from the outside, but also demands an informed respect for the culture of people in the past and a readiness to see the world through their eyes.¹⁷

The present project could be seen as both historical and anthropological as it is concerned with a small group of institutions a considerably distance in the past but, rather than presenting a simple chronological “story,” it attempts to elucidate, in detail, their structures and practices, and the ethos of their governors.

It should be said at this point that, although the aim of the project was not specifically to produce a chronological account of the institutions, the largely atemporal nature of the account did not result from any theoretical antipathy to the chronological ordering of material. Rather it was the consequence of the research questions and, consequently, the need to amalgamate, and make sense of, large

volumes of material from the internal records of widely differing institutions, in order to draw some sensible conclusions about their internal practices and their governors' intentions. The approach taken to the collection of data was to amass as wide a range of material as possible which could illuminate these matters. The analysis then focused on grouping together material which was relevant to specific aspects of their interior systems, and organising this into a comprehensive model which detailed the way in which the organisations functioned, and what their governors took themselves to be doing. Consequently, what was produced was a thematically organised model of their typical features that can be seen as providing a basis for further work to elucidate their chronological development and, where possible, the relation of this to external changes. That is to say the present account, in the main, has detailed what needs to be examined chronologically rather than providing such a chronological account.

Turning to the second type of atemporality a further aspect of the project's outcome was a lack of evidence that change in the institutions was simply a matter of responding to external imperatives. It was rare for their records to refer to external events, and even to other institutions of the same type. In general, change appeared to be initiated from within, and the institutions appeared to learn from their own experience. Nevertheless external influence cannot be discounted and, while it may sometimes have been masked, it has to be accepted that explanations of institutional change will have to take into account both external factors, and those coming from within. However, although the main aim of the project was to produce an internal account of the institutions it would have been impossible, from their own records, to have produced any adequate account of the influence of external events on their organisation and development. In conclusion, it should be said that as external events were rarely referred to in the institutional records, and as an awareness of the internal organization and practices of the institutions has not been an element of the secondary literature, the construction of explanations combining both external and internal influences will require very painstaking historical work indeed and will necessitate both detailed examination of the institutions' own records and of a very wide range of primary sources external to them.

Having stressed the broadly atemporal nature of the account it must be said that some specific internal institutional changes over time will be noted. First there was an early shift in the justification for coercive confinement of the mad from public protection to care and cure. Second there was a progressive enlargement of almost all of the institutions in the face of unsatisfied demand for places and, third they became more spatially diversified over time. This could be seen, for instance, in the creation of separate spaces for different categories of inmate and in the addition of “therapeutic” spaces such as baths, airing yards, day rooms and infirmaries. Again, although references to external events, and to other institutions of the same type, were sparse in the records of the institutions, these did, occasionally occur, and a number of them will be discussed. For example, in section 5.13, it will be noted that, in December 1764, the competence of the Bethlem Hospital governors was anonymously criticised in the press. In consequence they demanded to know the author of the criticism and threatened the paper with prosecution if this information was not provided, or if further criticism was published. Occasional references to other institutions in the sample also occurred. For instance, in section 4.4.3 it will be noted that, in April 1754, the committee for rebuilding the French Hospital’s lunatic house ordered that the cold bath to be included in it was to have the same dimensions as that at Bethlem Hospital. However, although this showed an awareness of this facility at Bethlem, it was not clear that the French Hospital’s bath was being built *because* Bethlem had one.

Turning to the concept of historical change in relation to the sampled institutions a house in Rye, Sussex, at the end of Tower Street, bears a plaque reading:

On this site
Sept 5. 1782
Nothing happened

This wry comment challenges the assumption that, over time, something ought to have happened, and it raises the question of whether closed institutions such as those examined in the present project can endure, in much the same state, over considerable periods of time. Coercively confining lunatics could be seen as a task which did not change significantly, even if different justifications for it could be advanced, and the practices associated with it may have remained more or less static.

However, as has been noted, the institutions did show some evidence of development, and a number of models, which are concerned with change, could be advanced. First, that institutional development was on an entirely individual basis, each institution learning from its own experience, with commonalities arising because of the similar nature of the task they were all performing. Second, that the institutions learned from each other, but this learning was opaque in their records. Third that change in them was the result of external forces but the influence of these was similarly opaque. Clearly any, or all, of these models may be valid, and it would be wrong to simply assume that change must have occurred, and that it must have been externally driven. All that can be said on the basis of the present project is that, for each institution, change driven by external events, or by events in other institutions, was not obvious, though its possibility should not be dismissed. Neither should the possibility that individual institutions learned from their own experience be dismissed, and more complex models of change involving both internal and external factors will probably be appropriate for future work on these institutions.

1.2.4 The term “ethos”

1.2.4.1 Introduction

During the analysis of the collected material it became apparent that a descriptive term was needed which would encapsulate the ways in which the governors of the institutions viewed their role in running their institutions, and the practices which resulted from this. The terms “world-view,” “values” and “ideology” were considered. However, the first did not adequately cover the moral element of their conception of their role, and the second the practical aspects of this conception. The third, “ideology” tended to imply the negative use of power for purposes of domination and, although the institutional governors had power, and used it both to manage their staff, and confine their inmates, there was no reason to believe that their primary intention was to dominate. Eventually the term “ethos” was accepted as the most adequate descriptive term to cover both their shared moral position, and their need to translate this into a set of roles, relations and practices within their institutions. The modern use of this term has become relatively fluid, and some classical and modern uses of it will first be considered. Some examples of these will

then be presented, backed up by research examples where possible. However, no attempt to provide a comprehensive discussion of the use of the term will be made, the purpose being to provide a basis for a discussion of its use in the present project, which will complete this section.

1.2.4.2 Some uses of the term “ethos”

The term “ethos” derives from classical Greek and was used to refer to an individual’s moral character, hence the derivation of the modern word “ethics” from it. Aristotle, in his treatise on rhetoric, used it to describe one of the three appeals a speaker could make to an audience in order to establish himself as credible, the others being pathos, an appeal to the audience’s emotions, and logos, an appeal to the audience’s reason, through logical argument. Ethos, for Aristotle, embraced the speaker’s “*good sense, good moral character, and goodwill.*”¹⁸ The first referred to his ability to understand the issue, that is, his expertise, the second to his perceived truthfulness, the members of the audience having to be convinced that he would not, through moral turpitude, lie to them. The third aspect, goodwill, referred to his impression of friendliness towards the audience, which was to be based on an understanding of the character of different groups, and ability to adjust the style of his address to them.¹⁹

In modern usage the term ethos has broadened to refer, generally, to the moral values of a society, institution, group, or individual, and its Aristotelian association with persuasiveness has sometimes remained. There has also been modern concern with “global” ethics embracing matters such as human rights, and care of the environment, though these are beyond the scope of the present discussion.²⁰ It has also taken on a good deal of fluidity, and its implications can vary considerably. In one sense a structural conception can be implied in which ethos has an objective existence, independent of individuals and events, with the power to condition individual thought and action so that they become congruent with it. In another sense ethos can be seen as produced directly from the interaction of individuals within a society, organization or group. In yet another sense ethos can have an objective, structural, existence with the power to condition behaviour, but be open to modification by human agency. It is this latter conception of ethos which has been

adopted in the present project, and it is its application to organizations such as businesses, schools, and other public bodies which is the most relevant to the institutions under consideration here. Research in this area is extensive, and cannot be covered in any complete way. Instead, two studies will be briefly noted which illustrate the use of the term, and are of relevance to the present research.

Harking back to Aristotle, there persists a conception that the ethos of individuals, in the sense of their moral values, and their ability to present them in a convincing way, can be persuasive enough to transmit them to others. For example, Raya Yoeli and Izhak Berkovch, in a 2010 Israeli study, examined the personal ethos of visionary educational leaders, who were able to translate their personal vision into one shared by others in their organization. These individuals saw the organization, and its vision, as reflecting their own identity and self-worth, and had a strong sense of mission, commonly derived from earlier personal experiences which left a deep imprint on them. This led to an active impetus to change the educational system and to recruit others to this end.²¹

Turning to groups, Clifford Geertz, in an essay on religious symbols, differentiated “*ethos*”, the “*moral and aesthetic style and mood*” of a people’s life, from their “*world view*,” described as “*their picture of the way things in sheer actuality are*”.²² For life to be effectively lived it made sense that there needed to be congruence between their ethos and world-view:

It is only common sense because between ethos and world view, between the approved style of life and the assumed structure of reality, there is conceived to be a simple and fundamental congruence such that they complete one another and lend one another meaning.²³

Thus the term “ethos” can imply both a moral conception of the world, and its translation into practical actions and relations. As one moves from the sacred to the ethos of organisations such as businesses, schools and other public bodies which grapple with everyday problems, one might, perhaps, anticipate less congruence between their official ethos and that of those charged with implementing it. Organizational employees, even those who approve of their organization’s aims, often have the unenviable task of trying to put into practice the rather moralistic

pronouncements of those in charge, in less than ideal circumstances. Unsurprisingly rules and practices get bent to fit practical situations, and the official ethos gets changed, or watered down. Many organisations would not function without their official ethos being trimmed in this way, and this is the reason why “working to rule” can be used as a weapon in organisational disputes between workers and management. An example of such incongruence was shown in a piece of educational research by Caitlin Donnelly who, in 1999, contrasted two schools in Northern Ireland in terms of the congruence between the “*values and beliefs which the school officially supports*” and “*the observed practices of school members,*” using the term ethos to cover both. One was a Catholic school which officially aimed to make the Catholic faith an integral part of its curriculum and practice. The head teacher, and the majority of the governors, had received their formative education there, and in the related secondary school, and Catholic symbols and activities pervaded the school. Nevertheless, interviews with governors and staff suggested that, although outward support of the Catholic faith was accepted, there were many who did not privately agree with the official ethos, who thought it outmoded, and as having little relevance to their own lives. The other school was also Christian in character but with an official policy dedicated to the integration of Catholicism and Protestantism, with governors and teaching staff drawn from both of these groups, and school committee structures constituted to represent both. However, both parents and staff had often received their own education in segregated schools, and many parents had chosen the school for their children because of dissatisfaction with the segregated system. In practice there were many points of disagreement between parents, teachers and governors, and the tolerance, openness and respect officially advocated were often far from evident. Thus, in both schools, though more overtly in the integrated school, there was evidence of incongruity between the officially stated ethos and that which was actually practised.²⁴

1.2.4.3 The suitability of “ethos” to the present project

The intention here will be to illustrate the suitability of the conceptions of ethos outlined in the preceding section to the present project, though without going to the lengths of providing a resumé of the whole project.

Although Aristotle was discussing individuals, his rhetorical meaning of “ethos” was quite congruent with the way in which the governors of the institutions, as a collective, presented themselves. They appeared to see themselves as well-intentioned individuals with a morally worthy task to perform in running their institutions. They attempted to perform this task as ably as they could, and took exception to any external claims that they were doing this less than competently. However, it will be suggested that the task they saw, and presented, themselves as performing was, in some respects, a less morally worthy one than they allowed. It will be argued that they, in fact, coercively confined lunatics, largely for the public good as they were dangerous, and socially disruptive, but that this was interpreted as caring for, and curing, helpless and sick individuals. While a certain amount of care was actually provided, it will be suggested that they were not, in fact, curing anybody, but were, instead, claiming spontaneous remissions as cures.

The ability of visionary leaders to communicate their ethos to others was noted in the preceding section. This was also evident in the foundation of the institutions studied in the present project, which came into being as a result of the efforts of either individuals, or small groups, with a strong desire to improve the lot of lunatics. These founders were inspired by strong moral principles and were able to implement this ethos through others, by means of personal influence, and through donations of money, buildings or even fully functioning institutions, along with their rules and practices. The ethos of these founders lived on in that of the governors of the institutions, and in the roles, relations and practices within them. Founders were also often symbolically present in the institutions, for instance in in portraits, statues, and inscriptions chosen by them.

Although founding figures of the institutions had an initial and, commonly, abiding influence, the governors also took care to bind themselves together as a group, to protect their ethos from undesirable influences, and to ensure its stability, through a variety of group practices such as meetings, dinners, prayers and sermons. The governors of some institutions also constituted themselves as a legal collective through charters of incorporation and used a common seal to symbolise this. When necessary, new governors were recruited who were sympathetic to the prevailing ethos, and were carefully inducted in into it, sometimes also being given symbolic

objects such as staffs, or books of rules. Their ethos could also change over time, by collective decision, to cope with new circumstances. As will be discussed, procedures were in place to ensure that this occurred in an orderly manner, without improper influences, and that decisions, once made, were binding on the whole collective

The ethos of the governors of an institution was rarely expressed in a direct way and was partly inferred from their attempts to communicate it downwards to their paid staff, to ensure its appropriate implementation, and from the practices which resulted from it. This downwards communication of what could be termed the “official” ethos’ of the institutions was done through hierarchies of sub-committees, and managers, and by means of bodies of rules, role prescriptions, exhortations, systems of monitoring staff conduct, rewards and punishments. As noted above, the daily practices of the institutions, concerned with effective management, with care and with cure, were also taken as representing their ethos.

However, material was also collected which illustrated things going wrong in the institutions. These examples included errors, incompetence, malice, corruption, theft and so on, and illustrated that the percolation of an official gubernatorial ethos downwards was generally less than complete, and that there were practices occurring in the staff group which were incongruent with it. These could vary from individual error, incompetence or malpractice, to what might be viewed as institutionalised corruption and could, at least in some cases, be seen as indicating the operation of an unofficial ethos, or a variety of these.

The gubernatorial ethos in an institution would, ideally, not infuse only the staff, but would also influence the way the institutional inmates viewed their treatment. Thus, they might be expected to be thankful for the care, and the opportunity of cure, extended to them. In some cases this may have been true, and in other cases inmates probably accepted their confinement with resignation, making what they could of institutional life. However, there were a good many who protested vehemently against their confinement in whatever ways were available to them, and who clearly did not accept it as either caring or curative. Again, it could be said that there was incongruence between the official ethos of the governors, which emphasised care,

and cure, and that of many inmates, which emphasised coercive confinement. It could, of course be argued that a group of lunatic inmates were unlikely to hold any collective view of their position and that protest was an entirely a matter of individual grievance. However, even on an individual basis the ethos of many inmates was clearly incongruent with that of the governors, and the same could be said of relatives and others, who also, at times, protested.

1.3 Historiography of accounts of madness, and its management

The term "historiography," in modern usage, refers to the analysis of the way history has been written, the assumptions, concerns, intentions, and omissions, of individual historians, those of different periods, or those in different historical fields.²⁵

Little such attention has been given to histories of madness, and its management, though their authors have often commented on the accounts of other writers, generally unfavourably. Much of the comment has taken the form of sniping between historians from the psychiatric profession, and their supporters, who have presented a progressive account of the treatment of mental disorder, and "revisionists" taking a more critical, often sociological, perspective. For instance, Andrew Scull, a sociologist, described most histories written by psychiatrists as:

...the construction of versions of the past that serve (in ways generally obscured from those offering such accounts) to legitimate the activities of psychiatrists in the present.²⁶

Conversely, from the position of a 1997 professional historian favouring modern psychiatry, Shorter took on the revisionists:

Above all, I have tried to rescue the history of psychiatry from the sectarians who have made the subject a sandbox for their ideologies. To an extent unimaginable for other areas of the history of medicine, zealot-researchers have seized the history of psychiatry to illustrate how their pet bugaboos - be they capitalism, patriarchy, or psychiatry itself - have converted protest into illness, locking into asylums those who otherwise would be challenging the established order.²⁷

To date there has been only one attempt to provide a historiographic review of histories of psychiatry, and the management of madness, Micale and Porter's *Discovering the History of Psychiatry* (1994). This attempted to take a neutral

position in relation to the progressive-revisionist debate and, to quote from its introductory chapter:

Accepting that historians of the 1970s and 1980s had the right and duty to deconstruct past psychiatrists' histories of psychiatry, exposing their biases and ulterior motives, the histories constructed by such critics must equally be exposed by equivalent styles of analysis.²⁸

1.4 Historiographic Analysis of Histories of Madness and its Management

1.4.1 Introduction

The following analysis, which was initiated by the initial observations on the literature on nineteenth-century asylums in section 1.1, made no pretence to cover the voluminous literature on madness, and its management, in any complete way. Instead, a sample of accounts written between 1937 and 2001 was chosen to represent the major approaches which have had some bearing on the institutional management of the mad. The aims were to establish the normative historical account of madness, and its management, together with the major deviations from it and, more importantly, the representation of early English institutions for the mad in such accounts.

Twenty-two accounts were chosen, the following six of which presented themselves as histories of psychiatry, or “medical psychology.” Five were written by psychiatrists and only one (Shorter's) by a trained historian, a profession largely absent from such accounts:

- Zilboorg, G. & Henry, W. *A History of Medical Psychology*, 1941.²⁹
- Leigh, D. *The Historical Development of British Psychiatry. Volume 1 18th and 19th centuries*, 1961.³⁰
- Hunter, R. & Macalpine, I. *Three Hundred Years of Psychiatry 1535-1860: A History Presented in Selected English Texts*, 1963.³¹
- Alexander, F. G. & Selesnick, S. T. *The History of Psychiatry: An Evaluation of Psychiatric Thought and Practice from Prehistoric Times to the Present*, 1967.³²
- Berrios, G. E. & Freeman, H. *150 Years of British Psychiatry, 1841-1991*, 1991.³³
- Shorter, E. *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*, 1997.³⁴

A further five histories could be viewed, broadly, as histories of the management of madness and comprised:

- Deutsch, A. *The Mentally Ill in America: A History of their Care and Treatment from Colonial Times*, 1937.³⁵
- Rosen, G. *Madness in Society: Chapters in the Historical Sociology of Mental Illness*, 1968.³⁶
- Skultans, V. *English Madness: Ideas on Insanity 1580-1890*, 1978.³⁷
- Busfield, J. *Managing Madness: Changing Ideas and Practice*, 1986.³⁸
- Jones, K. *Asylums and After: A Revised History of the Mental Health Service: From the Early 18th Century to the 1990s*, 1993.³⁹

Medical concepts and practices were less central, and these accounts emphasised the influence of a variety of social variables in the recognition, labeling and management of madness. One of the authors, Rosen, was a doctor, though not a psychiatrist, another, Deutsch was an unqualified researcher, while the remaining three were academics in areas related to mental disorder.

The following five histories were chosen as, in various ways, “revisionist” in challenging progressive historical accounts, and emphasising the construction of the confinement of the mad in a variety of ways:

- Foucault, M. *History of Madness*, 1961. (English Translation, 2006).⁴⁰
- Szasz, T. *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, 1961.⁴¹
- Doerner, K. *Madman and the Bourgeoisie: A Social History of Insanity and Psychiatry*, 1969. (English Translation, 1981).⁴²
- Showalter, E. *The Female Malady: Women, Madness and English Culture 1830-1980*, 1985.⁴³
- Scull, A. *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900*, 1993.⁴⁴

Though, in the main, academics, two of their authors (Doerner and Szasz) were psychiatrists, and Foucault a psychologist, while Scull was a sociologist, and Showalter a professor of English. The relatively high proportion of psychiatrist and psychologist authors might suggest a within-profession critical stance, balancing that of more progressively oriented psychiatric histories.

The remaining six histories were grounded in primary sources, though not in records of public institutions for the mad. They particularly included accounts by mentally disturbed individuals, and of confinement in madhouses. Like the histories of madness they attempted to place madness in a social context, though with less theoretical interpretation.

- Parry-Jones, W. Ll. *The Trade in Lunacy: A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries*, 1972.⁴⁵
- Clarke, B. *Mental Disorder in Earlier Britain: Exploratory Studies*, 1975.⁴⁶
- Porter, R. *A Social History of Madness: Stories of the Insane*, 1987(a).⁴⁷
- Porter, R. *Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency*, 1987 (b).⁴⁸
- Ingram, A, ed. *Patterns of Madness in the Eighteenth Century: A Reader*, (1998).⁴⁹
- Andrews, J. & Scull, A. *Undertaker of the Mind: John Monro and Mad-Doctoring in Eighteenth-Century England*, 2001.⁵⁰

Their authors (or editors) were academics, their specialities being history (Porter), psychiatry (Parry-Jones), English (Ingram), Celtic studies (Clarke), sociology (Scull) and humanities (Andrews).

1.4.2 The Normative Trajectory of the Histories

Deutsch's book *The Mentally Ill in America*, focused mainly on American management of madness but, probably because of its early influence, illustrated the normative narrative pattern of the histories, particularly the psychiatric histories, very well, and will be used to exemplify this. Deutsch, in his final pages, gave a convenient summary of his account:

We have traced their history from the days when they were believed to be possessed and elaborate rites of exorcism were performed over them to drive out the devils, down through the times when they were chained in cages and kennels, whipped regularly at the full of the moon, and hanged as witches in New England. We have seen how the only public institutions provided for them in early America were the almshouses and prisons; how they were sometimes "bid off" as paupers on the auction block, like common chattels; how they were exhibited like animals in a menagerie before crowds who paid admission fees in our earliest mental hospitals, how our early psychiatrists drained them of pints of blood in the hope of cooling their fevered brains. We have traced the gradual evolution of the modern state hospital, and the rise of the state care system. We have sketched the origin and rise of the mental hygiene movement, and the consequent raising of standards of care and treatment for mental patients, the encouragement of psychiatric research, and the beginnings of an organized drive

toward the prevention of mental disease.⁵¹

This narrative presented early conceptions of mental disorder as resulting from “possession,” treatment being largely by exorcism. These magical procedures were supplemented, in Egypt and the classical world, by herbal and other physical remedies, along with some more natural explanatory, and therapeutic, approaches. This classical learning, and humane management, was lost in the medieval period and, following a retrogressive mix of astrology, alchemy, magic and theology, demonological explanations re-emerged, resulting in the witch-hunts of the sixteenth and seventeenth centuries, in which many of those tortured, and executed, as witches were, in reality, mad.

In the latter part of the sixteenth-century, and the early seventeenth-century, rare heroic and humanistic individuals, often physicians, questioned demonological explanations of madness and inched towards a more rational understanding:

Here and there men of science could be found groping through the thick fogs of ignorance, fear and superstition that enshrouded in mystery the phenomenon of mental disease. Imperceptibly they were piling up contributions to the knowledge of the subject for future generations to build upon.⁵²

Although demonological explanations had all but died out by the eighteenth-century the lot of the mad did not improve:

Regarded as sub-human beings, they were chained in specially devised kennels and cages like wild beasts, and thrown into prisons, bridewells and jails like criminals. They were incarcerated in workhouse dungeons, or made to slave as able-bodied paupers, unclassified from the rest. They were left to wander about stark naked, driven from place to place like mad dogs, subjected to whippings as vagrants and rogues.⁵³

At the end of the eighteenth-century, a new humanitarian attitude emerged, exemplified by the development of moral treatment by the European innovators Chiarugi, Pinel and Tuke. However, this humanitarian gain, and therapeutic optimism, dissipated during the nineteenth-century due to the inexorable growth in the number, and size, of asylums in the face of what was considered to be an “epidemic” of insanity, and an accumulation of chronic cases, partly resulting from transfers from workhouses. Asylums became increasingly custodial, and

expectations pessimistic, though Deutsch maintained a touching faith in the value of institutional management:

State hospitals were enlarged; new ones were erected. But still the number of insane deprived of hospital care continued to keep pace with the number who found refuge (in varying degrees) in hospitals and asylums.⁵⁴

In the late nineteenth-century psychiatry's dependence on institutional care, and its lack of a scientific research base, was under criticism from an emergent neurology. This was met by increased psychiatric research, improved education and training, and an expansion of psychiatric activity into private practice, out-patient work and the detection, classification and treatment of early, and incipient, mental disorder.

Deutsch's narrative, of twentieth-century developments was also of continuing progress, despite his acknowledgement of the persistence of mechanical restraint, its substitution by chemical restraint, worn out facilities, overcrowding, understaffing, political interference, and corruption. Much of it concerned the development of somatic therapies, and his faith in institutional care was maintained despite his report of an overall 1934 recovery rate in state hospitals of only 16% with a further 25.7% "improved." He asserted:

The encouraging advances recently made in psychiatric study have done much to dispel the fatalistic attitude toward mental disease that has hitherto served as a brake on progress.⁵⁵

Deutsch's account of a bumpy, but upwards, trajectory of humanitarian and scientific progress was typical of the majority of the other histories. Virtually all presented some version of "progress" in which the mad were now more humanely treated than formerly. Even Andrew Scull, a consistent critic of psychiatry, confinement, and social policy, accepted that a more humanistic view of madness resulted from the development of moral treatment, the early nineteenth-century non-restraint movement, and the efforts of well-meaning reformers:

The abandonment of external coercion, the emphasis that the insane were susceptible to many of the same emotions and inducements as the rest of us, the belief that the qualities that the lunatic lacked could and should be reawakened: taken together, these

marked an authentic shift in moral consciousness whose dimensions and cultural resonance are clear.⁵⁶

For social historians the emphasis tended to be on kindness and human understanding and, for psychiatric historians, on the accretion of scientific knowledge, though they too were not slow to claim increasing benevolence.

Thus, the most common narrative trajectory encountered, and the majority of the specific features of the histories analysed, could be seen as falling within Butterfield's conception "whig" history⁵⁷ which was summarized by Micale and Porter:

Whig narratives were presentist, progressive and tenaciously internalist. They typically presented a dual historical movement from cruelty and barbarism to organized, institutional humanitarianism, and from ignorance, religion and superstition to modern medical science. They often consisted of dramatically juxtaposed dark ages, enlightenments, and revolutions that heralded the way to the present.⁵⁸

1.4.3 Deviations from the Normative Trajectory

A number of the accounts, however, deviated from this upward trajectory, suggesting that the conception, and treatment, of madness was constructed differently at different historical periods, without any conception of progress.

Foucault argued (as did Rosen) that a medieval dialogue existed between the reasonable and the mad, in the face of looming cosmic disintegration, the mad sometimes being seen as having special insight into this. Subsequently, however, madness, along with other forms of deviancy, was constructed, and reconstructed, as something alien to reason and its practitioners were subject to various types of confinement. Doerner also argued that the forms of unreason which, in the middle-ages, had been part of a divine world, in the Renaissance became part of a secularising world of commerce, morality and work, and were, increasingly, subject to a Foucauldian, pan-European, "great confinement" as they threatened civil order, calculable labour, scientific mastery of nature, the church and the family. The mad occupied a special position by virtue of their "bestial" nature and freedom, and were bad social examples, from which society needed protection. The subsequent

emergence of psychiatry translated their sequestration into the “scientific” correction of madness.⁵⁹

Szasz reached much the same conception of the role of psychiatry from a right wing position espousing self-help and personal responsibility, charting the pathologisation, and medical mystification, of interpersonal difficulties for which the “patient” should be held responsible.⁶⁰ Scull’s account, similarly argued that the institutional management of madness, and the development of psychiatry, were disguised mechanisms for locking up troublesome people.⁶¹ Again, Showalter’s concern was to examine the history of shifting conceptions of female insanity which she saw as socially constructed, predominantly by men, without any significant conception of progress.⁶²

Porter, in *A Social History of Madness*, also attempted to offer a flat trajectory by situating personal accounts of madness within their historical context of belief and practice, avoiding a progressive narrative. This was, perhaps, evident in his closing statement which suggested that the mad had always been badly treated, albeit in different ways at different times:

Have not the true fantasists been those psychiatrists who have claimed to hold the master-key to madness? In truth, such theories and therapies have all too often only proved a philosophical warhorse useful for riding roughshod over resistance and protests. The pontifications of psychiatry have all too often excommunicated the mad from human society, even when their own cries and complaints have been human, all too human.⁶³

Ingram too, avoided a progressive narrative, concluding, rather like Porter, that the relationship between doctor and patient was generally one of incomprehension of the second by the first.⁶⁴ Finally, Andrews and Scull’s analysis of John Monro’s private case book also gave a value-neutral account of Monro’s practice as a mad doctor.⁶⁵

1.4.4 The Treatment of Early English Institutions for the Mad in the Histories

1.4.4.1 Lack of attention to Early Institutions for the Mad

A notable aspect of the histories was their lack of attention to early institutions for the mad, English or otherwise. Deutsch, Zilboorg and Henry, Alexander and Selesnick, Rosen, Szasz, Showalter, Busfield, Berrios and Freeman, and Shorter barely mentioned them at all, and Leigh dealt with them only briefly, apart from some nineteenth-century material in his chapter on John Haslam.⁶⁶

Foucault's account gave only brief attention to Bethlem, and mentioned St. Luke's, the Guy's Hospital lunatic house, and some mid-eighteenth-century provincial asylums, his major focus being the later regime at the York Retreat.⁶⁷ Doerner too, while mentioning Bethlem and St. Luke's, along with the early provincial asylums, showed little interest in their function, being more interested in the move from simple sequestration of the mad, to their moral management at the York Retreat.⁶⁸

Andrews and Scull's book⁶⁹ concerned John Monro, Bethlem's physician, and management and practices there, particularly medical practice, and public visiting, were reported in some detail. The only other contemporary institution mentioned was St. Luke's Hospital, largely because of the implicit criticism of Bethlem's management in its founding document, and in the 1758 *Treatise on Madness* of William Battie, its first physician.⁷⁰

The other histories, in the main, briefly visited early institutions for the mad by way of introduction to the meat of the accounts, which lay in the late eighteenth-century emergence of moral treatment, and the nineteenth-century development of county asylums. Bethlem received most coverage, and St. Luke's somewhat less, but provincial institutions, and the lunatic houses attached to general hospitals, rarely merited anything but a mention.

1.4.4.2 Lack of Scholarship

A lack of scholarship also characterised the histories, shown, first, in a conspicuous lack of original archival research on early institutions, and an apparent ignorance, or neglect, of the few published sources based on their archives. For instance, Bateman and Rye's history of the Bethel Hospital (1906) was rarely mentioned.⁷¹ Again, French's book on St. Luke's⁷² was available from 1951, but this institution did not receive anything like the coverage of Bethlem. Instead there was reliance on easily obtained documents, the same sources tending to crop up repeatedly, notably the founding prospectus of St. Luke's Hospital⁷³, and the report of evidence given to the 1815/16 Parliamentary Select Committee on Madhouses,⁷⁴ neither of which gave an accurate account of early institutions.

Second, what seem to be unreasonable conclusions about the treatment of the mad tended to be copied from one psychiatric history to another, most notably that they were regularly viewed as witches and, consequently, tortured and executed.

Third, primary material, when referred to, was often interpreted in a naive way in which its context and purpose were not properly taken into account. For instance, the founding document of St. Luke's Hospital⁷⁵ was commonly taken as evidence of a progressive regime at the hospital, and not considered as an advertising brochure aimed at bringing in donations.

1.4.4.3 The recruitment of early English Institutions into historical narratives.

Neglect of early English institutions for the mad could have also resulted from the difficulties they presented for historical accounts of increasingly humanitarian, or scientific, progress. In particular, the activities of medical practitioners in early institutions could hardly be claimed as humanitarian or scientific from a modern perspective. One way of dealing with this was to simply ignore them, and to fix the start of modern psychiatry in the moral treatment of the late eighteenth-century, when something positive could be claimed. For instance, Shorter saw Battie's *Treatise on Madness* (1758) as ushering in the late eighteenth-century "*therapeutic asylum*."⁷⁶ Berrios and Freeman adopted a variant of this by aligning the birth of

psychiatry with the 1841 foundation of the Association of Medical Officers of Asylums and Hospitals for the Insane. From this point positive advance could be claimed, which ignored lay involvement and a medically compromised past.⁷⁷

However, as early institutions represented a major development in the management of madness they could not be completely ignored, and the common second strategy was to construct them as part of a “bad old days” from which the mad were rescued by humanitarian reformers. Such accounts represented them as simply confining lunatics in inhumane conditions, and applying abusive and non-scientific “treatments” to them. At the same time, islands of more enlightened care could be pointed out, and seen as precursors of modern mental health provisions, however tenuously. By way of example Clarke, describing the treatment of inmates in the first Bethlem Hospital, wrote:

Some of them moved about freely. The dangerous ones were chained and lay on straw, and were by turns humoured and whipped but not apparently on a consistent and thought out principle. The only fire was in the kitchen. The public could inspect, and it was said that 'privileged visitors' could make game of them.⁷⁸

Even histories which avoided placing early institutions within a narrative of scientific or humanitarian progress presented a negative picture of them, though for different reasons. For these histories they formed one example of an oppression of the mad, which simply varied in its nature over time.⁷⁹

1.5 Implications of the Historiographic Analysis.

While a much more detailed account of the preceding analysis could be presented, enough has been said to allow three implications for historical research to be highlighted.

First, a notable feature of the histories, perhaps as few were written by professional historians, was a tendency to create rather simplistic explanations for changes in the treatment of the mad.⁸⁰ Commonly these involved the operation of a particular variable, or a small number of variables, to explain changes, rather than a complex of interacting variables and events.

For instance, “*great confinement*” explanations⁸¹ stressed the development of a bourgeois fear of “unreason” during the classical period, while other explanations drew on the influence of capitalism and the markets it created.⁸² For Jones the important influence was “*the twists and turns of social policy*”, the mad being rescued from abuse by reformist legislation,⁸³ while other models, such as that of Szasz,⁸⁴ emphasised the growth of institutions for the mad as a means of disposal of social nuisances. For the psychiatric historians there was generally an assumption that mental disorder, as currently conceived, had always existed, and this tended to produce a teleological narrative of “discoveries,” or “revolutions,” as its true nature was uncovered.⁸⁵

Second, there was a tendency to attribute changing views of madness to intangible social forces, in a rather tautological way, without relating them to specific institutional events. For instance, Shorter argued that, by the mid-eighteenth-century “*a new therapeutic optimism*” was afoot, which led to the founding of institutions such as St. Luke’s, though he did acknowledge that this:

...originated in a wide variety of social and economic settings, making it unlikely that any single social force such as capitalism offered the answer.⁸⁶

Third, changes in institutional practice tended to be seen as arising only in response to external forces, ignoring any effect of the accumulated experience of managing the mad which could have passed from earlier institutions to later ones. While interactive models, in which internal and external events influenced each other, would seem to be appropriate, they were not in evidence, probably because of the lack of any detailed knowledge of the practices in the institutions.

The foregoing discussion has implied the need to look to institutional practices as both a source of, and influence on, theoretical models and, hence, a clear need for detailed knowledge of how institutions for the mad actually functioned. The present project, it is hoped, will go some way towards remedying this lack.

1.6 Histories of the Sampled Institutions

1.6.1 Introduction

Although the foregoing general histories of madness, and its management, showed little reliance on primary research, most of the institutions sampled have, individually, been the subject of historical accounts, and this section will comment on their quality, and value.

1.6.2 Bethlem Hospital

Bethlem Hospital has been the most extensively covered, its first history, in 1783, being by Thomas Bowen, its chaplain. However, his very positive, partial, account, was probably designed to elicit donations and is of little historical value, except as an artefact in its own right.⁸⁷ Conversely, Daniel Hack Tuke's 1882 *Chapters in the History of the Insane in the British Isles* included a brief chronological history of Bethlem, with little reliance on primary records, which portrayed the hospital rather negatively until the satisfactory management of his day.⁸⁸ Another brief history, from 1892, *Bethlem Royal Hospital*, by A. J. Copeland, its treasurer, derived from a paper by Tuke, though it was somewhat less condemnatory. Seven years later *A Short History of the Royal Hospitals of Bridewell and Bethlem* appeared, by J. G. White, one of the hospital's doctors. This resembled Copeland's account, to which it was probably indebted.⁸⁹ None of these accounts gave any accurate insight into the hospital's practices, and they cannot be considered very useful for any critical approach to its management.

The first serious history, *The Story of Bethlem Hospital from its Foundation in 1247*, by Geoffrey O'Donoghue, its chaplain, appeared in 1914, and did draw on the hospital archives. However, it suffered greatly from the intrusion of popular, and literary, material, irrelevant digressions, and a lack of critical attitude, leading to an unreasonably positive account of humanitarian progress.⁹⁰ Andrews (1991) has commented on the inaccurate, "merrie England" accounts, drawing on literature and drama, to which the first Bethlem Hospital, particularly, has been treated.⁹¹

From the 1970s Patricia Allderidge, the hospital's museum curator, drew on its archives to fill gaps in the hospital's history, and correct some of O'Donoghue's erroneous statements, in a series of papers, and book chapters, for instance on its department for criminal lunatics (1974), and early administration (1979). However, this never amounted to a complete history. Anthony Master's *Bedlam* (1977) drew on O'Donoghue's account, and Allderidge's notes, to present an unreasonably unbalanced, bleak, picture of the hospital to its third incarnation in 1815, after which a belated reformation was seen to take place.⁹²

Jonathan Andrews's 1981 Ph.D. thesis *Bedlam Revisited: A History of Bethlem Hospital c 1634 - c 1770* was a balanced, archive-based, account of the hospital and was followed, in 1997, by David Russell's *Scenes from Bedlam*, and the multiply authored *The History of Bethlem* commemorating its seven hundred and fiftieth birthday. Both were useful, scholarly productions.⁹³ Finally two recent books, Catherine Arnold's *Bedlam* (2008), and Paul Chambers' *Bethlem* (2009), were popular histories, drawn from the secondary literature. Both gave rather negative accounts of neglect and cruelty up to the nineteenth-century, after which a reformation took place. Neither has added anything in the way of new research, or insight, the monolithic *History of Bethlem* remaining the best source available.⁹⁴

1.6.3 St. Luke's Hospital

Earlier comments on Tuke's 1882 history of Bethlem also applied to St. Luke's Hospital, which he also covered. Subsequently, *A Short History of St. Luke's Hospital* by William Rawes, its medical superintendant (1904) and a longer 1951 account, *The Story of St. Luke's Hospital 1750-1948* by Charles French, the hospital secretary, drew on hospital records. Both were, essentially, in-house narratives, stressing progressive and humanitarian change, and lacking critical balance.⁹⁵

1.6.4 The Bethel Hospital, Norwich

The History of the Bethel Hospital at Norwich Built by Mrs. Mary Chapman in the Year 1713, by Frederic Bateman, its physician, was completed, and published, in 1906, after his death, by Walter Rye, a local solicitor and, presumably, a governor.

Although replete with useful archive-based detail it also presented a relatively uncritical in-house narrative of continuous progress.⁹⁶ Three papers were also of note. *An Eighteenth Century Mental Hospital*, by C. V. Barclay, a psychiatric social worker (1963) was, again, a positive historical account, though with a useful focus on inmate details. The other two papers, by Mark Winston, a local psychiatrist (1989 and 1994) were similarly positive, also drawing on the hospital's records, though emphasising medical matters.⁹⁷

1.6.5 St. Peter's Hospital, Bristol

Only two archive-based histories of St. Peter's hospital exist and were invaluable for the present project, as the hospital's records were destroyed during the Second World War. James Johnson was an ex-governor, and his *Transactions of the Corporation of the Poor in the City of Bristol During a Period of 126 years* (1826) presented a reasonably neutral account of its history, based on the Corporation's records. The other, 1932, account, by E. E. Butcher also provided an unbiased account of the hospital's history, along with extracts from the Corporation's records, from 1696 to 1834. Although lunatics formed only a small part of the inmate population both histories provided some details of their management.⁹⁸

1.6.6 The Remaining Hospitals

There is no published history of the Newcastle Lunatic Hospital, but it has been briefly mentioned in two papers by Le Gassicke.⁹⁹

The French Hospital has been the subject of a number of historical accounts, notably by Browning, and by Marmoy, the latter giving some details of its lunatic population. A recent book on the hospital, and its art collections, by Murdoch and Vigne (2009) has, however, added little to these.¹⁰⁰

A number of histories of Guy's Hospital have been produced, though none have done more than mention its two lunatic houses, and then inaccurately. Wilks and Bettany's (1892), for instance, gave the incorrect date of 1774 for the first (1727),

and the correct date (1797) for the second, while Cameron's 1954 history also inaccurately dated the first building as 1744, while correctly dating the second.¹⁰¹

1.6.7 Summary

These accounts, insofar as they drew on institutional records, were invaluable as a partial guide to what material was available, and its possibilities. In the case of St. Peter's Hospital they contained the only remaining hospital records and were essential. However, each account dealt with its own institution in isolation, and often selected information for interest rather than historical value. They were also commonly written by individuals associated with the institutions, largely to legitimise the practices of their own day, this often being achieved by condemning those of previous periods and by presenting unreasonably whiggish narratives.

Histories written by those not associated with the institutions varied from the balanced and scholarly, to those more concerned with telling an interesting story, than with strict historical accuracy. Such stories could be unreasonably positive, or damning.

1.7 The orientation and organization of the Project

1.7.1 Introduction

It has been suggested that histories of the management of madness have, generally, been concerned with explaining the development of early institutions for the mad by recourse to a variety of variables within their external social environment. In the view of the present writer this has led to rather simplistic, and commonly negative, accounts which have ignored the influence of the internal practices of the institutions on their development, and any interaction between these practices and external variables. This limited, "external", view appeared to have arisen because of the relative opacity of the internal practices of the institutions, resulting from a lack of primary archival research, and an apparent ignorance of such primary research as existed. The present project has attempted to remedy this deficiency by providing an "internal" account of the the ethos of the governors, and the day-to-day management

processes, of all the early English institutions for the mad, founded from 1546 to 1756, largely based on their own records. While acknowledging the individuality of the institutions it was hoped to provide an integrated, comprehensive, model of their internal functioning, which could provide a base for future research.

The project attempted to avoid any interpretive trajectory of advance (or decline), and was grounded in day-to-day practices, and material objects, rather than in abstract ideas, or the actions of significant individuals. Despite this it attempted to move from simple description of daily practices, to a higher-level account of the managerial systems, and structures, which allowed a group of governors to maintain their institutions, recruit, monitor and control bodies of staff, admit, manage and discharge inmates, deal with relatives and suppliers, develop and maintain their own ethos, recruit to their number, and make binding rules and decisions.

1.7.2 Source material.

The material for the analysis came, almost completely, from original documents in well established archives. These were related to others of similar type, for instance series of minute books, or accounts. Some use was made of transcriptions and summaries, for example the published Acts of the Privy Council of England, and occasional recourse was made to archived documents of unknown authorship, or date, such use being indicated where it occurred. Overall, the major sources were official records of public institutions and were unlikely to be seen as sufficiently important for falsification to be an issue.

Most of the material analysed was transcribed, verbatim, from the original documents. However, for lengthy records, selected passages were transcribed, and notes made on the remainder. Again, for repetitive material, such as records of purchases, verbatim transcriptions were made of a typical sample. Considerable effort was made to transcribe material accurately and to indicate missing, or unreadable, sections, ambiguities, and insertions. In short, every effort was made to meet normal standards of historical rigour.¹⁰²

1.7.3 Data collection

Beyond the two research questions the records were approached without specific hypotheses, or preconceptions. An attempt was made to collect as wide a range of material as was feasible, and to amass a similar range for all the institutions. However, this process soon gave rise to three particular influences on data collection. First, a conviction that the material institutional world was important. For instance, the purchase of blankets for inmates was taken as indicating care of them as much as declarations that they were being cared for. This led to particular attention being given to the collection of records concerning material objects and processes. Second a concern with mundane institutional processes. Thus, processes of food preparation, cleaning, or vermin removal were given as much weight as resolutions of the governing bodies. Third, negative events, errors, accidents and resistances, were recorded in the same way as more positively intended actions. The means the governors employed to put these right were also given attention, particularly as they could be the engine of changes in institutional practice.

1.8 Organisation of the thesis

Chapter 2 will outline the historical and analytic approach which was taken to the collected material. Chapter 3 will then begin the presentation of the results of the analysis, beginning with the means through which the collective ethos of the institutional governors was formed, and mechanisms through which it was maintained, and changed. Chapters 4 to 7 will then explore the four major themes which emerged from the analysis, and which represented the content of governors' ethos. These were conceptualized as discourses (see Chapter 2 section 1). Cutting across these were events which were inconsistent with these discourses and which could often be seen as directly opposing them. This led to two, contrasting, accounts of each discourse. The first reported its positively presented elements, for instance adequate care, or good management. The second presented a 'challenged' version in which the reported events ran counter to the first version, for example representing lack of care, inadequate management, or protest. These 'challenges' were considered to be important as they frequently led to attempts by the governors to prevent their repetition, and hence to institutional change. They also gave a voice to the

institutional inmates, and sometimes to others, by recording what appeared to be their protests against the institutional regime. Chapter 4 will discuss, in these terms, the confinement of the mad, Chapter 5 management practices, Chapter 6 care of inmates, and Chapter 7 the issue of Christian piety.

Chapter 8 will then broaden the discussion by examining the the possible influence of the institutions on each other, and on those which followed, and Chapter 9 will expand it further in three ways. First it will briefly outline the range of other institutions in which the mad were housed, and their relationship to those in the present sample. Second, it will provide statistical estimates of the overall capacity of the various institutions for the mad, and the proportion of the mad which was likely to have been housed in them. Third, it will attempt to place the sampled institutions in a broader context of opinion by considering a variety of visual, literary, dramatic and poetic representations of them and, where evident, the involvement of their governors in such representations. Finally, Chapter 10 will summarise and present conclusions for the project, and finish with a methodological critique and some brief suggestions for future research.

Three appendices will supplement this information. Appendix 1 will give a short account of who the governors of the institutions were and, tentatively, suggest some motives which may have led them to take up this role. Following this, and in view of the fact that the analysis of the collected material was thematic, rather than chronological, Appendix 2 will, first, provide a short, chronologically organized, account of the foundation, and development, of each institution. This will be followed by a brief chronology, and discussion, of the emergence of some key institutional practices. Finally, Appendix 3 will provide examples of the analysis which was carried out on the sampled material.

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CHAPTER 2

METHODS

2.1 Historical sources, their interpretation, and the present project.

The first major issue concerning historical sources is their validity, which is generally discussed in terms of external, and internal, source criticism. External criticism concerns the authenticity, and comprehensibility, of sources, and asks questions such as whether a source was original, whether it could have been produced by the putative author, and whether it is intelligible enough to be interpreted at all. Internal criticism questions the credentials, and purposes, of those producing sources, particularly whether they were in a position to give an accurate version of events, and whether there may have been circumstances, or personal inclinations, which introduced biases.¹

As indicated in Chapter 1, with a few exceptions, the sources used in the present project were original records of public institutions, in reputable archives, so that falsification was not a significant issue. Where published versions of documents, or those of unknown date, or authorship, were used, this has been indicated. Although occasional difficulties of intelligibility arose, mainly due to the vagaries of handwriting, these were not major, and have been indicated in quotations. The credentials of those who produced the documents (mainly governors) were, generally, not in doubt, and it was acknowledged that institutional records were produced for their own purposes. Consequently, instances of institutional practice, challenging the prevailing account were noted.

Although research questions commonly guide the collection of material, its interpretation also begins at the collection stage, as what is selected involves initial conceptions of its meaning.² Again, formal analysis proceeds through a series of stages which, as a final synthesis emerges, may involve re-analysis of material already been examined. As Shafer has noted:

Analysis is a systematic attempt to learn about a subject or problem by looking at its elements, breaking it into components. The first set of components arrived at is likely to be much altered in the course of investigation.³

The present project proceeded very much in this way. Although data collection was initially guided by the research questions, further analytic concepts rapidly began to develop, and to influence the collection of subsequent data. These particularly concerned material aspects of the institutions, mundane practices, and unanticipated, challenging, events. Again, formal analysis moved through a number of stages. An initial stage of coding was followed by a stage of sorting, and amalgamating, the coded material into broader categories of institutional practice, and this was followed by the construction of a fuller explanatory narrative. These stages were not pre-planned, but grew out of consistent immersion in a large body of unknown material, and the writer's attempts to understand it.

Tosh has identified two major approaches to historical records. The first, applicable to newly discovered material, allows the content of the source to determine the nature of the inquiry. The second, applicable to a reliable body of previous research, involves examining sources with a specific questions, or hypotheses in mind.⁴ The present project was something of a blend between the two, having two rather open research questions, while also examining a relatively unexplored body of material. Although the research questions exerted some control on the collection of the material, there is no doubt that its content strongly influenced this, and the model of institutional functioning which emerged.

Beyond Tosh's bipartite categorisation, a wide range of approaches to the interpretation of records is possible, depending on the purposes of the inquiry, and the nature of the material. Approaches traditionally used by historians may also be supplemented by those from other disciplines. There is, in short, no prescribed approach to records, though much advice is available which derives from the experience historians have of interpreting sources.

Claims to be able to access historical truth through the interpretation of sources have been the subject of considerable post-modernist criticism. This has argued that there is no 'past as such,' waiting to be discovered, sources being essentially stories

constructed for particular purposes, about which historians construct further stories for their own, modern, purposes. Furthermore, meaning is indeterminate and any one reading of a source is as good as another.⁵ However, the approach taken to interpretation in the present project was that argued by Fulbrook, that social life would be impossible if postmodernist claims, at least in their more extreme form, were accepted. Humans are well aware that other people produce narratives serving particular ends rather than referring to fundamental social “truth” and, consequently, they interpret such narratives in the light of relevant contextual information:

.....there is no more any given ‘reality as such’ for the present than there is for the past. But this does not prevent us from, for example, having fairly rational views on whose account to trust in the case of an accusation of bullying, in the light of other evidence and ‘knowledge’ (previous behaviour, ‘character’, the coherence or otherwise of independent witness reports, the existence of bruises or more serious injuries, other physical evidence).⁶

Equally, historical sources do not simply ‘speak for themselves’ and, as Fulbrook suggests, their interpretation is assisted by the repertoire of interpretative skills applied to communications in everyday life:

The possibility of ‘interpretive understanding’, which seems to be an essential and intrinsic feature of being a human, social animal capable of highly sophisticated levels of inter-subjective communication should, as Max Weber pointed out, make for easier, not more difficult, explanation of past human actions and events – and by extension, of historical sources.⁷

It cannot be claimed that the analytic approach used in the present project went beyond the application of everyday understanding. However, prolonged immersion in the sources, in itself, led to a broader understanding of the overall institutional context, increasing the probable accuracy of interpretations of specific actions, decisions and processes. Translated into anthropological context this is close to what Geertz termed ‘thick description,’ the reading of:

...a multiplicity of complex conceptual structures, many of them superimposed upon or knotted into one another, which are at once strange, irregular and inexplicit, and which he [the ethnographer] must contrive somehow first to grasp and then to render. And this is true at the most down-to-earth, jungle field-work levels of his activity: interviewing informants, observing rituals, eliciting kin terms, tracing property lines, censusing households.....writing his journal. Doing ethnography is like trying to read (in the sense of “construct a reading of”) a manuscript – foreign, faded, full of ellipses, incoherencies, suspicious emendations, and tendentious commentaries, but written not in conventionalized graphs of sound but in transient examples of shaped behaviour.⁸

A further aid to interpretation was a grasp of the broader context of the management of madness, derived from knowledge of the secondary literature, of published sources from the period under consideration, and of supplementary material collected alongside that from the institutional records. Three other “modern” influences also aided interpretation in a controlled way. First, the writer’s own experience as a clinical psychologist in institutions ranging from those built during the nineteenth-century, to recently built psychiatric units. Second, experience as a manager in the National Health Service. Third, experience as a member, and treasurer, of a local branch of MIND running a day centre for those with chronic mental disorders. These allowed a variety of interpretative stances to be adopted, particularly a grasp of institutional life and its problems. This included the perspectives of inmates, staff and managers, and a grasp of the managerial processes, and pressures within an organization putatively dedicated to caring and curing. Three particular elements of the account which will be presented drew on this reservoir of “modern” experience, the conception of inmate adjustment and protest, the idea that early institutions were not actually curing their inmates, and a modern view of institutional organization.

Inmates could be seen as making a range of adjustments to institutional life. Some were in a permanent state of protest, others protested sporadically, or reached an uneasy truce with the institution. Yet others made a satisfactory life by accepting the regime, and their lunatic position, and co-operating with the staff. This variability of inmate adjustment has rarely been discussed, though Nancy Tomes’ study of Kilbride’s moral therapy regime at the Pennsylvania Hospital, James Mills’ account of the “native only” asylums of British India, and Erwin Goffman’s classical account of the inmate “underlife” of a modern asylum have paid attention to this issue.⁹ Such accounts are important in moving away from a uniform vision of institutional life to a conception of inmates with varying needs, and propensities, interacting with regimes which, though routine, were capable of a degree of flexibility, or manipulation.

In the present project the concept of protest allowed an otherwise mute inmate group to be given a voice, albeit one inferred from their behaviour by the writer.¹⁰ This

concept was extended to cover relatives and parishes, and those less directly involved with the institution such as parliament and the press.

Two “modern” conceptions were used to conceptualize the issue of cure. The first was that a proportion of mentally disturbed individuals are known to spontaneously remit in the absence of any recognizable ‘treatment’.¹¹ The second was the argument that organically based medical approaches do not actually ‘cure’ mental disorders, but simply interfere with their symptoms.¹² The point here was not to view institutional beliefs and practices from a modern perspective, but to act as a devil’s advocate by asking what was going on if the inmates were not being cured. This led to a fruitful questioning of gubernatorial claims that the institutions were places of care and cure, rather than coercive confinement, and to the conception that confinement was being re-constructed as care and cure. This clearly owed something to Foucault’s argument that madness was reconstructed at different historical periods.¹³ Essentially it argued that simple acceptance of institutional claims to cure must be questioned, even if believed by the institutional governors, a position rather similar to the view of witchcraft and magic taken by modern historians, few of whom would accept past ideas concerned with such practices at face value.¹⁴

The third modern perspective was concerned with organizational functioning, as discussed in published literature¹⁵ but, more directly, as experienced by the writer as a National Health Service manager. This led to a focus on institutional organization, and on practices such as decision-making, staff recruitment, monitoring, control, and financial management.

Although the importation of modern concepts into historical accounts can be criticized as “presentism,” to examine the management of early institutions for the mad in these terms is not to insist that it is ‘how it was’ to those involved. As Fulbrook has suggested, historical accounts have to be intelligible to those in the present:

...there is no reason in principle – in fact quite the reverse – to argue that historians should not also impose their own later categories and concepts for understanding the past in terms which contemporaries might not have recognised as valid.¹⁶

As noted in Chapter 1 the analytic approach adopted, though not planned, could be seen as a form of discourse analysis. Burr's broad definitions of 'discourse' captured this emergent conception well:

A discourse refers to a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events. It refers to a particular picture that is painted of an event, person or class of persons, a particular way of representing it in a certain light.¹⁷

Burr's definition of "text," similarly, embraced the expression of a discourse in a wide variety of modalities, including material objects and processes:

A discourse about an object is said to manifest in texts – in speech, say a conversation or interview, in written material such as novels, newspaper articles or letters, in visual images like magazine advertisements or films, or even in meanings encoded in the clothes someone wears or the way they do their hair. In fact anything that can be 'read' for meaning can be thought of as being a manifestation of one or more discourses and can be referred to as a 'text'.¹⁸

However, in keeping with Parker's evolutionary conception of discourse analysis, no rigid formula was followed:

Instead of trying to construct a discourse analytic machine which we could then use to shred all varieties of text, we have presented 'ways of reading' that may be useful and which will have to be adapted and modified for other circumstances. When we show you these examples, we also want to make clear some of the interpretative activity that researchers have to engage in as they develop a 'method.' Every discourse analytic researcher has to go through that process of arriving at an appropriate method if he or she is to be true to the text.¹⁹

2.2 The Analysis

2.2.1 Introduction

The data collection phase produced a large volume of material and the analytic method evolved from the need to handle this, while illuminating the research questions. In this section the analysis will be outlined as it evolved. Additionally specific examples of each stage of the analysis will be presented in Appendix 3.

2.2.2 Coding

Initially, examination, and coding, of discrete segments of the material was carried out for each institution. This derived from the initial coding phase of a grounded theory project²⁰ and ensured that the segments were closely read for recurrent themes which could then be individually analyzed. What constituted a segment could vary from a single word to a complete minute, or other statement. Larger passages of text, for instance a body of rules, were generally broken down into subsidiary units for coding, though they could, simultaneously, be coded for their overall significance. Several codes could also be assigned to a particular segment if it appeared to have a number of meanings.

Codings were intended to reflect the intention inherent in the text segment, what it was designed to achieve, and often involved a degree of abstraction. For example, a minute detailing a contract for the purchase of meat might be coded in terms of caring for inmates, or staff, but also as part of a financial control system for purchasing supplies which balanced price, quality and consistency of supply. Broadly, the size of each text segment was decided by whether it was thought to encompass a discrete intention, or action.

During coding the records were not taken to reflect some un-interpreted historical reality, but as accounts produced for particular purposes. This was consistent with Charmaz's suggestion that such material should be interrogated with general questions such as:

- “What are the parameters of the information?
- On what and whose facts does this information rest?
- What does the information mean to various participants or actors in the scene?
- What does the information leave out?
- Who has access to the facts, records, or sources of the information?
- Who is the intended audience for the information?
- Who benefits from shaping and/or interpreting this information in a particular way?
- How, if at all, does the information affect actions?”²¹

Although the internal practices of the institutions, and their gubernatorial ethos, were the primarily foci, where possible additional material was collected in the form of plans, prints, photographs, city guides, newspaper reports, records of visits, literature

and drama. Resources did not permit this to be gathered as systematically as the institutions' records, but it assisted their interpretation within their context, and supplemented reading on contemporary views of madness. The 'internal' analysis of institutional records thus took place with an awareness of their local and national context.

In addition to its inherent meaning each text segment was also coded for its 'modality', in order to ensure that due attention was given to material objects and processes, to interpersonal processes, and to textual processes such as record keeping. The 'modality' categories were as follows:

- **Material modality:** This coding of material objects and processes, derived from Hall,²² and indicated whether the text segment related to "fixed elements" of the environment such as buildings, or windows, "semi-fixed" elements such as water supplies, or cooking equipment, or "non-fixed" elements such as furniture, clothing and so on. For instance, routine purchases of 'physic,' a non-fixed element, could be seen as part of a broader pattern of medical activity which helped to present the institution as devoted to cure.
- **Relational modality:** This coding was applied to interpersonal processes, which could involve governors, staff, inmates, relatives, tenants, suppliers and so on. For example it would be an element in coding a minute referring to a supplier who had been required to attend a meeting of governors to explain himself, after complaints had been made about his goods.
- **Textual modality:** This coding was used to ensure that records, books of rules, accounts and so on were recognized as having functions which went beyond their obvious content. Thus, material from an account book, as well as indicating that a payment had been made, would be given this coding so that its function, as part of processes of financial recording, monitoring and control, was recognized.

In addition to the coding process memos were used to record additional observations on the text segments. These highlighted the underlying processes exemplified by the segments, allowing additional, and subsidiary, codes to be elaborated. This allowed

the analysis to move from simple description to a more sophisticated grasp of institutional processes, and to questions which could be explored further as the analysis proceeded.²³

Attention was also paid to the way institutional events and practices were described. For instance terms such as “hospital”, “poore lunatic”, or “cure” were seen as presenting the institutions positively, and as persuading the governors, and others, of their beneficial qualities. The term “rhetoric” has been used to describe such presentations, though it did not imply any formal rhetorical analysis, simply noting the use of persuasive language.

2.2.3 Sorting and Identification of institutional processes

The initial coding phase led to the conception of the material in terms of major themes which were consistent across the institutions. In the second analytic phase the coded material for each institution was sorted under these thematic headings, which comprised Care, Confinement, Piety and Commerce. This latter category was broadened during this phase to include material pertaining to the monitoring, and control of, staff, finances, purchasing, and so on, and was re-designated ‘Control and Commerce.’

The process of sorting the material began to elucidate specific practices associated with the different themes, generating categories and sub-categories associated with them, which were further refined through memo-writing. At this stage the previous modality classification was abandoned, as it made sorting unwieldy and was, by this time, implicit in the analysis.

A further aspect of the sorting process was the identification of material running counter to an identified theme. For instance the theme of Commerce implied good commercial practice, but the sorting process also brought to light examples of bad practice, and malpractice, and these were separately grouped as a ‘challenged’ commercial theme. The outcome was that each of the themes acquired a ‘challenged’ version which recorded events arising from corruption, accident, negligence, external influences, direct resistance, and so on, which ran counter to the

prevailing theme. At the same time an attempt was made to examine the governors' response to such events, in terms of putting things right and preventing their recurrence, and repairing damage to their collective ethos. Thus, a dynamic picture began to emerge in which the governors' collective ethos both constructed, and was constructed by, institutional events and practices.

At this stage the thematic categories began to be conceptualized as "discourses", or ways of conceiving and constructing the internal world of the institutions, represented by their prevailing concepts, written texts, language, rules and practices.

A further conception which began to emerge at this stage was a distinction between the 'content' of the governors' ethos, represented by the discourses described above, and the mechanisms of formation, maintenance and change of this ethos. Material concerned with this subsequently became the subject of chapter 3.

2.2.4 Amalgamation of institutional material and the construction of explanatory narrative

The final phase of the analysis amalgamated the material for each institution into a view of the institutions as a whole. Thus, practices within each institution which had been grouped together under the thematic headings were combined with similar practices in the other institutions. This involved some redefinition of category content and boundaries, and the creation of new categories. As this occurred more general explanatory narratives concerning specific aspects of institutional practice emerged, which drew on this amalgamated material, and these were progressively integrated into the comprehensive model of institutional functioning reported in chapters 4 to 7.

Notes to Chapter 2

1 Howell, M & Prevenier, W. *From Reliable Sources: An Introduction to Historical Methods*. Ithaca: Cornell University Press, 2001, pp. 57-68.

2. e.g. Shafer, R. J. ed. *A Guide to Historical Method*. Third Edition. Homewood, Illinois: The Dorsey Press, 1980, p. 120, pp. 171-172.

3. Ibid. p. 172.

4. Tosh, J. *The Pursuit of History: Aims, Methods and New Directions in the Study of Modern History*, 5th Edition. Harlow: Pearson, 2010, pp. 120-121.
5. e.g. Jenkins, K. *Re-Thinking History*, London: Routledge, 2003. pp. 14-15.
6. Fulbrook, M. *Historical Theory*. London: Routledge, 2002, pp. 105-6.
7. Ibid. p. 104.
8. Geertz, C. *The Interpretation of Cultures: Selected Essays*. New York: Basic Books, 1973. The edition published under the same title by Fontana, London, 1993 was used here. p. 10.
9. Tomes, N. *The Art of Asylum Keeping: Thomas Story Kirkbride and the Origins of American Psychiatry*. Philadelphia: University of Pennsylvania Press, 1994. Mills, J. H. *Madness, Cannabis and Colonialism: The 'Native Only' Lunatic Asylums of British India, 1857-1900*. London: Macmillan Press Ltd, 2000; Goffman, I. *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. Harmondsworth: Penguin Books, 1961.
10. For a discussion of voice and viewpoint see Berkhofer, R. F. Jr. *Beyond the Great Story: History as Text and Discourse*. Cambridge Mass: Belknap Press of Harvard University Press, 1995, Chapter 6, pp. 138-169.
11. The issue of spontaneous remission is not well dealt with in the literature, but see: Macalpine, I. & Hunter, R. Porphyria and King George III. *Scientific American*, 1969, **221** pp. 38-46; Suin, R. M. *Fundamentals of Behavioural Pathology*. New York: Wiley, 1970. pp. 365; Rachman, S. J. The effects of Psychological Treatment. In H. D. Eysenck (ed) *Handbook of Abnormal Psychology*. London: Pitman Medical, 1973, pp. 805-819; Coles, E. M. *Clinical Psychopathology: An introduction*. London: Routledge, 1982, pp. 376-378; Suin, R. M. *Fundamentals of Abnormal Psychology*. Chicago: Nelson-Hall, 1984, p.362.
12. Johnstone, L. *The Limits of Biomedical Models of Distress*. In D. R. Double, ed, *Critical Psychiatry: The limits of Madness*. Basingstoke: Palgrave Macmillan, 2006. pp. 81-98.
13. Foucault, M. *Folie et Dérison: Histoire del la folie à l'âge classique*. Paris: Librairie Plon, 1961. Published in an English translation as *History of Madness*. London: Routledge, 2006. This translation has been used for the present analysis.
14. Fulbrook. op.cit. p. 84.
15. e.g. Agyris, C. *Integrating the Individual and the Organization*. New York: Wiley, 1964.
16. Fulbrook. op.cit.. p. 86.

17. Burr, V. *Social Constructionism*. Second Edition. London: Routledge, 2003, p. 64.
18. Ibid. p. 66.
19. Parker, I. Introduction. In: I. Parker & the Bolton Discourse Network. *Critical Textwork: An introduction to varieties of discourse and analysis*. Buckingham: Open University Press, 1999, p. 2.
20. Charmaz, K. *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. London: Sage Publications, 2006, pp.47-57.
21. Ibid. pp. 37-8.
22. Hall, E. T. *The Hidden Dimension*. Garden City: Doubleday, 1966, pp. 97-105.
23. Charmaz. op. cit. pp. 73-79.

CHAPTER 3

THE GOVERNORS AND THEIR ETHOS

3.1 Introduction

The general managerial pattern, during the period sampled, was of a group of “governors” with responsibility for each institution. Each governing group generated a collective ethos comprising beliefs, values, and practices concerned with the purpose, and management, of their institution. This chapter will, first, suggest mechanisms by which this ethos was formed, stabilised and protected against challenge. Following this, mechanisms by which the collective ethos could undergo controlled change, by collective consent, will be examined.

What will be presented is a “normative” account, from which occasional deviations will be noted. The external social context has largely been “bracketed”, the aim being to elucidate the inner workings of the institutions, rather than to explain their existence in terms of external forces. However, external factors did impinge on the governors’ ethos in ways which require acknowledgement, as they produced change. One example will be given here, that of benefactions, which supported their ethos. Additionally, appendix 1 will provide a brief account of the social origins and affiliations of the governors of three of the sampled hospitals.

Although the generic term “governors” will be used, some were, initially, “executors”, or “trustees”, those of the French Hospital “directors” or “commissaires,” and those of St. Peter’s Hospital “guardians”.

3.2 Formation and Maintenance of the Governors’ Ethos

3.2.1 Introduction

This section will argue that the governors’ collective ethos was formed and maintained through:

1. Prescriptions of the institutions founders.
2. Charters of Incorporation.
3. Regular meetings.
4. Integrative collective practices.
5. The selection and induction of new governors.
6. Maintenance and protection of a documentary “memory.”
7. Institutional buildings.

3.2.2 The Prescriptions of Founders.

Founders influenced their institutions in a number of ways, which can be seen as additive. First by transmitting their own beliefs, and values, to those responsible for bringing an institution into being. More proximally, founders could have a personal involvement in its foundation. Further, they could provide material resources, in some cases amounting to an actual building. At the most proximal level a fully functioning institution could be provided, together with a set of managerial rules.

At the first level, of distal influence, the first Bethlem Hospital, and the French Hospital provide examples.

Bethlem Hospital was not founded as an institution for the mad, and there is no indication that Simon FizMary, its founder, intended anything beyond lodging the Bishop of Bethlehem, and his staff, when in London, and the erection of a church, or oratory.¹ However, something of his original charitable intention persisted, and he made the later institution a material possibility by his original gift of land and buildings.

Similarly, the prime mover of the French Hospital was a single individual, Jacques de Gâtigny, a French Protestant who had fled from France to Holland to escape religious persecution, and who is reported as having come to England in 1688 as William of Orange’s Master of Buckhounds. His 1708 bequest was of £500 to the London Pest House, by then a hospital, to build additional lodgings for needy Huguenots, and a further £500 to provide revenue for beds, linen, clothes and other necessities.² It proved impossible to implement Gâtigny’s wishes, as the city of

London refused to sell the necessary land, and the bequest was invested until 1716 when land adjoining the Pest House site was leased from the Ironmonger's Company.³ The project had, by then, grown into the building of a separate hospital for French Protestant refugees. This could not be funded from Gâtigny's bequest, necessitating an appeal for donations, which amounted to £2,372.16.0 by the time the hospital opened, in November 1718.⁴

Gâtigny made no specification that the enlarged Pest House should house lunatics, whereas the minutes of the Committee for the Distribution of the Royal Bounty for 3rd March 1716 read:

L'importance et la nécessité d'un tel Hospital pour les Pauvres François Refugiez sont manifestes et sensibles. Combien de Personnes ou affligées dans leur Esprit. Ou attaquées de maladies longues & incurables, ou accablées de vieillesse & d'autres infirmités trouveront là une retraite et de secours qu'il seroit difficile de leur procurer autrement?⁵

[The importance and the necessity of such a hospital for poor French refugees are clear and obvious. How many people whether mentally afflicted or attacked by long and incurable illnesses, or weighed down by age and other infirmities will find refuge and help there which it would be difficult for them to obtain elsewhere?]

Thus, the founders of lunatic care of the hospital can be seen as comprising Gâtigny, the Committee for the Distribution of the Royal Bounty, which built the hospital and decided to admit lunatics, and those who responded to the appeal for additional funding, allowing the hospital to be built.

At the next level founders could transmit their beliefs by personal acquaintance with the original governors of institutions, and through personal involvement in their material construction. This was the case of St. Peter's, the first St. Luke's Hospital and the first Newcastle Lunatic Hospital.

St. Peter's was not founded as a lunatic hospital, or even a hospital, but as a workhouse; though it progressively became a hospital, with an institution for the mad gradually growing out of it. Butcher recorded that the passing of the 1696 Bristol Poor Act led to its opening. The Act was largely the brainchild of John Cary a Bristol merchant who, in a number of highly moralistic tracts, campaigned for a

workhouse to serve the Bristol parishes. It led to the establishment of the Corporation of the Poor, in which Cary was an active participant, and whose beliefs permeated its early days. This was funded by the pooled poor rates of the Bristol parishes, and administered by a court of guardians elected by their residents. The Corporation quickly established a workhouse for female children, followed by the purchase of the building which eventually became St. Peter's Hospital. Although nominally a workhouse it gradually became a repository for the aged, impotent and insane.⁶

The first St. Luke's Hospital was a dedicated lunatic institution founded by six men, who became members of its first management committee, and had a major role in its construction, and in producing its rules and practices. In the mid-1750, they produced a document entitled "*Considerations upon the usefulness and necessity of establishing an Hospital, by subscription, as a further provision for Poor Lunatics*" which detailed the conditions for subscribing to the project.⁷ Each subscriber was granted a governorship of the hospital, a benefit which was characteristic of the subscription hospitals for which the eighteenth-century was notable.⁸ "*Considerations*" can be seen as a complex piece of rhetoric, emanating from the original six founders, and serving to attract funding, and to kick-start the collective ethos of subsequent governors, as well as feeding back into the broader social circles of the population of London through its wide dissemination in the newspapers.⁹ Similarly, the blueprint for the first Newcastle hospital was generated by a group of donors and subscribers, the latter arranging its first accommodation and becoming its first governors.¹⁰

Guy's Hospital represented a further level of founder influence. Guy died on 27th December 1724, before his hospital was completed and two founding "texts" simultaneously passed to his executors, who subsequently became governors. The first was a material one of a virtually complete and "modern" hospital building. The second was Guy's will, which detailed the administrative structure to which the governors were to adhere, and the arrangements for funding the hospital. His executors were enjoined to complete the hospital and admit up to four hundred patients who, because of doubts about their curability, or the time cure would take, were ineligible for admission elsewhere. This number included:

Lunaticks, adjudged or called, as aforesaid incurable, not exceeding Twenty in Number at one time; such poor Persons to be chosen and appointed by my said Executors and Trustees, out of such Patients and Persons who shall be discharged out of the Hospital of St. Thomas, or Bethlehem, or other Hospitals, on account of the small Hopes of their Cure, or the great length of Time for that purpose required or thought necessary and on such or any other account, adjudged and called Incurable, and not fit to be continued in the said Hospital of St Thomas, or Bethlehem, or other Hospitals: Or such other poor sick Persons, or Lunaticks, as under such or the like Circumstances, shall apply to my said Executors and Trustees for Relief, at the Discretion and Pleasure of my said Executors and Trustees.¹¹

However, while Guy intended, from the outset, that twenty “incurable” lunatics were to be inmates of his hospital, the lunatic house was not built until 1727.

The next level of founder influence can be seen as occurring when governors were handed fully functioning institutions, along with their practices and, at least implicitly, their rules. Three of the institutions sampled can be seen as falling into this category, Bethlem Hospital, the second Newcastle Lunatic Hospital and the Bethel Hospital.

When the governors of Bridewell Hospital took over the management of the small Bethlem Hospital, in 1557, they inherited a functioning hospital for the mad, with ingrained practices and implicit rules, but one that bore no significant traces of its founder beyond a name and a vaguely charitable intent. On this they gradually brought their own ethos to bear but, at least initially, adopted a markedly “hands off” approach which will be presented, in Chapter 4, as significant for the later development of institutions for the mad.

Again, the practices of the first Newcastle Lunatic Hospital probably formed a founding text for the purpose-built second hospital which was, again, a subscription hospital, with a minimum subscription of a guinea a year, a governorship being conferred by each subscription and continuing as long as it was paid.¹²

Finally, the Bethel Hospital brought all these foundational influences together. It was built, at her own expense, by a Norwich widow, Mary Chapman, in 1713, as an institution for lunatics. Following the death of her husband, who was rector of

Thorpe, near Norwich, and consistent with his wishes, she is recorded as having erected:

....a House in the Parish of Saint Peter of Mancroft in the City of Norwich for ever thereafter to be used and employ'd for the convenient reception and Habitation of Lunaticks willing and appointing the same to be called Bethel according to the advice and desire of the said well beloved Husband and did commit the care and government thereof to a Master under the direction of seven Trustees maintaining several poor lunatics therein at her own Expence during the time of her Life and at her decease.¹³

In this account she was constructed as a pious and faithful wife and the “*House*” as the site of a miraculous event, as Bethel was the place where the dream of Jacob occurred.¹⁴ The writer of the above account suggested that she lived in the Bethel at some time during her last years and instructed its Master in how she wished the lunatics cared for:

....the said Mary Chapman having observ'd that abuses of several kinds had been committed in the said House by & through the default of the Master thereof for the regulating of all abuses & for the better governing of the said House she for some years dwelt therein & from time to time gave such Instructions to the Master thereof as occasion required and did so continue to do until the day of her Death.¹⁵

She died in 1724 and, at this point, a second foundation occurred as the main part of her will placed the management of her functioning institution in the hands of seven named trustees, and gave extensive instructions for their running of it, amounting to the rules and regulations typical of other institutions for the mad. Her will also gave her reasons for founding the institution, noting that God had afflicted some of her relatives with lunacy, but had left her reason intact, in thanks for which, and consistent with her husband's wishes, she felt impelled to create an institution for the care of such disturbed individuals who were devoid of other resources.¹⁶

As well as being a major factor in the formation of the governor's collective ethos founders often maintained a continued symbolic presence for the governing body, staff and public, in the form of statues, portraits, insignia, and other representations. These made them materially present in the institution, particularly in the rooms in which governors met. They could, perhaps, be seen as overseeing the activities of governors, constructing a creditable history, legitimating their activities, and

reminding them of the original purpose of the institution, and their responsibility to maintain this.

The Bethel Hospital was particularly notable in this respect, Mary Chapman, being materially present in numerous aspects of the institution. For example, she left each trustee twenty shillings to buy a ring to remind them of her, and an annual expenses payment of twenty shillings. Her hospital was also named to symbolise a miraculous event and contained a variety of biblical texts and inscriptions specified in her will, the building being, in a sense, written on by her.¹⁷

Despite these symbols the trustees clearly wished for a more personalised presence and, in 1756, had a portrait of her painted, which was probably placed in the room in which they met. She would, if this was the case, have looked down on their deliberations from a higher position, and reminded them of the trust she had placed in them.¹⁸

Thomas Guy's trustees also had memorial rings to remember him by and, in July 1730, a portrait of him was commissioned, presumably to hang in the court room. Like Mary Chapman, he would have kept watch over the proceedings there. The 1725 Act of Incorporation, which he had urged on the governors, also permitted them to erect a monument to him at the charge of his estate, and a statue, in brass, was ordered to be made, in March 1731.¹⁹

Somewhat more dubiously, the governors of Bethlem, when the second hospital was nearing completion in 1675, inserted into its façade the arms of Henry VIII as well as those of the reigning monarch, Charles II, and the city of London. Henry was thus credited with having given the hospital to the city and the three sets of arms created a convenient narrative of past and present royal, and city, support of the institution.²⁰

Significant officers who were held to have acted creditably were also given a material presence in the institutions, again associating them with individuals of virtue and status. For instance, in November 1786 the governors of St. Luke's resolved to approach the Duke of Montagu, the first president, to sit for a portrait to hang in the committee room of the second hospital.²¹

Benefactors also signalled support of governors' activities and contributed to the maintenance of their collective ethos. They were commonly memorialised in books devoted to donations and legacies, as in the case at the Bethel Hospital under its 1765 Charter of Incorporation.²² More accessibly, they could be memorialised on plaques placed in prominent positions in the institution, as at Bethlem. This could be seen as a means of generating further donations and legacies, but such public acknowledgements could, again, be seen as giving benefactors a watching brief over the conduct of the governors.²³

3.2.3 Charters of Incorporation

Charters of Incorporation were granted by parliament following a petition by those given long-term administrative responsibilities by a will. Charters changed their status from legally liable individuals, confined to the minutiae of a will, to a corporate entity with full financial and legal power to manage their corporation according to its specified aims. They could name themselves, and their corporation, make whatever rules they thought necessary for its management, and use a common seal. While these charters could be seen as simple managerial conveniences, they can also be seen as contributing to the binding of institutional governors into a corporate entity with a single ethos and a single, symbolic, seal.

Three of the institutions in the sample sought Charters, though under different circumstances. The trustees of the Bethel Hospital pursued their charter some forty years after the founding of the hospital, while the executors of the founding bequests of the French Hospital, and Guy's Hospital, sought theirs while their hospitals were being established. As the Charters followed a common pattern, that of the Bethel Hospital will be used as an example.

On 10th December 1764 its trustees agreed to seek a Charter of Incorporation, and established a committee of three to achieve it.²⁴ On 8th June 1765 it was granted. After reiterating the conditions of Mary Chapman's will the trustees were created "*one Body Politick and Corporate in deed and in Name*" in control of all the assets of the institution, and given the title "*Governors and Guardians of the Hospital*

called Bethel in the City of Norwich of the Foundation of Mrs Mary Chapman for the Relief and Assistance of poor Lunaticks.” In a manner typical of such documents they were granted corporate legal powers and responsibilities, symbolised by their use of a common seal.

The charter went on to require them to meet in the hospital monthly and gave them power to admit and discharge inmates, to elect committees for particular purposes, hire and fire staff, pay them such salaries and wages they thought appropriate, and make such rules as were useful to them for the government of the hospital.

The newly termed governors were allowed to elect a treasurer, and to require of him any security they saw fit. He was to serve for three years, unless they saw cause to the contrary, and was to receive, and receipt, all income, pay the hospital’s disbursements, and be subject “*to such Inspections Examination and Controul*” as the governors saw fit. Finally, benefactors’ names, and the nature of their benefactions, were to continue to be entered in the book kept for that purpose.²⁵

Though not having a Charter, it should also be mentioned that the guardians of the poor, responsible for St. Peter’s Hospital, were constituted in a rather similar way by the 1696 “*Act for Erecting of Hospitals and Workhouses within the City of Bristol, for the better employing and maintaining the Poor thereof.*”²⁶

3.2.4 Regular Meetings and Procedural Controls

The ethos of the governors was also formed, and consolidated, by regularly meeting and making collective decisions. However, dissident governors could attempt to form an alternative ethos, for instance by regularly attending court meetings when the attendance of others was lax, achieving election as officers, or engineering the passage of resolutions and rules reflecting dissident views. It will be suggested below that procedural controls for meetings prevented serious challenges to the prevailing ethos, and enabled its repair when damaged by successful assaults. These controls covered the legitimacy of meetings, the election, conduct and service of officers, rules for conducting meetings, and the right of ordinary members to initiate them.

A means of making it difficult for a dissident group to gain power was to ensure that enough governors attended meetings to ensure the dominance of the majority's ethos. This could be achieved by notifying governors of forthcoming meetings in good time, and by setting a minimum attendance level likely to guarantee this dominance. The first point was illustrated by the 1792 Rules and Orders for the Bridewell and Bethlem Hospitals, which detailed that governors should have at least a week's notice of meetings:

.....that due notices of every Court, and of the business or motion then to be considered, be always inserted in the summons; and that all summonses be issued at least one week before every Court-day.²⁷

The second point was illustrated by the 1751 rules for St. Luke's Hospital which required "*that every General Court shall consist of thirty Governors at least.*" for decisions to be legitimate.²⁸

Governorships were normally for life, though, in the case of the Newcastle Hospital, this depended on paying the annual subscription. The governors met regularly and created officers to carry out particular functions, normally a president and a treasurer, though auditors, and other officers, were sometimes appointed. In terms of the protection of the collective ethos three points should be made. First, officers were empowered to act on behalf of the collective body by being elected, sometimes by a "ballot", implying a degree of secrecy which would avoid pressure on individual governors by dissident factions. Second, the danger of a dissident ethos taking hold was commonly guarded against by the election of officers for fixed periods of time, enabling their removal if incompetent, or dissident. Third, for the same reasons, officers could generally be removed at the collective wish of the governors.

The simplest example of this pattern was that of St. Luke's Hospital, where the Rules and Orders required annual election of a president, four vice-presidents, a treasurer, and a general committee from the governor body, together with other "*officers*" who were not governors.²⁹ Again, the rules for the Newcastle Lunatic Hospital allowed "*THAT all Elections and Resolutions, be determined by Ballot, if demanded by two or more of the Governors present....*"³⁰

The mechanism for removing unsatisfactory officers, or directors, was illustrated by the 1718 rules for the French Hospital, which allowed their dismissal, and replacement, for just causes:

Tous les Officiers de la Corporation, comme aussi tous Directeurs pourrent être destitues pour des justes causes, et d'autres nomme en leur places.³¹

[All the Officers of the Corporation, as well as all the Directors could be dismissed for just causes and others named in their places.]

Specific rules for meetings ensured that individual governors had a right to be heard, but that they could not dominate the meeting, or attempt to impose any idiosyncratic agenda. This was well illustrated for St Peters Hospital, by the 1696 procedural orders for Corporation of the Poor. For example:

3. That when any Member hath a desire to speake he shall decently stand up at his place, and shall address his speech to the Person in the Chair, and to no other.

4. That if Two or more Members shall stand up to speak to the present business; that Member which the Person in the Chair shall observe and declare did Stand up first; Shall have precedency of Speaking unless the Court be of another opinion.

5. That no Member shall speak before the other that is speaking, shall have fully ended his speech.³²

Such rules included control of the chairman, who was in a powerful position to control who could speak. For instance, the Rules of the Newcastle Lunatic Hospital stipulated:

THAT all Questions be fairly stated by the Chairman; that he shall not refuse to propose any Question...³³

Additionally, a number of the institutions had rules which ensured that existing Rules and Orders could not be changed without proper debate, and reflection. For instance, those for St. Luke's were particularly stringent:

...none of these Rules and Orders be repealed, but by a General Court of Governors, in which fifty at least shall be consenting thereto. Or the Majority of that and the next succeeding General Court.³⁴

Institutional rules sometimes allowed ordinary governors to call extraordinary meetings. While this could be seen as a response to urgent business, it could also be a mechanism for ensuring that officers could not prevent discussion, allowing the dominant ethos to be maintained, and asserted, in the face of officer intransigence. Rules for St. Luke's, for instance, allowed any twelve governors to request an extraordinary general court.³⁵

3.2.5 Collective Symbols and Practices

The collective ethos of governors was also formed by material symbols which represented them as a group, and by practices in which they collectively engaged. Materially, the use of a common seal has already been mentioned, and this normally bore a symbol of the institution, or its aims.

Governors most often met together at court meetings, and the reading of minutes at the start of these meetings, while clearly practically necessary, can also be seen as a mechanism which moved them from external reality into the ethos of the collective. Records of St. Luke's Hospital, for example, consistently noted that the minutes of the preceding court had been read:

The minutes of the former meeting were read and confirm'd except as to the Sum of One Thousand Pounds.³⁶

Similarly, General Assembly meetings of the French Hospital began with a collective prayer urging the care of the needy, and ended with a blessing.³⁷

The first Bethlem Hospital, and the French Hospital, had annual sermons preached, together with a collection, Bethlem's occurring at the regular round of Easter Spittal sermons. The material for this was provided by the court of governors, and typically, constructed the lunatics as needy and suffering, and the hospital as a place of care and cure, though, itself, suffering from lack of income, and a fit object of charity:

This hospitall is of great antiquitie and necessitie for keeping and curing distracted persons whoe are all of the most miserable by reason of their wants both both for soule and body and have noe sence thereof. That the charge thereof is very great there being kept and mainteined with diett phisicke & other releife 44 distracted persons

continually at least and the rents and revenues thereof very small not amounting to two thirds of the yearly charge and therefore is a fit object of Charity.³⁸

Annual governors' dinners were a feature of St. Luke's Hospital from its inception. At the general court on 26th June 1751, with the hospital nearing completion, it was agreed that the governors should dine together, but that no French wine was to be drunk, presumably a reflection of a political situation which would shortly lead to war.³⁹ In December 1751 it was suggested that the dinner should be preceded by a sermon. However, it appears that no bishops could be found to lend themselves to this proposal, and it was dropped.⁴⁰ However, as a further consolidation of the collective ethos, in February 1753, it was ordered that a report on the state of the hospital should be printed, and a copy given to each governor at the dinner. These reports became a regular feature of the dinner and contained information on the hospital's financial state, as well as inmate admissions and discharges during the preceding year, and from the hospital's inception.⁴¹

Other special collective gatherings took place in connection with new hospital buildings. For example, the laying of the first stone of the second St. Luke's Hospital by the Duke of Montagu, on 30th July 1782, was celebrated by the governors moving their annual dinner to that date. The Duke was to have joined them, but declined the invitation as he had to meet the king at Westminster. A smaller celebration took place during the laying of the stone, as fruit and wine were provided for the president and governors, and ten guineas was distributed amongst the workmen.⁴²

Another collective privilege, often available to the governors of subscription hospitals was the right to propose inmates for admission. However, the only formal arrangement of this sort, in the present sample, was at Guy's Hospital, where lunatics could only be admitted after nomination by a governor. The original system is obscure but, in January 1737 it was changed as follows:

.....from this time to the future all such nominations shall be first by the President next by Mr Treasurer and then by the Executors of the worthy Founder Thomas Guy Esq and the Governors named in his Will in the order they are there named & then by the other Governors as they stand in priority of Election.⁴³

3.2.6 *The Recruitment and Induction of New Governors*

New governors could, potentially, pose a threat as they could import discrepant ideas. Care was therefore taken to recruit those sympathetic to the prevailing ethos. Suitable candidates might be invited to become governors, or might have to demonstrate their sympathy with the collective ethos by making a donation, or subscription. New governors might also be “inducted” into the collective ethos by the enactment of a formal ritual or, materially, by being given a copy of the institution’s rules, or a staff marking their membership of the governor group.

The recruitment and induction of governors of Bridewell and Bethlem Hospitals, in the early years of the nineteenth-century, illustrated these procedures in their most extensive form:

The President for the time being has the privilege of appointing two Governors annually, and the Treasurer one; and every Governor having served as Steward has the right of nominating one person, for a Governor; but all persons, so nominated or proposed for any other reason, are to be approved, first by the Committee, and afterwards by the Court, before they be chosen; but no staff is to be sent to the person so nominated, until he shall have given a benefaction, to one or both Hospitals, of 50*l.* at the least; and no person is in future to be put in nomination to be a Governor of these Hospitals on account of a benefaction, unless such benefaction shall amount to the sum of 100*l.*⁴⁴

Two other important elements of this process can be seen in an earlier rule requiring new governors to be given a copy of the standing rules and orders, representing the existing ethos, and that their “*charge*” should be read to them by the chaplain in open court, with “*all imaginable solemnity.*” This was, effectively, an oath to abide by the collective gubernatorial ethos, and constructed the new governor’s role as a quasi-religious obligation to care for, and reform, the mad and misguided, through a process of remedial confinement. The first section of the charge read:

YOU have been elected, and are come to be admitted a Governor of the Royal Hospitals of Bridewell and Bethlem; a station of great honour and trust, which will afford you many opportunities of promoting the glory of GOD and the welfare of your fellow creatures: For in these Hospitals a provision is made for employing and correcting idle, vagrant, and disorderly persons, and educating poor children in honest trades; and also for maintaining and curing needy and deplorable lunatics.⁴⁵

The two subscription hospitals recruited their governors more democratically, anybody paying the required subscription being given this status, though subscribing presumably indicated some degree of approval of the governors' ethos. However, as at neighbouring Bethlem, St. Luke's governors were inducted by being given a copy of the rules, and a staff, though nothing resembling an oath was required.⁴⁶

The procedure for replacing governors at Guy's Hospital is unclear, but personal acquaintance, and sympathy with the governors' collective ethos were probably paramount factors. However, the Charter of Incorporation also provided a mechanism for maintaining a requisite number of governors if the existing court failed to recruit enough. The Lord Chancellor, or other government officer, could appoint suitable replacements if the number fell below forty, opening up a possibility that a dissident ethos, convenient to the government, could be imported into the existing collective. However, such a possibility would, presumably, have encouraged the existing governors to ensure that their number was maintained.⁴⁷

Uniquely, the ruling body of St. Peter's Hospital, the Corporation of the Poor, consisted of guardians elected by the city's ratepayers, and their collective ethos, though formed in their own court was, presumably, strongly influenced by this external group. However, the 1696 Act, which formed the Corporation, also permitted those donating £100, or more, to be elected as guardians, a civic office being open to purchase in this way. While such donors might generally be expected to be in sympathy with the collective ethos, and were likely to have been ratepayers, their election could allow dissident ideas to be imported into the existing collective. However, it was not binding on the guardians to elect such persons, or to allow them to remain, and some measure of control on such discrepant ideas was possible.⁴⁸

3.2.7 Collective Memory: Minutes, Rules and other Documents

Everyday reality persists through time in the memory, and actions, of those adhering to it, and in documents detailing the transactions which made, maintained, repaired and transmitted it. The records of the institutions considered here can be seen as

creating a material collective memory, the importance of which is shown by the means used to protect it.

A major part of this memory was formed by the minutes of governors' meetings and committees, and excerpts from these occur frequently in the present account. Another very significant element of the collective memory, and ongoing ethos, of governors was the generation of rules and orders for the governance of their institutions and staff. These generally formed part of the court minutes but were often, later, printed and periodically revised. As well as constructing an ideal pattern of behaviour, they can also be seen as arising from the need to deal with problems which breached the governors' prevailing ethos, being, in another sense, an accumulated history of repairs to these breaches, which attempted to prevent their repetition. Thus, rules, while expressing an ideal, also contained memories of staff misbehaviour, maladministration and other untoward events.

Many other documents such as financial audits, records of supplies and expenditure, and admission documents can be seen as part of an historical web forming the collective memory of the governors. These will not be examined here, but will be encountered throughout the present account.

The importance of the corpus of documents of the institutions was indicated by the lengths gone to to protect them. These attested to practical problems which would arise if documents were lost, stolen, damaged or fraudulently altered. However, as has been suggested, the documents also formed a complex web of collective memory extending beyond the living memory of the governors and giving their ethos an historical base and legitimacy in the actions, and values, of their forerunners and founders.

The Rules and Orders of Bethlem Hospital, for instance, required the Clerk to maintain the hospital's documents in a secure place, and forbade their removal from the hospital:

That all records, and antient books and writings of value belonging to the Hospitals, be collected together and arranged by the Clerk, and deposited in some secure and

suitable place; and not delivered or taken out of the Hospital without an order in writing from the President or Treasurer.⁴⁹

Even more stringency was shown in the 1718 rules of the French Hospital, which required that the charter, seal, titles of acquisition of the corporation, and keys of donation boxes, were to be kept in a coffer placed in view of the general assembly. This was to have two locks, and two keys, to be in the keeping of the governor (or deputy governor), and secretary, who were to bring, or send them securely, to meetings. The treasurer's account books were to be kept in a locked cupboard in the room in which the general assembly met, the secretary holding the key. If the secretary was unable to attend a meeting, the key was required to be sent to the general assembly "*securely*." Such provisions were, presumably, intended to prevent loss, theft, falsification, or unauthorised perusal, of documents, and multiple keyholders were a feature of some of the other institutions in the sample.⁵⁰

3.2.8 The Institutional Buildings

The institutional buildings were constructed by founders, and governors, to represent their ethos, and to turn it into a practical form in which care and cure could happen. Their buildings also contained their collective ethos in the form of the inmates, the resident staff, the governors in their managerial functions and the visitors who came to see the institutions and the inmates. The buildings also contained the means, and practices, of management, care and cure and, themselves, required ongoing care and cure. In their continuous adaptations, the buildings also contained a material history of the institutions.⁵¹

However, the buildings also constructed the governors' ethos. They mixed coercively confined inmates, poorly paid staff, in constant danger, governors attempting to implement their ethos, and visitors wishing to see the results. Further, they mixed these volatile elements in restricted spaces which, themselves, determined who could meet and communicate with whom, and the nature of such communications. Such a mix produced events which could not be foreseen and which required continuous changes to the governors' ethos and practices. Such changes

produced further unforeseen consequences, and so on, the gubernatorial ethos evolving to cope with these events, and never entirely stabilising.

3.3 Changes to the Governors' Ethos

Although issues of formation, and maintenance, of the governors' ethos have been emphasised in this account, it has also been suggested, above, that that this changed over time in response to unforeseen challenges.

The major formal mechanism by which changes in the governors' ethos could be seen was the process of making resolutions, particularly resolutions which gave rise to new rules and orders. There were particular controls on how resolutions could be made, and for their subsequent ratification. These, broadly, ensured that governors were given time to consider the matter in hand, that parties with a personal interest in it were not be able to unduly influence the discussion, that a fair vote took place when necessary, and that the chairman, as representative of the collective ethos should have a casting vote in the event of a tie. Additionally, as no vote was likely to be entirely unanimous, some institutions had rules which made clear that a properly agreed resolution was then binding on all members of the collective.

The rules for Bridewell and Bethlem Hospitals exemplified all but the last of these:

III. That notice of every motion intended to be made be given at a preceding Court; and that due notices of every Court, and of the business or motion then to be considered, be always inserted in the summons; and that all summonses be issued at least one week before every Court-day.

“XIX. That in all other cases, both at Courts and Committees, all questions be decided by the majority of Governors present; the President or Chairman to have a double or casting vote in case only of equality; and, if a ballot be required, that the Presiding Officer fix the commencement and duration thereof, so that the same continue at least one hour; but that no Governor interested in the question before the Court be allowed to vote.⁵²

Turning to the binding nature of resolutions, the rules for the Bethel Hospital provided an example of this, by indicating that four of the seven governors were sufficient to pass a resolution and make it binding on the others. That is, when the collective ethos changed, it changed for all concerned.⁵³

3.4 Conclusions

This chapter has outlined the processes through which the governors managing the sampled institutions formed, maintained and changed their collective ethos. Although they each imported an individual conception of their governing role, it was necessary for these to be welded into a collective view of their management task in order to run their institutions effectively. It was suggested that an important aspect of this process lay in the prescriptions left by the founders of the institutions, expressed in the form of expressed intentions, rules, buildings and practices. Further, founders often maintained a material presence in the institutions through depictions in portraits, statues, and other material forms such as inscriptions, or rings. Similarly, significant officers, or benefactors, could be memorialised to construct a creditable history, which legitimised the ethos of the existing governor body. Again, Charters of Incorporation, for some institutions, legally constructed the governors as a collective body rather than a group of individuals, and provided symbolic evidence of this in the form of a seal.

The process of meeting regularly, it was suggested, also contributed to the formation of a collective ethos, with controls on the conduct of meetings serving to protect this against infiltration by dissident, factional, ideas. Similarly, collective practices such as prayers, or dinners, helped to bind the governors into a cohesive group with a common purpose. Additionally a memory of the collective decisions of the governors existed in the form of minute books, and other records, and gave legitimacy to their current activities. The reading the minutes at the start of meetings helped to continually re-induct the governors into their collective ethos.

It was further suggested that new governors were subject to processes which both ensured that they were likely to be sympathetic to the prevailing ethos, and which symbolically inducted them into this. Finally, the institutional buildings represented and contained the governors, their inmates, staff, and practices and, materially, “remembered” changes in their ethos.

Although the above processes formed, maintained and protected a collective ethos, unforeseen events had to be continually dealt with. It was argued that such events

caused changes to the prevailing ethos, which could be monitored through the collective resolutions, and orders, of the governors, but that mechanisms were in place to ensure that such decisions were collectively made and binding on all members of the collective.

Having examined the formation, and maintenance, of the governors' ethos, and collective mechanisms for changing it, the next four chapters will each examine one aspect of its content in the form of the four discourses outlined in chapter 1.

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CHAPTER 4

THE DISCOURSE OF CONFINEMENT AND ITS CHALLENGES

I. The Discourse of Confinement

4.1 Introduction

The sampled institutions coercively confined their inmates, though this was seldom directly alluded to, except in the early days of Bethlem Hospital when such confinement was overtly justified as necessary for public protection or, at least, the protection of its proxy, the crown. Although public protection remained one justification for confinement, it will be argued that this was added to, and generally superseded by, a “rhetoric of care” which reconstructed confinement as protective care and, subsequently, by a “rhetoric of cure” which, further, reconstructed inmates as “sick”, and their confinement as directed to their cure. The outcome of these reconstructions was that confinement of the mad could be justified in a number of ways although putative “cure” progressively became dominant.

4.2 Public Protection as a justification for confinement

4.2.1 Introduction

No records were kept for Bethlem hospital until it was placed under the management of Bridewell, in 1557, and the earliest reports of admissions and discharges came from other sources, mainly from the Acts of the Privy Council.¹ However, there is a problem of whether these were typical of the general run of inmates, particularly as the Privy Council may have been using the hospital as a means of disposing of those who were politically embarrassing. However, early Bridewell records, although limited, showed a similar pattern of concern with worrying, objectionable, or dangerous, behaviour, a similar language of confinement, and an intention to confine lunatics until their behaviour improved. It seems reasonable to suppose, then, that the earliest justification for the confinement of the mad was public peace, propriety

and safety and, though such direct references to confinement waned over time, public protection remained a justification which could be drawn on when required.

It will be suggested in the next section that the Privy Council, in their disposal of those who were a threat, or embarrassment, to the crown, sent those suspected of being mad, to Bethlem, rather than imprisoning them in a more conventional manner. This implied that the mad were not considered culpable in the way that other wrongdoers were. This distinction between madness and badness appears to have continued after Bridewell assumed managerial responsibility for Bethlem, and could be seen as crucial to the later management of madness in England.

Bridewell Hospital was an imprisoning institution which inculcated virtues of work in the vagrant, work-shy, petty criminal, loose-living and young. Bethlem was a small institution, requiring effective management, and placing it under Bridewell's control was a logical step, as they both coercively confined those creating problems of public order. However, a question arises. Why did Bridewell, a large institution, not simply absorb Bethlem, a small one? Managerially, and economically, moving the lunatics to Bridewell would have made perfect sense. However, it was never suggested, nor apparently considered, and two related answers to the question suggest themselves, one moral and one practical.

Morally, Bridewell provided a reformatory programme for the socially disruptive, within a discourse of public order, culpability and the responsibility to work. However, lunatics, although they were as socially disruptive as Bridewell inmates, were not normally seen as morally culpable, and a reformatory work programme did not appear to apply to them. Further, even if this moral problem was overcome, most disturbed lunatics could not, practically, be made to work. Their idleness, and disruptive behaviour, would, therefore, have made Bridewell's atmosphere inimical to the conduct of a work programme. The problem presented by Daniel Ball, who was returned to Bridewell after a spell in Bethlem, in 1664, illustrates this disruption:

.....Daniell Ball lately sent from Bethlem to this hospitall is soe distempered that hee cannot be made to worke and that hee maketh such a noise in the night tyme that neither prisoners nor neighbours can take any rest Itt is therefore ordered by this courte that hee be sent backe to the hospitall of Bethlem.....²

Although it would have made managerial, and economic, sense to merge Bridewell and Bethlem, it would probably not have made moral, or practical, sense, and the two were kept separate. This could be seen as an important development (or non-development) which, for more than three centuries, affected the management of lunacy. An accredited body concerned with public order, and with the power to incarcerate, placed the mad into a category which clearly differentiated them from the morally culpable, and from the population at large, and placed them in a separate, dedicated, place of confinement. Almost by accident, an official “lunatic” category, separate from that of “criminal” appears to have been created by the pronouncements of the Bridewell and Bethlem court that individuals were to “be sent to Bethlem,” and the further legitimation of a specific building to which they were sent.

Clearly this is opposed to the accounts of Foucault and Doerner which stressed a pan-European “great confinement” which lumped together the mad, and other practitioners of “unreason.”³ The maintenance of Bethlem as a separate institution, it is suggested, may have set the pattern for the later English management of madness in institutions specifically dedicated to this, and separate from those managing “badness”.

4.2.2 Terminology

In April 1546 the Privy Council ordered the “release” of an unnamed Bethlem “prisoner” and the order gave the details of his offensive behaviour, his “committal” and “imprisonment.” His discharge appears to have been allowed more because he had been found to be harmless than from any consideration of his mental state.

“Release of a prisoner from Bedlam

_____ being committed to Bedlam for certeyne lewde wordes in tyme of his frenesey spoken agaynst the kinges Majestie, was discharged of that imprisonment in respect there appered no malice in him.⁴

Again, in July 1546, Richard Cleseman was also “sent” to Bethlem for lewd language and was to be “kept” there, presumably until his behaviour improved, although there were references to his lunatic and frenzied state.

A lunatic sent to Bedlam

Oone Richard Cleseman, of the Parishe of Lye in Surrey. Sent hither by Sir. Mathew Browne for lewde words, was sent to Bedlam to be kepte there for that he semed to be in a freneseye.⁵

The Privy Council continued to indicate a concern with publicly disruptive behaviour and to use Bethlem as one means of disposing of those who came to its attention for this reason. In 1630, for instance, a small gang which it supposed to be composed of those who were either lunatic, or counterfeiting lunacy, was ordered to be sent to Bethlem to be “*kept, ordered and looked into*”:

A letter to the Justices of the peace of the City of Westminster. Whereas there are certaine persons who run up and downe the streets and doe much harme, being either distracted or els counterfeictes, and therefore not to be suffered to have their liberties to range, as now they doe; of which persons one is called King Robert, another Doctor Owen and the third Mistris Vaughan: we doe hereby will and require you to see them all sent to Bedlam, there to be kept, ordered and looked unto, to which purpose wee sende you herewith a warrant directed to the Master and Matrone of Bedlame, for the receiving of them. An soe etc. Signed as the minute.⁶

The records of Bridewell Hospital, after it had taken over administrative responsibility for Bethlem in 1557, described the offensive behaviour of those brought in, and it was clear that those thought to be mad had arrived there because their conduct had caused public concern. For instance, in October 1617, Richard Brawell was brought in for creating a disturbance and spoiling merchandise taken from stalls. The governors, initially, were in some confusion about whether to treat him as a lunatic, or a miscreant, but eventually decided that he was mad, partly on his own description, and “sent” him to Bethlem:

Richard Brawell brought in from Mr Treasurer by Constable Addyson and Constable Shacklady for breakinge the peace and takinge wares from mens stalles and spoylinge them, he seemeth crased in his witts as himselfe confesseth it is ordered he shalbe kepte at worke afterwards agreed he shalbe sent to Bethlem.⁷

The above example indicates that disposal to Bridewell or Bethlem depended on a judgement of culpability, those judged mad being sent to Bethlem and those bad to Bridewell, the behaviour which could bring an individual before the governors being much the same.

The use of terms such as ‘release,’ ‘prisoner,’ ‘sent,’ and ‘kept,’ in the examples which have been given, signal that Bethlem was a confining institution though ‘kept’ tended to be used very ambiguously, perhaps deliberately so, and could also mean the provision of bed and board. After Bridewell assumed responsibility for Bethlem the mad inmates of the latter were commonly described as ‘*prisoners*’ and the hospital as a ‘*prison house.*’ as in a minute of June 1607 which managed to blend caring concern for the inmates with the language of confinement. It referred to:

.....a ditch adioyninge to the garden plott on the back of the prison house of Bethalem that standeth full of filth and stincking water which is verry noisome to the prisoners in the said house....⁸

Examples such as that given above could be seen as “leakage” of prison language into more caring hospital language, and the opposite effect will, later, be seen in the case of Guy’s Hospital, where hospital language infiltrated discussions of the lunatic house.

A similar blend of care, for both inmates and relatives, and acknowledgement of confinement, was seen in a 1763 minute of the Bethel hospital in which the governors decided that, as the hospital’s financial state was good, all “*poor lunatics*” from Norwich could be both “*supported*” and “*confined*” on the foundation, that is, gratis:

“.....the present Trustees think themselves in a condition to support all the poor lunatics that belong to the City of Norwich upon the Foundation. Except such whose relations or friends are able to pay for their being confined here, but security must be given to find them with necessaries.”⁹

4.2.3 The Apparatus of Confinement

Although the fact of coercive confinement was increasingly suppressed by the rhetorics of care and cure, aspects of confinement such as perimeter walls, cells, locks, grilles, wire mesh, and so on, required purchase, replacement, maintenance and repair, and both materially attested to the fact of confinement, and required direct reference to it.

For example the brick wall at the back of Bethlem had to be raised, in 1642, to prevent the lunatics climbing over it:

Item itt is thought fitt and ordered by this courte that the Brickwall of the Backyard of the hospitall of Bethlem bee made higher with bricke att the charge of this hospitall to keepe the distracted people from clyming over the same.....¹⁰

Containment also involved locking inmates in cells, and chaining, as shown in the case of Edward Purser in 1673. Notably, as well as being mad and, thereby without agency, he had agency ascribed to him for his “*wicked*” propensities:

Alsoe itt is ordered by this courte that Edward Purser sent to Bethlem Hospitall to be cured of his lunacy being found to be a wicked desperate & dangerous person be kept in chaines & locked upp to prevent danger of fire & hurting the persons of the officers there.¹¹

Again, in March 1738, Mr. De Camargue suggested to the visiting commissaires of the French Hospital that chains should be fitted to two of the cells in the lunatic house:

Mr. De Camargue ayant representé qu’il seroit necessaire de faire mettre des Chaines dans 2 des loges de la maison des fols, la Compagnie l’a prié de la faire.....¹²

[Mr. De Camargue having made representation that it would be necessary to have chains fitted in 2 of the cells of the mad house, the Company has asked for it to be done....]

Rules concerning care of keys, locking of doors, surveillance, and so on, unavoidably referred to confinement. For instance, in June 1772, the newly appointed resident apothecary at St. Luke’s Hospital was the subject of an inquiry which led to his dismissal. Among other misconduct he had apparently been leaving the key to the apothecary’s shop with one of the incurable inmates while he was away from the hospital.¹³

The use of handcuffs, and leg-locks, was also common to prevent inmates throwing things, and hitting, or kicking, others. For instance, at St. Luke’s Hospital, in August

1764, chains and leg-locks were ordered to be purchased in association with the building of new cells.¹⁴

From the mid-eighteenth-century strait waistcoats began to be favoured for upper body restraint as they were believed to be more humane. In July 1758 three such “waistcoats” were ordered to be bought for “disorderly” lunatics at the Bethel Hospital:

Ordered that the master of this hospital provide three waistcoats for the disorderly lunatics.¹⁵

4.3 The “Rhetoric of Care”

In this section a distinction will be made between the “rhetoric of care” which served to obfuscate the confining function of the institutions, and a degree of actual care which was delivered to inmates, staff, tenants, and the public, which will be reported in chapter 6. Thus, it is not argued that the sampled institutions were entirely uncaring.

A little prior to Bridewell’s assumption of responsibility for Bethlem, two developments can be seen in the way madness was described in relation to admissions. The first was a softening in the language of confinement. Whereas, formerly, inmates had been “sent,” “imprisoned,” or “kept,” the language became more caring, and began to suggest that they were privileged to be allowed into the institution. For instance, King Robert, Doctor Owen and Mistris Vaughan, in the preceding section, were to be “*received*” into ‘custody’. Earlier, in 1550, an order of the Privy Council had asked the Lord Mayor of London:

“.....to receyve into Bethlem twoo madde women sent to him by their Lordships from the Courte.”¹⁶

“*Receyve*” was softer than former terms, more redolent of caring absorption than imprisonment, and was, thereafter, commonly used. A second aspect of the above example was the decontextualisation of madness. There was no recitation of social affront, or danger, as formerly. Madness, per se, appeared to be sufficient to justify

confinement, and came upon a person without any cause. The two women were simply “*madde*,” and in need of confinement until the luncy passed. The mad person was beginning to be represented as in need of care and protection, and the institution as providing this. Confinement here was becoming reconstructed into “caring confinement”.

After Bridewell’s assumption of responsibility for Bethlem the discourse of confinement was paralleled by a gradually strengthening rhetoric of care, which increasingly suppressed the fact of coercive confinement. For example, Humfrey Whitlock, in 1577, was “*sent*” to Bethlem, simply because he was a lunatic, and would be “*received*” there and “*kept as well as we can*”:

It is agreed that yf it be agreed by the quenes justice at benche that Humphre Whitlock be sent to Bedlem because he is lunatike, Then he shalbe received thether and kept aswell as we can att his frendes chardge for his dyet.¹⁷

In contrast to this decontextualisation of lunacy, a typical Bridewell confinement continued to require a justification in terms of misdeeds. For example, in August 1617, two vagrants had their lewd behaviour recorded and were ordered to be “ponished,” ie. whipped:

Brought in by Constable Dore in Fyshstreete for vagrants of loose and lewde disposicon and ould guests to this hospitall who have had a childe betweene them about one year since beinge never married She sayeth he had the use of her body about a moneth since in White Chappel Feilds, and he confesseth the same also, they were both by order of court po.¹⁸

Thus, the terms used to describe confinement could imply that inmates were privileged. “*Admitted*” was the most frequently used and, in a rather oblique way, ascribed agency to the inmate, as if they had personally requested entry. The term “*received*” could also imply a degree of hospitality and privilege. Similarly, references were occasionally made to “*entertaining*” inmates in the manner of old fashioned hospitality. For instance, in April 1648, John Theobald “*being lunatique*” was “*admitted into Bethlem*,”¹⁹ and, in March 1700, the Bridewell and Bethlem court ordered the Bethlem Committee to:

...examine and inspect the nature and circumstances and conditions of the severall lunaticks harboured in the said hospitall and consider which of them are proper objects to be entertained and capable of receiving their cure therein.....²⁰

The development of the “rhetoric of care” can also be seen in the descriptor “poore” which constructed inmates as suffering, and needing protection. For example, in 1620, this term was used in the case of Henry Hobson:

It is ordered that Henry Hobson a poore lunatique shall be sent by warrant to Bethlem.²¹

An even more overt aspect of the rhetoric of care was the annual Spittal sermon, for which the governors presented a written case for the preachers, and for public distribution, to acquaint them with the cost of maintaining Bethlem, and its small means. The 1650 text neatly combined inmate misery and need, a spurious possibility of cure, and the crippling expense of the project:

The hospitall of Bethlem is of great antinquitie use and necessity for keeping and curing distracted persons whoe are of all other the most miserable by reason of their wants both of sole and body and have not sense thereof. The charge thereof is very greate there being kept and mainteyned with phisicke diette and other releife thirty five distracted persons constantly att least besides the charge of servants to looke to them.....²²

At a later date, the 1750 founding document of St. Luke’s Hospital bristled with phrases descriptive of its potential inmates in terms of the awfulness of their state, their inability to care for themselves and their families, and their need for protection. They were variously described as “*Incapable of Providing for Themselves*”, “*Melancholy Objects*,” “*Unhappy Objects*,” and as suffering from the “*Worst of All Disorders*” and “*this Dreadful Disease*.”²³

As well as representing inmates as wretched and needy, the rhetoric of care constructed the institutions as places of care and protection, rather than confinement. The term “harboured” was often used to imply the provision of protection from a cruel world. This was evident in 1643, when the Bethlem governors were negotiating with William Woodcocke, for part of his land, to assist the enlargement of the hospital. As well as being ‘*harboured*’, the ‘*poore lunatiques*’ were presented

as making use of, and being accommodated in, the hospital and, again, the ambiguous term ‘*kept*’ was applied:

.....to bee added to & used with the hospitall house of Bethlem for the necessary use & accommodaton of the poore lunatiques therein harboured & kept hereafter.²⁴

Again, in May 1678, the governors of the second Bethlem Hospital proposed to lease the basement of the hospital to the East India Company as this would:

.....yeeld a very considerable rent and thereby much increase the revenue of the said hospitall for the keeping and mainteyning the poore lunatikes therein harboured and kept.²⁵

This example also represented the inmates as being “*maintained*” in the institution and this was another common constructions of caring practices though, as previously noted, “*kept*” was a rather ambiguous term which could imply confinement, or the provision of subsistence, in fact a perfect encapsulation of “caring confinement”.

An institution could also commonly be described as a “house”, a term implying both a familial arrangement, and a place dispensing hospitality. For example, the Bethel Hospital was often described as a “house,” as in August 1729, when John Flegg petitioned for his son “*a Lunatick in this house*” to be placed on the foundation as a result of his poverty.²⁶

In the earlier quotation concerning the use of William Woodcocke’s land for the enlargement of Bethlem Hospital it was described as for the “use” of the inmates. Not uncommonly inmates were assigned a spurious agency and constructed as “using” the institutions, and their facilities, rather than being confined in them. Inmates at the Bethel Hospital, could even be represented as organising their own restraint, as on 7th January 1805 James Rippin was paid paid £1-12-6:

...for six waistcoats order’d by Dr Beevor for the use of the patients in this hospital.²⁷

4.4 The “Rhetoric of Cure”

4.4.1 Introduction

Unlike the rhetoric of care it will be suggested, in the present section, that cure, although claimed by the institutional managers, was unlikely to be a real outcome of the institutional experience. Although some inmates did recover, it will be argued that that these were likely to be spontaneous remissions which could be claimed as “cures.” Furthermore, it will be suggested that institutional policies refined intake and discharge processes to maximise spontaneous remissions, which could be claimed as “cures.” This involved the creation of categories of “unfit objects” which avoided the admission of those unlikely to remit, and represented those who failed to remit as having qualities rendering them impervious to cure. This minimised the institutions’ responsibility for failure to cure their inmates. Further, apparent cures were, later, enhanced by expanding the “cured” category to include “partial cures.”

4.4.2 Terminology

References to “recovery” were present in the Bethlem material at an early stage. For instance, in 1575, Margaret Nixon was returned to Bridewell from Bethlem, having recovered:

Margaret Nixon: also Tull sente from Bedlam for that she was madde & is nowe recoverd of the same.²⁸

Clearly recoveries were occurring, and it is suggested that these were due to spontaneous remission, and would have occurred whether or not the individual had been placed in the hospital. This would be particularly likely in the case of recurrent disorders, with periods of remission. Such spontaneous recoveries could be claimed as “cures,” and it is argued that this was the beginning of a “rhetoric of cure” which, along with the “rhetoric of care”, served to further suppress the fact that the hospital coercively confined the publicly disruptive, or dangerous.

The first clear indication that Bethlem hospital was being constructed as curative occurred in September 1618 when Henry Shalcross was sent to Bethlem “*to be cured*”:

“Henry Shalcrosse a lunatique is by order of Court Warrant sent to Bethlem to be cured.”²⁹

Discharges of those “cured” were also recorded, as in 1647, when a committee of governors was to decide which inmates “*cured of their lunacy may bee delivered.*”³⁰

Just as the rhetoric of care appears to have overlaid that of confinement, the rhetoric of cure seems to have developed somewhat later than that of care and, increasingly constructed inmates as “sick” in a manner analogous to those in general hospitals, and their mental disorder as analogous to the illnesses of those in such hospitals. The institutions, their staff, practices and facilities were gradually constructed as dedicated to “cure.”

This position should be qualified by noting that Guy’s Hospital, while demonstrating elements of the rhetoric of cure, and having occasional recoveries, did not consistently construct itself as a place of cure in relation to its putatively incurable lunatic inmates. A somewhat similar situation existed at the French Hospital which only rarely claimed “cures.”

The governors of the other institutions also termed them “hospitals” and, despite its earlier use as a term for a hostel, or alms-house, it does not seem unreasonable to suppose that they increasingly wished them to be seen as analogous to hospitals for the physically sick.

Within the rhetoric of cure lunatic inmates were increasingly termed “patients” and, in some instances, female staff were called “sisters,” “nurses” and “matrons,” and the rooms where the inmates were kept “wards.” As shown by the Guy’s Hospital material related to non-lunatics, these were terms commonly in use in institutions for the cure of physical ailments, and can, tentatively, be seen as representing mad inmates within this framework. Broadly, the material sampled showed a gradual

infiltration of such terms into institutions for the mad, suggesting that their governors found it progressively advantageous to represent them as similar to general hospitals, and to de-emphasise their incarcerative qualities.

Male medical staff were always called “physicians,” “apothecaries” and “surgeons,” as in institutions for overtly physical disorders. However, in general hospitals there were only female staff directly concerned with patient care, below the medical level. Perhaps for this reason only female staff of institutions for the mad attracted such “medical” titles. The term “matron” for the highest ranking female member of such staff was in use at Bridewell by 1610, and at Bethlem by 1630, and may have derived from its use in hospitals for the physically sick, though it was used in other types of institution. There was certainly evidence of its increased use in relation to the mad as the eighteenth-century moved on. Use of the term “nurse” was rarer, and tended to be associated with care of physically ill inmates. At Bethlem it had a clear medical origin as, in December 1692, Dr Tyson, the physician, requested a nurse to be added to the staff for the care of patients “*ill of other distempers besides lunacy and such who cannot helpe themselves with their dyett*”³¹.

Thereafter there were both nurses, and gallery maids, at Bethlem, the nurses having duties more concerned with physically sick inmates than more domestically oriented gallery maids. Much the same situation pertained elsewhere.

Guy’s Hospital’s lunatic house, uniquely, it had its own “sister,” a good example of the “leakage” of general hospital discourse into the discourse of an institution for the mad, due to their physical, and managerial, proximity. Another odd example of leakage was the styling of John Smith, the madhouse “keeper,” as “brother” in receipts for salary payment, perhaps, a logical analogy to the term “sister within an institution which was not geared to the appointment of male nursing staff. For instance, in December 1730 Mary Jones signed for her salary as “*sister*” and John Smith as “*brother*”:

Rec^d then Eight pounds fifteen shillings, as, Brother to ye Lunatick Ward £8-15-0 John Smith.³²

This example also illustrates another aspect of “leakage”, the translation of the “lunatic house” into a “*ward*,” on the same basis of other wards in the hospital. This term was also used at St. Peter’s Hospital for the spaces allocated to the lunatic inmates, though spatial divisions in workhouses were commonly called “wards” and this could as easily be an example of “workhouse-speak” rather than a medicalisation of the space for the insane.

4.4.3 Medical Staff, Practices, Equipment and Therapeutic Space

General Hospitals had medical staff, generally physicians, surgeons and apothecarys, who carried out practices such as “admitting”, “examining,” “prescribing” and “bleeding.” They administered “vomits,” “purges” or “physick” and bought “drugs”, “chemicals,” “stills”, “vials,” and so on. Therapeutic spaces such as bath houses, examination rooms, apothecary’s shops, and laboratories were also created.

Presenting the spontaneous recoveries of lunatics as cures required something which could be invoked as curative. The provision of such medical personnel, procedures, equipment and spaces, was the major explanation, and references to them increasingly presented institutions for the mad as analogous to general hospitals, dedicated to cure, and their inmates as potentially curable.

In 1619 Helkiah Crooke, a physician, was appointed as a medically qualified master at Bethlem and, according to the royal inquisition which led to his removal in 1633, was expected to devote himself to curing the inmates. This inquisition listed, as one of the charges against him, that he had not:

.....of long time used any endeavour for the cureing of the distracted persons: Onely he alledgeth that at his first comeing to the place, he cured 17 and since that time, he hath not endeavoured any thinge, because he saith the Governours of Bridewell doe refuse to pay him his Apothecaries bills....³³

Despite Crooke’s apparent neglect, physicians and apothecarys became permanent members of the hospital staff thereafter, and the fact that medicines were regularly administered to inmates was shown by the appearance of physick as part of the charge which was levied for an inmate’s stay in the hospital. For example, in

September 1642, Robert Leigh was to be admitted to Bethlem at a charge of three shillings a week towards his “*phisicke diett and other releife*.”³⁴

Physick was prescribed by the physician and was then made up by the apothecary and administered by him, or a trusted staff member. At Bethlem, at least, medicines appear to have been routinely administered in Spring and Autumn as a minute of 1700 indicated that, under the physicianship of Edward Tyson, an outpatient service was offered to prevent the relapse of discharged inmates, who were to be allowed free physick “*at the spring and fall*”³⁵

As well as dosing inmates with physick, there was evidence that discharge was contingent on medical certification of recovery as, in January 1648, Dr. Nurse was recorded as having pronounced six Bethlem inmates fit to be discharged:

Item upon the certificate of Dr Nurse phisitian for the hospitall of Bethlem to this court that John Newton John Blackwell Mary Beedle Frances Teames Elizabeth Fishwater and Edward Hurst are fitt to bee discharged out of the said hospital.³⁶

Again, from November 1653, medical procedures also embraced the certification of lunacy at the time of admission:

Alsoe itt is ordered by this courte that noe lunatike shalbee taken into the hospitall of Bethlem unles the doctor of the same hospitall shall first finde and reporte such person to bee a lunatike to prevent the keeping of idiots and sottish people there which are noe lunatikes.³⁷

Even at Guy’s Hospital, where the lunatic inmates were “incurables,” remission sometimes occurred, and the physicians were called upon to examine them and certify whether this was the case:

Resolved that the Physicians of this Hospital be desired to attend the Lunatic Patients and to make their Report to the Taking in Committee whether any of them have recovered their senses and ought to be discharged.³⁸

However, in all the institutions the ultimate right to admit, and discharge, clearly lay in the hands of the governors, not the doctors, who merely advised them.

Physicians “attending” inmates typically “examined” them, though precisely what this entailed is obscure. These procedures led to the creation of spaces in which such medical activity took place. For instance, at Bethlem Hospital, in November 1780, rooms on the male and female sides were created for this purpose:

It is Ordered that a Room on the Men and Women sides be appropriated for the use of Examining the Men and Women Patients and that it be painted on the Doors Room for Examining the Patients Previous to their Admission.³⁹

Again at Bethlem, a “*surgery*” existed in 1780. This was, presumably, a space in which surgical procedures such as bleeding, setting bones or pulling teeth could take place, though its use was not specified.⁴⁰

Another site of medical activity could be the mortuary, and post-mortem examination of lunatics’ brains certainly took place at Bethlem Hospital in the later part of the eighteenth, and early nineteenth, centuries though not alluded to in the present sample. Post-mortem examinations were also a feature of St. Peter’s Hospital in 1770 and could, presumably, have involved the bodies of lunatics.⁴¹

The presence of apothecaries led to the creation of “shops” in which they could carry out their activities, another element of the proliferation of “therapeutic” space. For instance, in February 1750 it was reported to the Bethlem court that Cordwell and Cleever had been given the contract for building the shop for the first resident apothecary, with his apartments over it.⁴² The activity of apothecarys may also have been responsible for the creation of new therapeutic spaces termed “laboratories.” For example, in 1791, a “*laboratory*”, was to be built at Bethlem Hospital, its position, and the description of it, suggesting that it may have been for the production and storage of drugs by the apothecary.⁴³

Bleeding and cupping were also common medical procedures and, normally, the responsibility of surgeons. For instance, on 30th January 1767, the surgeon at St. Luke’s undertook to cup the inmates if the hospital provided the necessary surgical instruments.⁴⁴

Apart from these remedies, hot and cold water baths, showers, and vapour baths became part of the therapeutic equipment of institutions for the mad, adding to their increasing spatial differentiation. They were used to calm, or activate, inmates and, sometimes, to try to shock their systems back into sanity, but the present material gave no indication of their precise employment in individual cases. In April 1754, for example, the committee for rebuilding the French Hospital lunatic house resolved that a cold bath should be made, like Bedlam's, with oak planks and two layers of lead lining, in the form of a large cistern about three feet above the floor, seven feet long, five wide and five deep:

Il a été Resolu que le Bain froid sera construit comme celui de Bedlam, Scavoir, avec des planches de Chêne doublées de plomb en forme d'une grande Citerne environ trois pieds au dessus du plancher de sept Pieds en Longueur, et Cinq en Largeur, et Cinq en profondeur.⁴⁵

[It was resolved that the cold bath would be constructed like that of Bedlam which is known to be of planks of oak lined with lead in the form of a large tank around three feet above the floor, seven feet in length, five in width and five in depth.]

Again, the Bethel Hospital had a bath in 1762 as it was ordered that iron bars should be made for the bath house windows.⁴⁶ A new bath, in brick, was ordered to be built in September 1785:

Ordered that Christopher Chadleigh build a brick bath of good grey stock bricks laid in terries according to his estimate delivered in this day for the sum of nine pounds the old materials to be his and he to make good all damages to pipes which may happen in the execution of the work.⁴⁷

Again, in February 1798 a shower bath was ordered to be provided at Bethlem, the relevant minute giving agency to the inmates, who were to "use" it.⁴⁸

The other major development of therapeutic space was the creation of infirmaries for physically sick inmates, which imported a miniature version of the general hospital, and its associated nursing staff. This development will, however, be discussed in Chapter 6.

Another medical development deserves mention. In December 1796 Dr. Monro, the Bethlem physician, asked the grand committee to purchase an electrical machine

which “*might be of considerable benefit to the Patients.*” The machine was purchased in February 1797 though no reports of its use were found.⁴⁹ This development appears to be unique, perhaps going some way to correcting the prevalent historical narrative that, in the late eighteenth-century, Bethlem was wholly abusive and therapeutically moribund, while its neighbour, St. Luke’s, was the epitome of humanitarian and progressive treatment.

Medical staff were also commonly consulted about inmate living conditions, and diet was a particular case. For instance, at St. Luke’s general court, in February 1750, William Battie, its physician, brought a dietary table, and a list of drugs and medicines, which he considered appropriate for the institution. He was asked to consult with other medically qualified governors over these matters, the general court apparently feeling unable to rule in this specialist area.⁵⁰

4.4.4 Representation of the Institutions as places of cure

References to cure at the point of admission were relatively rare and, as recoveries were eagerly represented as cures, it seems likely that governors were somewhat cagey about promising cure on admission, as it might not materialise. The major exception was Bethlem Hospital which commonly represented inmates as being admitted “for cure.” For instance, in June 1693, in a fine mix of the rhetorics of care and cure, Mary Burrows “*a poore lunatick,*” “*being in a miserable low condicon and one who has noe friends able to doe anything for her*” was to be “*admitted*” gratis “*in order to her cure.*”⁵¹

The French Hospital too, while doing little to promote cure, occasionally made reference to it on admission. For instance, in April 1741, Pierre Rocher was admitted to the *petite maisons* “*jusques Sa guerison*” [until his cure].

While shy about promising cure on admission institutions were eager to imply that recovery was due to the hospital’s ministrations, material from St. Luke’s becoming quite self-congratulatory in its reports of the profuse thanks of relatives, and inmates, for cures. For example, in October 1774, George De Horne donated £25, and wished to become a governor, on the “*cure*” of Jane Burnham:

Mr. George De Horne attended this Committee to return Thanks for the Care taken of Jane Burnham who was discharged Cured the tenth Instant and at the same time left a Bank Note of £25 to be given to the Treasurer for the Benefit of this Hospital and desired to be admitted a Governor.⁵³

Again, in May 1752, Susannah Barbor was to be discharged “*cured*” and “*returned thanks*.”⁵⁴

In contrast, the Bethel Hospital routinely used the term “recovered”. For example, in September 1780, John Cheyney “*a recovered lunatick*” was ordered to be discharged.⁵⁵ This use of “recovered” may simply have been custom, as it seemed to mean the same as “cured” elsewhere. The Bethel distinguished different degrees of recovery, structured in terms of the “benefit” received from the inmate’s stay. For example, the level immediately below “recovered” was “having received great benefit,” suggesting that “benefit,” derived from some aspect of the hospital. For instance, in April 1774, Susan Warns was discharged under this category:

Ordered that Susan Warns a lunatick be discharged out of this hospital having received great benefit⁵⁶

4.5 Admission and Discharge Processes, Unfit Objects, Statistical Rhetoric and the Construction of “Cure”

4.5.1 Introduction

This section concerns the institutions which clearly pursued a curative policy. Therefore it excludes the Guy’s Hospital’s lunatic house, St Peter’s Hospital and the French Hospital’s petite maisons, which were either intended for “incurables,” or did not appear to have clear curative intentions.

The argument to be pursued is that claimed “cures” were spontaneous remissions and that, by a mixture of logic, and trial and error, the governors, and medical staff, became increasingly able to discriminate between those likely to spontaneously remit, and those unlikely to do so. Those unlikely to remit were increasingly labelled as “unfit objects” for admission, and rejected. Admitted inmates later found unlikely to spontaneously remit, were discharged under a variety of “unfit” labels which

constructed them as impervious to cure, avoiding attributing its absence to a defective curative regime. This left a consistent level of spontaneous recovery which enabled the governors to claim systematic cure of lunatics. The apparent cure rate could be further boosted by creating a category of “partial” cure which minimised the “uncured” rate. Finally it will be suggested that this categorisation of intake, and discharge, processes allowed the beginning of a statistical “rhetoric of cure” through which governors could numerically represent their institutions in the best light, and compete with other institutions.

4.5.2 Admission

The admission process went through stages. First, a petition making a case for admission, was presented, sometimes accompanied by a physician’s certification of lunacy. The petition was considered by the governors, and either accepted or, alternatively, rejected on the grounds that the potential inmate was an “unfit object.” Before admission a parish certificate was normally required, confirming the lunatic’s residence and, for paupers, the parish’s willingness to pay necessary charges. Those seeking admission were required to provide two, or more, “securities,” normally householders, or parish officers, to be responsible for the payment of the charges, and to receive the inmate on discharge, or pay burial costs.

Those for whom the petition was successful were placed on a waiting list and, on a vacancy occurring, were brought for examination by governors and medical staff, who would assess their status as a fit object for admission, a critical aspect being medical affirmation of lunacy, and potential curability. Rejection as “unfit” could also occur at this point and, occasionally, inmates could not be produced as they had died, or absconded. Successful passage through “examination” resulted in an admission date being set, and the issue of a written order requiring the master, or steward, to admit the inmate on its presentation.

Petitions were written by parish officers, the inmate’s friends, or paid scribes, and, unlike the governors’ decontextualised accounts, were rhetorical constructions, redolent with the misery and danger lunatics could cause. Typical was the plea of Joseph Read who sought admission to Bethlem for his young son in 1776.

Surprisingly, the governors assented to a twelve month admission, though a more hopeless case can scarcely be imagined:

That at the age of Four Years and a half he was afflicted with the small Pox the consequences of which, it settled in his Brain ever since but more so within these twelve months. He is very mischievous will not wear any cloaths, and fearful will be more Outragious as he gathers strength, these circumstances render me very unhappy as I see no prospect of his reason returning, and (what increases my affliction) am totally Incapable of providing for him without the kind assistance of this worthy Charity, else must remain a Burthen to me all the days of my Life, having at this time a wife and three children And your Petitioner will ever pray Etc.⁵⁷

However, the major concern here is to demonstrate the creation of filters which screened out “unfit objects,” at the petition and examination stages. An early example was notable in a previous quotation (section 4.4.3) relating to Bethlem Hospital admissions which ordered that all potential inmates should be medically certified as “lunatike” to prevent “*the keeping of idiots and sottish people there which are noe lunatikes.*”⁵⁸

More comprehensively St. Luke’s issued instructions to petitioners listing its categories of “unfit objects”. Those who were not poor, and mad, were to be rejected and the list continued:

- II. Or who hath been a Lunatick more than twelve Kalendar Months.
- III. Or who hath been discharged uncured from any other Hospital for the Reception of Lunaticks.
- IV. Or who is troubled with Epileptick or Convulsive Fits.
- V. Or who is deemed an Ideot.
- VI. Or who is infected with the Venereal Disease.
- VII. Nor any Woman with Child.⁵⁹

The requirement that the potential inmate should not have been mad more than 12 months reflected the common belief that the prospect of “cure” fell dramatically with time, and is likely to have selected those with acute, short-lived, episodes of, sometimes recurrent, derangement, rather than the chronically insane. For example

Bethlem specifically excluded “mopes,” those with long-term, low-level, melancholy, who almost never remitted.⁶⁰

Those who had failed to remit elsewhere were relatively unlikely to do so in St. Luke’s, those with fits probably had chronic cerebral disorders, which would not remit, and “ideots” were known to remain in the same state. The exclusion of those with venereal disease was common and, presumably, indicated an awareness of the incurable neurological consequences of syphilis. The exclusion of pregnant women was more complex. Women discovered to be pregnant in the institutions were rapidly discharged, as were individuals judged too weak to take physick, and the inability to give pregnant women physick was a likely reason for not admitting them.

An attempt to hone the disqualification categories at St. Luke’s Hospital occurred in January 1771, when the physician, Dr. Brooke, proposed that palsied patients should not be admitted, as they did not recover. He was asked to confer with William Battie, the former physician, who wrote the original exclusion clauses. However, Brooke declined to humble himself in this way, and the committee decided there was no need to add another disqualification clause as, on medical recommendation, they could discharge any inmate considered unfit.⁶¹

4.5.3 Discharge.

The process of discharging those unlikely to remit from Bethlem began in mid-1624, apparently because of overcrowding. A visiting group of governors was appointed to examine the inmates and discharge any who were recovered, and did not need to be there, as well as “*idiots*” whose condition was clearly not going to remit.⁶²

Idiots apparently continued to be admitted, presumably mistakenly, and were regularly discharged. For instance, in July 1629, Robert Middleton was discharged for this reason:

Robert Middleton sent into Bethlem the last yeare being onely an idiote is to be devided out and to be sent to the place from where he was brought.⁶³

Similarly those with tertiary syphilis were typically discharged, as their mental disorder was not going to remit. For instance, in 1656 Robert Porter was discharged to his friends as he “...*hath the fould disease and is not fitt to be kept.*”⁶⁴

Another category of “unfit object” comprised those found to be sane after admission, who could not legitimately be claimed as cures. For example, in April 1659, James Smith was ordered to be discharged on this basis:

...itt appearing to this courte by a certificate under the hand of Doctor Nurse that James Smyth now in the hospitall of Bethlem for lunacy is noe way lunatike but fitt to be discharged thence.....⁶⁵

Again, the disqualifying admission clauses for St. Luke’s, noted in the preceding section, were followed by a further rule indicating that inmates later found to fall into any of the categories would be discharged.⁶⁶

Physical frailty was a common “unfit” category, sometimes represented as rendering inmates unable to take physick, without which a legitimate cure could probably not be claimed, but also in its own right, some with this label being terminally ill, or likely to be reduced to this state by physick. Governors, presumably, had an eye on death rates as well as cure. For example, on 2nd April 1785, Anne Ride, terminally ill, was discharged as an unfit object from Bethlem:

.....Anne Ride who was admitted into this Hospital on Saturday last is in a very weak and low condition and not likely to live long. It is ordered that the said Anne Ride shall be immediately discharged as an improper object of this charity.⁶⁷

A wide range of disabilities came under the “unfit object” category - rheumatic complaints, consumption, paralysis, deafness, mortifications, a fever, a delicate constitution, and smallpox all being noted.

For instance, in October 1766 Daniel Mileham was discharged from the Bethel Hospital as a result of the consequences of smallpox:

Ordered that Daniel Mileham a lunatick in this hospital having lately had the small pox be discharged at any time before the next meeting by the appointment of Dr Manning being degenerated into a state approaching idiocy.⁶⁸

Again, in January 1788 John Howlett was discharged following “*a sever illness*”

Ordered that John Howlett being recovered from a sever illness and not in a condition so well suited to this Hospital as to a cottage and being more reasonable in his behaviour than when admitted be discharg’d on the application of his friends to receive him.⁶⁹

A final category of “unfit” object represented something of a rhetorical coup, and a business opportunity. This was the “incurable” category which first emerged in mid 1681 at Bethlem, in relation to Francis Davis:

...whoe hath beene kept in the hospitall divers yeares” at 3s p.w. to be continued there. However it appearing to this courte that she is a very weake malancholly woeman and incurable the court says the parish will have to pay 5s p.w. to keep her there.⁷⁰

The tautological “incurable” label, first, constructed the institution as a place of cure, in which incurables did not belong. Second, it attributed lack of cure to some essential inmate quality which rendered them impervious to an institution’s curative influence. Third, it enabled their readmission at a reasonable charge, possibly for life, with no responsibility to provide more than basic care. Finally it allowed this warehousing to be represented as a boon to society, particularly as Bethlem specialised in violent or self-destructive “incurables.” This business became important enough for the Bethlem governors to build specialist male and female incurable wings during the late 1720s and 1730s.

St. Luke’s governors jumped on the same bandwagon, though they were slower to blame defective inmates, the term “uncured” being initially used. In February 1754 up to ten inmates discharged as “*uncured*” were to be taken back at five shillings per week. By 1755, however, the term “incurable” was coming into use at St. Luke’s⁷¹ and was used at the Bethel Hospital by 1773 when three “*incurable*” inmates were discharged:

Ordered that Elizabeth Fallgate, Hannah Trip & Martha Long lunaticks in this hospital having been under the care of the physician and being deemed incurable be discharged out of this hospital.⁷²

However, the Bethel Hospital governors never formally entered into the incurable business, keeping to a maximum period of stay of two years.

Another aspect of the rhetoric of cure gradually expanded the boundaries of “cure” to take in any degree of improvement in an inmate’s mental state. This increased the apparent cure rate while virtually eliminating the “uncured” rate, and any conception that the institution was ineffective. At the Bethel Hospital discharged inmates could be categorised, at the highest level, as “recovered” then, in order of improvement, “having received great benefit,” “having received some benefit” and “unlikely to receive further benefit.” Below this came categories of “unfit object” and there was, in fact, no “uncured” category. This can be seen in the 1813 report of the physicians which combined all degrees of improvement below “recovered” into a single “relieved” category, claiming that, of 49 inmates discharged, 20 had recovered, 5 had been relieved, 14 had died, 9 were incurable, or otherwise unfit, and one had been removed by their friends against advice.⁷³

Such statistical information was produced in the other institutions and presented opportunities, and temptations, to present them in the best light possible, for instance, stretching the concept of “cure” as far as it would go. An example of the result of such statistical rhetoric can be seen in a pamphlet concerned with the Newcastle Lunatic Hospital, dating from about 1817, which purported to present an unbiased comparison of its cure rate with those of Bethlem, St. Lukes and the York Retreat. A cure rate of 40% was claimed for the Newcastle Hospital, compared with 36% for the Retreat, 41% for Bethlem and 42% for St. Luke’s. Thus, the hospital was presented as equalling, or exceeding, the foremost lunatic hospitals in the country, with their highly selective intakes, despite the claim that it took in a wide range of inmates who would have been considered “unfit objects” elsewhere, including those near to death. The truth, or otherwise, of these claims cannot be determined, but it seems clear that statistical information was being rhetorically used to make a case that a relatively obscure provincial hospital could match the best in the land.⁷⁴

II. Challenges to the Rhetorics of Care and Cure

4.6 Introduction

Coercive confinement, as a means of managing madness, had a major flaw, as inmates confined against their will were unlikely to accept that the institutional regime was one of care and cure. They were likely to protest in whatever ways were available to them, some being in a virtually permanent state of protest. Protest would tend to negate any benefit the regime offered, and provoke repressive responses. Increased repression could provoke more protest, in an escalating state of conflict between inmates and staff. Further, inmates could protest by inciting staff to behave reprehensibly, getting them into trouble, or troubling their conscience. As a last ditch inmates could kill themselves, which was almost certain to get staff into serious trouble. Protest could also be designed to cause remorse in relatives, or others, responsible for their confinement. Institutions could discharge such troublesome inmates, and there is some evidence that they did. However, such discharges could hardly be claimed as cures, and demonstrated therapeutic failure. One mechanism for dealing with this problem was to label them “incurable,” implying some essential quality in them which made them resistant to the therapeutic regime.

This section will be devoted to a consideration of the ability of inmates, friends and the public to see through the rhetorics of care and cure, to recognise coercive confinement for what it was, and to protest against it.

4.7 Inmates

A major challenge to the governors’ ethos of care and cure was from inmates, who recognised the confining institution for what it was. Only one case was found of an inmate personally requesting admission and this was unsuccessful.⁷⁵

At the simplest level inmates could ask to leave and, rarely, this was granted. For instance, Elizabeth Marché, admitted to the French Hospital as a lunatic in May 1769, asked to leave a month later. Although not completely sane she was not considered suitable to be retained and was discharged.⁷⁶

Not returning from leave also resulted in discharge, though it is difficult to know whether non-return was attributable to the inmate or their “friends”. For example, in September 1792, four Bethlem inmates were discharged, having not returned “*to give any account of themselves.*” While such discharges gave governors some semblance of control, they also marked the end of their responsibility for subsequent events.⁷⁷

Those who could not leave with official blessing, sometimes escaped. Escapes indicated the inmate’s unawareness of the benefits bestowed on him, and the first mechanism of repair of the governors’ ethos was to retake him and restore the benefits so foolishly squandered. The escape, and re-taking, of John Bowley, a Bethlem inmate, in April 1765, suggests that these could be strenuous events:

Whereas John Bowley a Patient in this Hospital did yesterday make his escape by breaking thro’ the wall of the Hospital and in endeavouring to take him several of the tiles over the Store Celler belonging to Messrs Calvert and Seward and also the windows of the opposite Neighbours were broke. It is order’d that the Steward do forthwith give directions that the said tiles and windows be repaired.⁷⁸

The other repair mechanism was an inquiry designed to find, and punish, a culprit. Escapes were frequent at Bethlem by 1771, and staff negligence was held to be the main cause, a financial punishment being imposed, of paying the expenses of retaking the inmate.⁷⁹ Sometimes, however, the culprit was held to be the building. In January 1810, for example, the annual medical report to the Bethel governors advised attention to defects in the newly built section of the hospital, from which escape appeared easy, and a special meeting was scheduled to consider the matter.⁸⁰

The ultimate escape from an institution, as well as from any personal unhappiness, was suicide which could, simultaneously, express misery, protest and anger. Repair to the gubernatorial ethos was similar to that of an escape, an enquiry being held and any culprit found and punished. The impression was that suicide was seen as a consequence of madness, to be prevented by watchfulness, and removal of the means of its achievement. There was little evidence of consideration of the inmate’s mental state, or the broader significance of the act. For instance, on 10th July 1813, Ann Till was ordered to be discharged from Bethlem as she was pregnant.⁸¹ A week later she hanged herself. On inquiry, the gallery maids were found negligent, as they had

allowed her to acquire a rope from the greenyard. No punishment was recorded but, rather over-prescriptively, the governors attempted to prevent any repetition by barring female inmates from the greenyard if ropes were about:

....on examining Elizabeth Simmonds and Mary Howkins in whose care she was the Committee was of opinion that very great neglect had taken place in suffering the Patient to be in possession of a rope. And the Committee ordered that in future no female Patient do go into the Green yard, while there is a rope there either lying on the ground or elsewhere.⁸²

Inmates had numerous other ways of protesting though, first, the issue of agency requires comment. The rhetorics of care and cure constructed inmates as unable to care for themselves, as lacking agency. However, protest was often seen as intentionally “bad” behaviour, protesting inmates being seen as having agency. This can be seen in creation of a class of inmates judged to be “bad” who were, perhaps punitively, sequestered in inferior accommodation. For instance, at the Bethel Hospital in May 1749 the old straw room was to be fitted up to contain such a group:

.....the straw room to be fitted up as a celler for ye worst of the Lunaticks to be put in.⁸³

“Bad” behaviour could constitute noise, destructiveness, or aggression, which made the life of staff, and other inmates difficult. One gets the impression that virtually everything breakable was covered with wire mesh, or shielded by bars. More unusually, in July 1765, the privies of a new building at St. Luke’s were altered “*to prevent the Patients from throwing down their Cloths and other things.*”⁸⁴

Aggression, particularly towards staff, was probably common, although there were surprisingly few reports of it, and only one report of the death of a staff member at the hands of an inmate was found. This was the death of James Bullard, the master of the Bethel Hospital, in April 1813, following an attack by an inmate, Jonathan Morley, with a scythe. In this case any reparative action by the governors was preempted by the coroner’s judgement of murder:

At this meeting the clerk reported to the governors that Mr James Bullard the Master died on the twenty fourth day of April instant in consequence of a wound on his body inflicted on the 29th day of March last with a scythe by Jonathan Morley one of the

patients belonging to this hospital. – That a Coroner’s inquest was held this morning the 26th instant on view of the body and that a verdict of wilful murder was given against the said Jonathan Morley.⁸⁵

Again, there were often rules attempting to prevent dangerous implements falling into inmates’ hands. At Bethlem, for instance, basketmen and gallery maids were enjoined to search cells for implements which could cause self-harm, or harm to others.⁸⁶

Passive protest involved inmates refusing to give the governors what they wanted. For instance, they could remain in bed, or refuse to eat. More subtly, staff could be incited to behave abusively, in ways they would regret. Consequently, some inmates spent considerable time under personal restraint. It is unlikely that the sampled material covered the whole range of such behaviour, though some examples can be given.

Food refusal placed staff in a position of having to use force-feeding. Though probably ubiquitous, the only references, in the present sample, came from the evidence given to the 1815/16 Parliamentary Select Committee into Madhouses. One of the witnesses, John Haslam, the Bethlem apothecary, described force-feeding:

.....the patient is secured, the mouth is pulled open in some way or other, as well as they can; and if there is a great deal of difficulty, you will find in most of the persons who have been forced, that the teeth are broken out by the bolt, as it is called, or spout when the spout is put into the mouth, and the patient resists violently, it would injure the posterior part of the throat; and the number of persons whose front teeth are wanting, having been compelled to submit to this process, is a strong reason for an improved mode of treatment.⁸⁷

There were no direct references to inmates who refused to keep clean, or regularly soiled, though an indirect reference appeared in the 1765 list of the duties of the Bethlem matron:

That she shall see that the Patients in general are taken Care of and kept as clean as their Complaints will Allow⁸⁸

Inmates could also protest by refusing to get up and the 1765 morning duties of the Bethlem gallery maids required them to “*turn out the low Spirited and such as are Mopish.*”⁸⁹

An example of inmates refusing to work was also found in the Bethlem material. In November 1813 four inmates were identified to replace additional washerwomen but, a week later, the matron reported that all four had refused to work. In an attempt to retrieve the situation a governor, and the physician, were asked to go to the hospital, presumably to talk the recalcitrant inmates round. It is unclear what threats, or inducements, were offered, but two of the inmates were working in the laundry in January 1814.⁹⁰

4.8 Relatives

Inmates could protest via family members. In February 1760, for instance, the children of Pierre Brisson, who was on leave with them, complained of his bad treatment in the French Hospital’s petites maisons, presumably relaying his complaints. The commissaires rejected the complaint, reporting that he had not complained to them, and that other inmates complained of him because of his bad behaviour. They would not allow him back unless he behaved better, and it seems possible that Brisson was either making trouble for the staff, or avoiding being sent back, though the commissaires might have been trying to stifle a genuine complaint.⁹¹

Those placing an inmate in the institution were relatively unlikely to protest against their confinement though, when they had not had a hand in the confinement, they could protest vociferously about it. For instance, in March 1797, the wife of James Tilley Mathews attended the Bethlem committee, demanding to know on what authority her husband had been detained as a criminal lunatic:

’I am Wife to Mr Mathews and demand to know by what Authority my Husband is detained’

The Petition was then read to her by which he was admitted on 28th January last but she still persisted to demand her Husband and desired that he might be discharged from the Hospital and allowed to return with her.

Mrs Mathews then withdrew, and A Motion was made and seconded and it was unanimously Resolved ‘That the Committee do not comply with the request made by Mrs Mathews.’⁹²

Sometimes family members were dissatisfied that the inmate had not been “cured” and sought a placement elsewhere. For example, in April 1772, Polinette Soblet, a lunatic inmate of the French Hospital, was discharged at request of her sister, and her securities, with the intention of procuring a cure in Bethlem. However, after a year in Bethlem, she was still uncured, and was readmitted to the petites maisons.⁹³

Again, some removals may have been a protest against institutional conditions, as in the case of Mrs. Mack, a Bethel inmate, whose son, in May 1806, asked for the governors’ agreement to remove her to “*a more private situation,*” presumably a private madhouse.⁹⁴

Labelling such removals as “against advice” allowed governors to reduce their negative impact on their ethos, by suggesting that those instigating it were misguided. A vindictive addition could be made to the discharge minute, indicating that the inmate would not be accepted back under any circumstances. The wayward friend, or parish, having made their bed, would have to lie on it. For instance, in May 1764, Susan Singley was barred from future admission to the Bethel Hospital:

This day Susan Singley a lunatic in this hospital was taken out against the advice of the physicians and without the consent of the trustees and it is ordered that she shall not be again admitted into this hospital.⁹⁵

One example was found of a relative taking legal action. In 1802, the wife of Bannister Truelock, a criminal lunatic implicated in an attempt to murder George III, indicted Edward Watkins, an assistant Bethlem keeper, for assault of her husband. Inexplicably, the governors decided to defend Watkins in court, leading to his acquittal.⁹⁶

4.9 Public, Press and Parliamentary Protest

Towards the end of the eighteenth-century, protest against conditions in institutions for the mad grew, and they were particularly presented as as places in which the sane

could be improperly confined. Former inmates published self-serving, accounts of wrongful detention, and the press, “pro bono publico”, kept up a barrage of similar allegations. Parliament was provoked into holding inquiries about such concerns, and the 1815 Parliamentary Select Committee, in particular, revealed that institutions were often far from caring and therapeutic. Where direct allegations about a particular institution were made, the governors commonly attempted to mend the breach in their ethos of care and cure by holding an inquiry, which normally found that there was no substance to the allegations.

For instance, in June 1814, the president of Bridewell and Bethlem convened a special court in response to allegations of cruelty at Bethlem in the public papers, following discussions in the House of Commons. Some MPs had alleged cruelty in discussions of the Bill for Regulating Madhouses, and the case of James Norris, who had been confined in a iron harness covering the whole of his upper body, was particularly referred to. The reports of the Times, and Morning Chronicle, were read to the court, which resolved to appoint a Select Committee of governors to inquire into the hospital’s management, and the general health of the inmates.⁹⁷

The Select Committee took only five days to report back to a special court, having examined the physician, apothecary, steward, and keepers, and taken information from governors who regularly visited, and viewed the state of the inmates. It appeared to the Select Committee that no foundation existed for the charges, and that no complaints of ill-treatment had been made by patients, or their friends, despite ample opportunity to do so. They attributed the accusation to the rule that no incurable patients were admitted unless “*satisfactory proof is produced that they are absolutely mischievous and dangerous to others and themselves.*” These inmates, therefore, required more than usual restraint. In the particular case of James Norris no evidence was found of cruelty towards him or, more generally, to the other inmates.⁹⁸

These convenient findings, however, provided only a brief respite, as the report of evidence given to the parliamentary *Select Committee for the Better Regulation of Madhouses in England*, in April 1816, was devastatingly critical of Bethlem’s practices, particularly in relation to the over-use of restraint.⁹⁹

4.10 Conclusions

It has been argued, in the first section of this chapter, that the true nature of institutions for the mad, as places of coercive confinement, was progressively suppressed by the sequential development of rhetorics of care and cure. These represented inmates as needy, suffering and sick, and the institutions, their staff and practices, as dedicated to their protection, care and cure. However, internment of lunatics for the protection of society remained part of the repertoire for justifying confinement, and could be drawn on when convenient.

A further argument has been that the spontaneous remission of inmates was increasingly represented as cure, supported by an apparatus of cure in the form of personnel, practices, equipment, “therapeutic” spaces, and an increasing ability to select inmates likely to spontaneously remit. This is the most uncompromising claim of the chapter and, in the view of the present writer, the issue of cure has not been adequately addressed, in fact barely addressed at all, in published accounts of institutions during the period considered. If the opposite position is taken, that the institutions were actually curative, an account of systematic mechanisms by which cure was achieved must be presented.

The rhetorics of care and cure represented the institutions as places in which something positive might be achieved, and this may have helped to overcome the reluctance and guilt which families might have felt about locking up a relative. At best they might expect a cure, at worst good, experienced care. This could have contributed to an increasing demand for places, and the consequent institutional expansion, which will be discussed in Chapter 5 (section 5.6).

However, it was clear that inmates confined against their will, as well as those who had placed them there, did not always accept that the institutional regime was for their benefit. Section two of the chapter examined the ways in which inmates, and their relatives, could protest against their confinement, or the conditions in which they were kept. As inmate protest was predominantly mute, and was expressed in oppositional behaviour, this section, in its interpretation of this behaviour, attempted to give the inmates a voice which would otherwise have been absent from the

account. Additionally, the voice of protesting relatives, as well as that of the public, press, and parliamentary reformers, though more overt, was also represented.

Notes to Chapter 4

1. The Acts of the Privy Council have been published, in printed form, by the Stationary Office, and this source has been used in the present project.

2. BBCM 23/11/1664.

3. Foucault, M. *Folie et Déraison: Histoire del la folie à l'âge classique*. Paris: Librarie Plon, 1961. Published in an English translation as *History of Madness*. London: Routledge, 2006; Doerner, K. *Bürger und Irre. Zur Sozialgeschichte und Wissenschaftssoziologie der Psychiatrie*. Frankfurt am Main: Europäische Verlagsanstalt, 1969. Published in an English translation as *Madman and the Bourgeoisie: A Social History of Insanity and Psychiatry*. Oxford: Basil Blackwell, 1981. These translations have been used for the present analysis.

4. Dasent, J. R, ed. *Acts of the Privy Council of England Vol I A.D. 1542-1547*. London: HMSO 1890. p. 388, Fol 358, 16/4/1546

5. Dasent. op.cit. p. 481, Fol 498, 16/7/1546.

6. Penfold, P. A. ed. *Acts of the Privy Council of England Vol 46 A.D. 1630-1631*. London: HMSO, 1964. p. 108, No 289, 10/11/1630; p. 108, No 290, 10/11/1630.

7. BBCM 18/10/1617.

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CHAPTER 5

THE DISCOURSE OF CONTROL AND COMMERCE AND ITS CHALLENGES

5.1 Introduction

This chapter will describe the governors' managerial discourse, and practices, in the following areas:

- Transmission of the governor's ethos downwards through sub-committees and staff.
- Monitoring and controlling staff behaviour.
- Income.
- Expenditure.
- Supply and demand, planning, development and improvement.
- Financial monitoring and control.

Two types of challenge to this discourse will then be considered, along with mechanisms for repairing the consequent damage to the governors' ethos. First, challenges to the governors' right to govern and, second, challenges to specific aspects of the governors' discourse of good management within the following five areas:

- Poor commercial practice.
- Conflict between commercial and charitable practices.
- Governor and staff misconduct.
- Misconduct by relatives, parishes, tenants, suppliers, visitors and neighbours.
- Criticisms by the public or the press.

I. The Discourse of Control and Commerce

5.2 Downwards Transmission of the Governor's Ethos

5.2.1 Introduction

Generally, the governor group was too large, and too part-time, to run their institution directly, and this was delegated to a hierarchy of committees and staff, requiring the transmission of the governors' ethos downwards, through this system, to the lowest level, if its agendas were to be successfully implemented.

5.2.2 Sub-Committees

The Bethel Hospital, with seven governors, was the only institution in which the governing body related directly to its staff. In the other institutions, day to day management was delegated to a formal sub-committee of governors, or a group of visitors which functioned in much the same way. These met regularly and were appointed for a fixed term, sometimes with a proportion retiring annually, allowing easy induction of replacements into a body with a stable ethos, and skill repertoire.

Appointment of sub-committee members from the larger governing court ensured direct transmission of its ethos, and the limited period of service of sub-committee members meant that realities discrepant with it were unlikely to arise. However, institutions could continually present problems and sub-committees were less "pure" in their managerial ethos than the courts, being "infected" by daily contingencies. However, the overlap, and rotation, of governors between the two meant that the ethos of the sub-committees constantly informed that of the larger bodies, and were informed by them, keeping their ethos' aligned. Sub-committees generally kept minutes, which the courts monitored, and were required to produce reports on particular matters. Further, their scope was often limited, important issues having to be referred upwards for court sanction.

Even sub-committees could be too large for specific tasks and could generate sub-groups for these, often with staff members, or other experts, in attendance. Examples were tasks such as viewing provisions, or inmates, and, particularly, dealing with admissions and discharges. These task-based groups often rotated sub-committee members, all gaining direct experience of the institutions' systems and practices. They were commonly the interface between governors and staff, and an important mechanism for the downwards transmission of the governors' ethos.

St. Luke's Hospital provided an example, with a general court of all the governors meeting bi-annually, and a general committee of twenty four annually elected governors, the president, one of the four vice-presidents, the lease-holders of the hospital site, and those who had paid £100 or more for their governorships. This met at least monthly, kept minutes, and had delegated power to manage the hospital.¹

However, this arrangement was still too cumbersome, and infrequent, for day-to day running of the hospital, which was delegated to a smaller, weekly, house-committee consisting of the treasurer, four vice presidents and nine governors. This could have more direct relations with the hospital's staff, and transmit the governors' shared ethos to them.²

The general committee also appointed sub-committees for specific tasks, for instance:

Resolved that a General Committee be summoned to meet at this place on this Day Fortnight at Seven o'Clock in the Evening in order to appoint a Sub Committee to treat for the purchase of Ground whereon to build a new Hospital.³

In contrast the Bethel Hospital governors numbered only seven and related, as a body, directly to the hospital's master, who managed subordinate staff, though the governors may have had informal contact with staff below the master, as they met regularly in the hospital. However, they also appointed committee's for specific purposes, as in December 1764, when three of them became a committee to seek a Charter of Incorporation.⁴

5.2.3 Paid Staff

Although the governors, through their committees, nominally managed their institutions, they were actually run, on a daily basis, by paid staff. This was the point of greatest danger for the emergence of challenges to their ethos, which staff did not necessarily share, and of which, at lower levels, they may not have been fully cognisant. They were simply earning their living as congenially as possible. Furthermore, they had an intimate knowledge of the institution's systems, and could manipulate these to their advantage.

There were, broadly, two levels of staff, those generally termed "masters," "stewards" and "matrons" and those termed "servants." The former were the paid managers of the institutions. Resident "matrons, generally subordinate to the steward, or master, were responsible for domestic management, and for delegated management of female staff and inmates. Although normally male, at the French Hospital the steward could be a woman, and the Newcastle Lunatic Hospital was managed on a day-to-day basis by a matron.

This managerial group was critical to the downwards transmission of the governors' ethos, being in regular contact with the governors, and controlling the servants. The governors placed considerable trust in these managers, who could cause major disruption to the diffusion of their ethos. However, they were relatively well paid, had good working conditions, and their behaviour was easily monitored by the governors, making conduct antithetical to the governors' ethos relatively unlikely, and quickly discovered.

Additionally, there were "medical officers" normally comprising a sessional physician and surgeon, and a resident apothecary. In some cases, a chaplain was also employed. They were not normally involved in general institutional management, though they were consulted on matters within their areas of expertise. Nevertheless, their presence and practices, particularly those of the medical officers, were a critical element in the formation of the governors' collective ethos, and the rhetorics of care and cure.

Below this level were the “servants.” Chief among them was the porter, with a critical role in controlling ingress and egress, as well as receiving supplies and messages and, sometimes, acting as a messenger. Then came those who managed inmates, normally called male or female “keepers” or, at Bethlem, “basketmen” and “gallery maids,” together with “nurses” for physically sick inmates. Below this level were cooks, scullery maids, cleaners, and washerwomen. Some institutions also had officially appointed artisans, though they were not waged, simply receiving regular work.

This servant group could pose three problems for the diffusion of the governors’ ethos. First, governors had minimal contact with them. Second, their poor pay and miserable working conditions, made departures from the governors’ agenda more likely. Third, they had regular contact with inmates, the very group the governors purported to be caring for. Thus, those most critical to the success of the governors’ project were the least likely to implement their agendas consistently, and with commitment. However, their challenges to the governors’ ethos were likely to manifest in inefficiency, uncaring dealings with inmates, and low level delinquency, rather than direct opposition.

Two main mechanisms ensured the effective downward transmission of the governors’ ethos to paid staff. First, appointment mechanisms, which were more elaborate for the management group. Second, rules governing staff conduct.

5.2.4 Appointment Mechanisms

Stewards, masters and matrons were crucial to the downward transmission of the governors’ ethos and, as far as possible, those in sympathy with this, and able to promulgate it, were chosen for these posts. They were almost always elected in competition with others, and by the general court, the candidates petitioning for the post before a designated appointment date. For instance, at Bethlem, stewards, matrons and barbers, though not other servants, were subject to competitive election by the governors’ court, following an assessment by the house committee that the post remained necessary.⁵

Competitive election of medical officers was not always the case, perhaps as they were hard to come by and, sometimes, were unpaid volunteers. Appointing volunteers may have ensured that post-holders were favourably disposed to the gubernatorial ethos, though it could also be argued that the governors had to take what they could get under these circumstances. For instance physicians and surgeons at St. Peter's Hospital were generally unpaid, though appointed competitively by a vote in the court of guardians, after advertisement:

The pioneer of the medical department, Dr. Thomas Dover, who on 9th December, 1697, "*offered himself to be Phisitian to the New Workhouse gratis*," was the originator of the Dover's powder which held its own as a remedy as late as the nineteenth century, when it formed part of Stanley's equipment for his African journeys. Other doctors, both "*chyrurgeons*" and "*Phisitians*," followed his example in giving their services to the Corporation; but in general appointments were made by the court after advertising for applications.⁶

Chaplains were rarer, and St. Luke's, the Bethel and the Newcastle Lunatic Hospitals appear not to have had them. Bridewell and Bethlem Hospitals had a joint chaplain, competitively elected, and the French Hospital had a minister, though it is unclear whether he was competitively elected. St. Peter's had a chaplain from 1767, though the appointment mechanism was unstated.⁷

Servants less crucial to the transmission of the governors' ethos, were more informally appointed, competition being relatively rare. Though appointments could be made by the court of governors they were commonly delegated to sub-committees, or even to stewards, masters and matrons. Those appointed were often already known, as they were seeking advancement within the institution, or related to existing, or former, staff. However, at Bethlem, all potential staff were subject to a pre-appointment inquiry as to their conduct, increasing the probability of compliance with the governors' agendas:

Alsoe itt is ordered by this courte that noe person hereafter be admitted into the service of the said hospitall until such tyme as the said committee have made inquiry of his or their behaviour and whether such person be fitt to be admitted into the service of the said hospital.⁸

The relative informality of servant appointments can be seen in that of a new cook at St. Luke's in April 1756:

Mary Ragg offering herself as a Cook in this Hospital in the Room of Winifred Lewis. Resolved to hire her at the Yearly Wages of Eight pounds.⁹

On the other hand higher level servant appointments could, sometimes, be competitive, as in November 1743, when the deceased sister of Guy's Hospital Lunatic House, was replaced by competitive election at the lower level court of committees. Five women petitioned the court and were "*put in nomination,*" Elizabeth Dorrington being elected, presumably by a show of hands:

Mr Treasurer acquainted this Court that there was a Vacancy of a Sister of the Lunatic House by the death of Margaret Sitch and Elizabeth Dorrington Mary Smith Elizabeth Thomas Mary Thomas and Ann Wright Petitioning to be chose in her room were called in and severally put in nomination and Elizabeth Dorrington was chosen Sister of the said Lunatic House during the pleasure of this Court at the Usual Salaries and Allowances and she was called in and acquainted with her Election and the Conditions thereof.¹⁰

5.2.5 Rules and Orders

The other major mechanism for transmitting the governors' ethos downwards was the generation of rules and orders concerning staff duties and conduct. While these could be seen as informing staff of the nature of a position, particularly when recruiting, they also had a control function, detailing standards of conduct with which the staff were expected to be acquainted, and against which misconduct, or incompetence, could be judged. Rules and orders can be seen both as an idealistic expression of the governors' ethos, and a system of case-law, derived from staff misconduct, and governors' attempts to repair the damage to their ethos which such behaviour caused, and prevent its repetition.

All the institutions had such rules, and these cannot be comprehensively covered. Generally they had two main elements, descriptions of the expected duties, and details of specifically prohibited behaviour.

In relation to the first aspect, the 1752 rules for the porter of St. Luke's provide a typical example:

1st That he attend the Door to prevent any of the patients going out and inform one of the Keepers when any Stranger comes in, And that he do not take upon himself to give Answer without calling a Superior Servant.

2^{dly} That whenever he shall be employed upon the Business of the house without Doors, he give notice to One of the Keepers that Somebody be ordered to take Charge of the Door till his Return.

3^{dly} That he deliver Summons's to the Governors when ordered and attend & obey All Orders of the Committees and Treasurer.

4^{thly} That when he is not employed on the above Attendances he do all the labouring Business of the House as he shall be directed from time to time by the Keepers.¹¹

In relation to the second element a rule in most institutions prohibited the importation of alcohol, and other unapproved provisions, suggesting attempts to prevent a recurrence of former problematic events. That for the Newcastle Lunatic Hospital was fairly typical:

THAT no Liquors, or Provisions of every Sort, be brought into the House to the Patients, from their Friends, or any others whatsoever.¹²

Uniquely in the present sample, the French Hospital governors made rules for the conduct of the inmates who, being mainly non-lunatic, were clearly seen as agents of their own actions. These rules seem to have derived from a long history of inmate misconduct and were, essentially, a list of repairs to the governors' ethos, which this had caused. For example:

V. "Common Swearers, Blasphemers, Drunkards, Thieves, Pilferers, and Disturbers of the Rules and Orders of the House, shall be Censured and Punished according to their Demerits, by the Quarterly Committee of Directors, who shall also be Judges of the Complaints of the Poor."¹³

The impact of such rules would clearly be increased if staff (or inmates) could not plead ignorance of them, and two mechanisms of achieving this were notable. The first was peculiar to Bridewell and Bethlem and involved formally reading the rules to new appointees:

That every officer and servant, when elected, have his duty read, and a copy thereof delivered to him, in open Court.¹⁴

The second was to place a copy of the rules where it would easily be seen. For instance, at the French Hospital, the by-laws were hung up in the male and female refectories, where they would be seen by both servants and inmates.¹⁵

5.3 Monitoring and Controlling the behaviour of Governors and Staff

5.3.1 Introduction

Diffusion of the governor's ethos was never complete, and was open to challenges by dissident governors and staff. For this reason monitoring and control systems were in place to prevent, and signal, the emergence of agendas discrepant with the governors' ethos, and to enable its repair. These have been grouped as follows:

- Records, Audits, and Inquiries.
- Incentives and Penalties.
- Surveillance, Visitations and Patrols.
- Complaints Mechanisms.

5.3.2 Records, Audits and Inquiries

Adherence to the governors' ethos was monitored through "books," detailing payments, purchases, deliveries, visits, complaints, and so on. Some were mandatory, while others were informally kept by individuals, for their own use. They formed an extensive network of information which could reveal mismanagement, inefficiency and abuse.

Masters, and stewards, were required to keep accounts, as at the French Hospital, where income and expenditure was detailed under different headings – wages and salaries paid, pensions received for inmates, cost of burials, brewing costs and so on. These provided an intimate glimpse of institutional processes. Record keeping could also devolve to the servant group, as at Bethlem, where the gallery maids were required to keep written records of linen, and other items, provided by relatives:

That they shall receive the Linen and other necessaries brought in with the Patients by their Friends and shall keep an Account in writing that they may be Delivered up when the Patient is Discharged or if Torn that the pieces may be returned to shew that they have not been purloined.¹⁶

Records kept for personal use, could be very revealing. The Guy's Hospital treasurer, for instance, kept a "Memo Book" containing details of salaries, appointments and the character of staff members. In relation to William Woodhouse, the porter, he noted:

Woodhouse, the porter, is a noisy, expansive, disolute encroaching fellow - needs much to be carefully watched & of his affair with the Sister of Lydia's Ward Woodbridge's [Woodhouse's?] wife is an Exceeding jealous woman.¹⁷

Supplies and equipment were important areas of audit, to avoid waste and petty theft. Inventories of institutional furniture and equipment were common when stewards, or masters, changed, presumably to ensure that these did not leave with the departing employee. For instance, at the French Hospital the steward was required to make an inventory of the furniture and clothing in his keeping, and a list of clothing brought in by each "pauvre" [pauper].¹⁸

Reports and inquiries generally occurred in response to challenges to the governors' ethos, and attempted to repair any damage. Commonly blame was fixed on a "bad apple" who was then expelled, rather than any institutional failure though, later, the rules might be adjusted, to avoid repetitions.

For example, in October 1777, it was reported that provisions were being regularly transported from Bethlem to the house of Thomas Horne, a governor, by one of the basketmen, with the knowledge of the steward. Horne was reprimanded, ordered not to attend future court meetings, and resigned. A subsequent inquiry concluded that the steward did not gain from Horne's activities, and did not inform the governors from fear, rather than corruption. He was reprimanded but, as he, and the basketman, kept their jobs it seems that the sacrifice of Horne was sufficient to repair the governors' punctured ethos.¹⁹

5.3.3 Staff Incentives and Penalties

In some institutions senior staff were subject to annual re-election so that failure to follow the governors' agenda could be dealt with by dismissing them. For instance, in May 1816, John Haslam, the Bethlem apothecary, failed to be re-elected to his position in the wake of damaging evidence he had given to the Parliamentary Select Committee on Madhouses.²⁰

Senior staff members were often required to give financial security for the adequate performance of their duties. For example, the first male and female keepers of the Guy's Hospital lunatic house had to provide securities of £50 each:

Resolved. That the said Keepers do give security of fifty pounds each for their Honesty and good behaviour.²¹

Institutional rules commonly contained threats of dismissal for breaches, coupled with exhortations to behave well. The 1792 rules for Bethlem illustrated this:

XL1. That it be the duty of every Officer and servant belonging to both Hospitals generally to promote the true interests of the Charities, as well by his or her own diligence and example in the department wherein he or she may be employed, as by recommending to others a strict observance of the rules and orders; upon no account conniving at, or concealing, any infringement on them by others.

XLV That if any Officer or Servant of either Hospital transgress or deviate from the true and plain meaning of any of the rules and orders, whether the same respect his own department or any others, he or they be immediately suspended by either of the Committees, and discharged by the next General Court, at the instance of any Three Governors.²²

Staff could also be paid gratuities for good service, either as a regular part of their duties, or in unusual circumstances. For instance, in March 1728, the Guy's Hospital steward received a £100 gratuity for establishing the lunatic house, and a system for monitoring the delivery of supplies.²³

However, these payments, though overtly rewarding past service, by their discretionary nature also looked forward, providing an incentive to continue good service, and discouraging conduct discrepant with the governors' agendas. Gratuities were thus a reward, an incentive, and a means of minimising

misconduct. For example, in December, 1657 Dr. Nurse, the Bethlem physician, was given a £20 gratuity for his past work and “*his future encouragement.*”²⁴

The incentive value of gratuities depended on their intermittent award. However, they commonly became a regular part of an overall wage package, so that their only incentive value lay in their removal, which was rare, as it depended on notable dereliction of duties. Governors gradually realised that their incentive value was compromised, and they became absorbed into the normal wage.

Additionally, servants could be sometimes be made to serve a trial period as a check on competence, and adherence to the governors’ agenda. For example, in June 1760, at St. Luke’s, Margaret Davey who had been “*well behaved*” during her trial, was hired:

Margaret Davey having been upon Tryal in the house as a woman servant since the 28th day of June last during which time she having been behaved well to the satisfaction of this Committee

Agreed to hire her as a Servant for £8 a Year.²⁵

5.3.4 Surveillance, Visitations and Patrols

Senior staff monitored servants’ conduct, and reported derelictions of duty to the governors. At the Newcastle Lunatic Hospital, for instance, the matron’s duties required:

THAT she see that all the Nurses and Servants do their Duty, and observe the Rules of the House; and that in case of Misbehaviour or Neglect, she acquaint the Committee or House Visitor therewith.²⁶

Stewards and matrons made regular “rounds” to monitor hygiene, quality of care and servant’s conduct. For example, the 1778 regulations for Bethlem gave a schedule for the steward to patrol different parts of the institution on different days:

That he shall go round the galleries, and up into the chequers both on the Mens and Womens side every Monday, Wednesday and Friday in the forenoon, to see that the galleries and cells are kept as clean and neat as the condition of the Patients will admit; and that such Patients as are not fit to be exposed, are properly confined.....²⁷

Similarly sub-committees regularly inspected the institutions. At the French Hospital, for instance, two or more members of the quarterly managing committee visited the hospital at least monthly, inspected the rooms, and ascertained whether inmates and staff were conforming to their duties.²⁸ This hospital had an additional system of surveillance through independent visitors from the general court. Reports of these “visites generales” indicated that they examined every room, talked to inmates, checked food, and assessed the cleanliness and state of repair of the building. Indirectly, both staff conduct, and the effectiveness of their own managing sub-committee, were being monitored.²⁹

5.3.5 Complaints Mechanisms

Another means of detecting malpractice, and initiating repair, was a complaints procedure. This designated an individual, or committee, to whom complaints could be addressed, or made a book available in which they could be written. Bridewell and Bethlem Hospitals, for example, provided books for this purpose, which also invited suggested remedies:

That a book, intituled, “The Visitors Book,” be constantly kept in some convenient and public place at each Hospital, wherein any Governor or Visitor may enter complaints of neglect or misconduct, and suggest reforms...³⁰

5.4 Sources of Income

Institutional income, broadly, fell into two categories. First, one-off injections of capital, for instance legacies, or donations. Second, regular income, for instance from charges for inmates, interest on investments, or rents from property.

Normally an institution would gain property, or investments, on its foundation. For example, Guy’s and the Bethel Hospitals began with donated buildings and legacies, and St. Luke’s with subscribed finance.

Donations and legacies were important sources of funding, often coming from those having previous contact with an institution. Deceased, or newly appointed.

governors, retiring officers, deceased relatives, and so on, might provide such finance. At Bethlem, lessees of hospital property would also often make small donations.

While donations were usually monetary, food, or other goods, could also be given. Unusually, in November 1695, an anonymous benefactor gave Bethlem sixteen tickets for "the million adventure" lottery, any income going towards the new "wardrobe" being established for poor inmates.³¹ Incurable inmates were also commonly designated recipients, as in 1780, when the St. Luke's governors accepted £100 in bonds, the income from which was required to maintain an incurable for life, before reverting to the hospital.³²

More rarely, gifts established a permanent service. An example was Bartholomew Balderstone's 1766 bequest of £1,000 to establish a trust for the maintenance of two lunatics at the Bethel Hospital, who were to be supplied with "*food, physick and ordinary apparel suited to persons of their distracted circumstances.*"³³ Donations were also sought for specific projects, such as the new incurable wing of Bethlem Hospital in 1725.³⁴

Income also came from collections, and most institutions had collection boxes for inmates, and sometimes staff, which were periodically opened. For instance, in March 1743, the "*Troncs & boites en divers espaces*" [Poor boxes and other collection boxes in various places] yielded £1.19.5¼ for the French Hospital.³⁵

Possibly uniquely, the French Hospital retained property left by dead inmates. This was generally of little of value, as in the case of Susanne Bailiff who died in 1772:

Le 11 Dec^r 1772 Nous avons fait L'inventaire des effets de Susanne Baillif 1 Robe, 3 Juppes, 1 Chemise, 2 Tabliers, 2 Mouchoirs, 1 Camisole, le tout vieux.³⁶

[On the 11th December 1772 we have made the inventory of the effects of Susan Bailiff 1 Dress, 3 Skirts, 1 Blouse, 2 Aprons, 2 Handkerchiefs, 1 Camisole, all old.]

However, on occasion, effects could be valuable. For example, Jeanne Harpin on admission, brought in 21 items of silver plate, cutlery, and other items which, when

she died, accrued to the hospital. Some were sold, and the rest placed “*a l’usage des Messieurs*” [for the use of the gentlemen], presumably the visiting governors.³⁷

Capital could also be generated by selling institutional investments, property, or land. The French Hospital, in 1761, raised £4,645 by selling its property at Walbrook, the proceeds being invested in bonds.³⁸ Another source of capital was the sale of materials from an old building, as in January 1806, when the Bethlem governors sold materials from the demolition of the old hospital to partly defray the expense of the new one.³⁹

Turning to regular income, most institutions levied weekly charges for keeping inmates, and additional charges could be made for admission, bedding, clothing and burial. The rules for the Newcastle Lunatic Hospital were fairly typical:

THAT the Parish Officers shall give a Certificate of his or her Poverty, to entitle them to be admitted as Poor. And that Security shall be given by the Parish Officers, for the Payment of FOUR SHILLINGS per Week, during their Stay in the Hospital; also for the Expence of their Cloaths and their Burial, in case they die in the Hospital.⁴⁰

Surplus funds were used to buy land, property, bonds, or other investments, to generate regular income from interest, dividends and rents. The governors of Guy’s Hospital, for instance, had considerable holdings of land in Hertfordshire and Essex.⁴¹

Bethlem’s governors regularly leased out land in the first hospital’s precinct, which became a residential area. In July 1634, for example, John Speakard was granted a 21 year lease of his house in Bethlem, and donated ten shillings to the hospital:

Upon John Speakards petiton for a lease of his house at Bethlem wherein he dwells it is ordered that he shall have a lease for 21 yeares from Midsomer last at Seaven pounds per anm without fine which he is content to accept and is to give in earnest to the use of the poor xs.⁴²

The cellars of the second hospital were also leased out as warehousing. Similarly, in January 1741, the Guy’s Hospital treasurer informed the court that he had let the cellar under the centre building to a brewer at £8 p.a.⁴³ St. Luke’s governors also

leased out part of the hospital site to tenants, including John Wesley, whose meeting house and personal dwelling, were there.⁴⁴

5.5 Expenditure

Expenditure involved outlay on single projects, and regular expenditure on supplies and maintenance. Governors were also alive to waste, and economised where possible.

Building costs were normally the largest item of expenditure. Although initial construction, or purchase, was generally covered by foundational funding, improvement, enlargement, or rebuilding involved expenditure outside the regular cycle. For institutions which leased out property, similar one-off expenditure was required, particularly when new leases were involved.

In October 1726, for instance, the Guy's Hospital court of committees embarked on building the lunatic house specified in Guy's will:

Mr Treasurer and Mr Lade are desired to consult with Mr Dance and proceed forthwith to have a building provided convenient for the taking care of Lunaticks mentioned in Mr Guy's Will.⁴⁵

The estimated cost was £320, but this rose to £434 with additional work.⁴⁶

Non-routine expenditure was also incurred in repairing hospital property prior to leasing it, though governors strove to shift such costs onto tenants. However, this was not always possible, as in November 1657, at Bethlem, when Elizabeth Withers held a lease of "*an old decayed house there ready to fall.*" She was financially unable to repair it, rebuild it, or pay any rent. It was agreed that she should surrender the lease to allow the governors to rebuild the property, in exchange for "*a fitt consideracon for her interest therein.*"⁴⁷

"Fitting up" a new, or improved, part of an institution's building involved expenditure on furniture, decorations, or equipment. For example, in March 1755,

bills amounting to £10.19.0 were paid for new chairs and upholstery, together with carpentry work, for the new committee room at the Bethel Hospital.⁴⁸

Non-domestic equipment was also frequently bought. For instance, in 1698, shortly after the opening of St. Peter's Hospital, equipment was purchased for disciplining disorderly inmates:

In 1698, an order was given to purchase two iron chains, with locks, to fasten disorderly people to the two blocks in purgatory (a place so called in the Mint Workhouse) and also to erect a pair of stocks and a whipping post in the yard.⁴⁹

One-off payments were commonly made to inmates, staff and tenants who were in some kind of need, though these will be discussed in section 5.10 below, and in chapter 6.

Regular expenditure in the institutions covered areas such as:

- Salaries, gratuities and pensions.
- Building maintenance.
- Heating and lighting.
- Food and drink.
- Inmate and staff clothing.
- Bedding.
- Laundry.
- Water supply.
- Night soil collection.
- Vermin control.
- Medical supplies.
- Restraining devices and clothing.
- Barbering.
- Stationery.
- Burials.
- Rent and other payments on leases.

A full account of expenditure would require more space than is available here, and three examples will be given to illustrate this area. These are food, restraining devices, and medical supplies:

The major items of food and drink purchased on a regular basis were meat, bread, butter, cheese, and beer. For example, in November 1751, a contract to supply beef and mutton to St. Luke's was made with Samuel Hall. As usual there was a fairly detailed schedule of what was to be supplied:

Ox Beef

Sirloins and Ribs once a Month

Clods and Mouse Buttocks without Bone

Buttocks, Thick Flanks, and thin flanks and Leg of Mutton

Pieces cut market fashion

Mutton in Sides to weigh about 35 pound.⁵⁰

Poor quality could lead to a loss of contract, as shown by the butter & cheese contract at Bethlem where, in July 1719, quality was inadequate. The existing cheesemonger was told this, and asked to attend the treasurer to explain himself. He failed to do so and was replaced by Edward Bosworth, with a saving on the previous contract.⁵¹

Restraint equipment was also regularly supplied. For instance, in January 1798, a dozen leg locks were ordered to be paid for by the treasurer of the Bethel Hospital:

Ordered that the Treasurer pay Mr John Browne two pounds for 1 doz leg locks for the use of this hospital.⁵²

Turning to medical supplies the most frequent item was "physick," which could take the form of herbs, spices, chemicals, roots, bark and many other substances. Records of payments were frequent, as at the Bethel Hospital in 1731:

Also that the Treasurer pay to Mr Tho Johnson his bill for physick from the 29th of March 1730 to the 16th of this instant June being Six pounds eleven shillings & 6d.⁵³

Governors were alive to economies, and rules sometimes counselled against waste. For instance, the Bethlem steward was required to ensure the cinders were sifted as an economy procedure.⁵⁴

Inquiries also considered economies. One such, at St. Peter's, in 1743, thought a salaried apothecary to be more economical than, presumably, buying in sessional services:

.....Great Expencc might be saved by Choosing an Apothecary that would take on him for a Settled yearly Sallery to Visit the Poor in and out of the House, give them proper Advice and Assistance, and supply them and also the Surgeons with Druggs and Medicins from time to time that will be proper for the use preservation and Benifit of such Poor People.⁵⁵

Another economy was to produce supplies in-house. For example, in January 1738, at the French Hospital, it was decided that it would be an economy if the hospital grew its own fruit, fruit trees subsequently being planted on newly leased land.⁵⁶

5.6 Supply and Demand, Planning, Development and Improvement

Providing lunatic confinement was an expanding business. Institutions were frequently full, with waiting lists. In the face of rising demand they expanded, converting surplus space and enlarging their buildings. Occasionally, governors attempted to predict future need. In addition there were opportunities to develop new lines of business, most clearly taking in incurables and, in Bethlem's case, criminal lunatics, and army and navy men who had become mad. Additionally most of the institutions gradually upgraded their facilities adding, or improving, day rooms, infirmaries, and recreational spaces, and providing better heating, clothing and diet.

Provision of services for "incurable" inmates was noted in chapter 4 (section 4.5.3), and will not be discussed further here. However, the provision of services for those judged criminally insane, who could be confined for a fee, generally for life, without any serious requirement that they be "cured," was similarly lucrative. This facility was only provided at Bethlem which, by the start of the nineteenth-century, housed a number of such inmates, and had a good working relationship with the Home Office. By late 1815 a new building for this category of inmate had been completed on the

site of the new hospital at Southwark, and was inspected by a representative of the Home Secretary:

Mr. Cupper from the Secretary of States Office attended the Committee and went over the Criminal Lunatic Buildings attended by the Treasurer, medical officers, Steward and Clerk of the Works....⁵⁷

Bethlem also housed, for a fee, mad army and navy personnel referred by government agencies. In 1814 a number of places were reserved for such inmates, despite government admissions being reduced:

...in consequence of the number of Government patients being reduced other male patients be admitted as there may be vacancies leaving room at all times for four Government Patients.....⁵⁸

Governors sometimes made attempts to produce a vision of the future. In 1806, for instance, the Bethel Hospital governors faced inmate numbers rising above the available space. At a special meeting the treasurer presented a number of alternative development plans:

1st Whether to make such additions to the present house as may not only more sufficiently accommodate 60 patients but be ample for the purpose of increased numbers or 2nd confining the improvements to the adequate accommodation of 60 patients, reserve the accumulation of our surplus income for the forming a separate establishment & 3rd In the event of a future establishment to determine the expediency of appropriating the present house to women & forming the separate one exclusively for men.⁵⁹

Governors also attempted to improve facilities in terms of comfort, efficiency, economy and modernity. A common improvement was the creation of an infirmary for sick inmates. For example, St. Luke's had an infirmary from 1764 and, in 1771, replaced this with two new infirmaries, presumably one for each sex, in two houses. These had more room than was needed, and it was ordered that they should also be fitted up to take in more ordinary inmates.⁶⁰

5.7 Financial Monitoring and Control

Governors were generally financially prudent, attempting to ensure that expenditure was directed to its intended object, was not excessive, and that quality was

commensurate with price. However, their prudence could be undermined by incompetence, inefficiency or corruption and, for this reason, financial monitoring and control mechanisms were in place, which could signal the emergence of events discrepant with the ethos of the governors, and enable suitable repair to take place.

The key officer was the treasurer. He was generally unpaid, but might receive perquisites, such as a house. Clear regulations governed his appointment, term of office, responsibilities, and conduct, and he could be required to provide security for his adequate performance. He monitored others, frequently being a member of sub-committees when financial matters were involved, but his own activities were also routinely monitored through his accounts, which were generally audited at least annually. The treasurer at Bethlem Hospital, for instance, was subject to stringent financial control and scrutiny:

He is to keep regular cash-books, and also to enter, in a book to be kept for that purpose in the Clerk's office, all his receipts and payments as they may occur on account of both Hospitals so that any Governor may at all times have it in his power to see what balance he hath in hand; and he is to invest all sums of money he may at any time have in his hands, exceeding a resting general balance of £500, [Handwritten note £1,000] in-the Public Funds, for the benefit of the Hospitals, when so required by a General Court, or by the House Committee, or by the Committee of Auditors, or by Nine Governors.....⁶¹

He did not normally manage the institution's finances personally, authority to spend being delegated to sub-committees, and to the steward or master.

For instance, the court of committees at Guy's Hospital, was permitted to purchase land and property up to £12,000 p. a.⁶² In contrast, the power of the St. Luke's house committee, which ran the hospital day-to-day, was restricted to paying routine bills and buying furniture.⁶³

Stewards, too, generally had limits on the funds they controlled, despite running the institution. The Bethlem treasurer, for instance, was required:

To advance the Steward, from time to time, such sums of money as may be necessary to discharge the Tradesmen and Workmens bills.⁶⁴

Humbler staff did not normally handle money, but this tacit prohibition was broken at the first Bethlem Hospital, where the porter was given a cash float of twenty shillings, to give visitors change, presumably removing any excuse to not make a donation:

And that there shalbe xx s. allowances remaine in the hande of Humfrey Withers porter there in small money to change the money of such persons as shall come into the said hospitall to see the poore.⁶⁵

Small purchases were commonly capped, controlling extravagance and waste. For instance, at Bethlem, in 1785, the steward was given permission to purchase sheets for the inmates, for a sum not exceeding £20:

It is ordered that a sum not exceeding £20 be laid out by the Steward in providing Sheets for the use of the Patients in this Hospital...⁶⁶

Treasurers and stewards kept regular accounts of income and expenditure, which were regularly inspected. The steward was normally expected to produce his “books” for inspection by the hospital committee, and the treasurer produced annual accounts which, with his books, were normally scrutinised by governors appointed as auditors.

For instance, at Bridewell and Bethlem Hospitals, a committee of auditors was annually appointed to maintain a continuous audit of accounts, audit and present annual accounts, ensure appropriate investment of surplus funds, and detect any negligence.⁶⁷

Financial control of purchasing was normally through contracts with suppliers. These were generally for six months, or a year, and specified a required level of quality. Like one-off projects, such as building repairs, contracts were generally awarded to the lowest bidder in a process of competitive tendering through sealed bids, following advertisement. For example, in July 1751, the general committee of St. Luke’s agreed to advertise for suppliers of provisions for the new hospital.⁶⁸ Following the receipt of bids, on 28th August, a six-month bread contract was awarded to John Thorogood:

Agreed to contract with John Thorogood untill Lady day next to serve this Hospital with Bread upon the Proposals Offered in his Letter Vizt three halfpence under the half Peck Second Loaf as that rises and falls, the same appearing the most reasonable.⁶⁹

Tradesmen's, and supplier's, bills were commonly examined by the treasurer, or a high level committee, before being passed for payment. This controlled for fraudulent claims, and for collusion between staff and suppliers to inflate bills. For example, at St. Luke's, only the treasurer handled money directly, bills being scrutinised by the hospital general committee and a draft given to the supplier, who could take it to the treasurer for payment. This ensured that bills were scrutinised by those able to judge their accuracy, and that payments by the treasurer were controlled.

Those placing inmates had to provide securities, normally two householders, who would enter into a bond to ensure payment of the institution's charges, often up to a value of several hundred pounds, and to undertake the reception of the inmate on discharge. For instance, in November 1757, Catherine Parkins was admitted to the Bethel Hospital, the Overseer of the Poor of Upton Parish having entered into the required bond:

Ordered that Catherine Parkins of Upton in the County of Norfolk aged thirty five years (having been examined by the physician & trustees) be & she is hereby admitted into this hospital, the Overseer of Upton having given the usual security for her maintenance.⁷⁰

Money paid out generally had to be signed for, often in the ledger detailing the payment so that a tangible record of its receipt existed. For instance, in January 1729, the new Lunatic House at Guy's Hospital was finished, and the final payment of £134 for carpentry and joinery was recorded in the hospital's receipt book, and signed for by John Purde:

Reced the 24th January 1729 of Charles Joye Treasr of M^t Guys Hospital one hundred thirty four pounds w^{ch} with £300 already payd is in full for all Carpenters & Joyners work done at & about the Lunatick House I say reced for the Ex^{ts} of Nicholas Swaine & myself. £134 John Purde.⁷¹

II. Challenges to the Discourse of Control and Commerce

5.8 Challenges to the Governors Right to Govern

Direct challenges to the governors' right to govern were rare, only occurring at the master, or steward, level. An example was the case of Robert Waller, the first master of the Bethel Hospital, a personal appointee of the hospital's foundress, who was continued in his post by her trustees, after her death. In July 1725, they minuted that he had been contemptuous when they gave him instructions, saying he would not be directed by anybody:

.....upon discourse had with him on these occasions has used severall contemptuous expressions against the said Trustees declaring that he would not be directed by any man and that they might put another person into his place as soon as they pleased & shld like.⁷²

Inexplicably he was not dismissed, and probably felt particularly safe, having been appointed by the foundress. The trustees may also have been loath to dismiss him for this reason.

Such staff could also challenge the governor's right to govern by blatantly flouting accepted practice. For instance, in March 1782, the St. Luke's general committee received a report concerning misconduct by the Pearsons, the newly appointed male and female keepers. According to the report Mrs. Pearson had received money from a deceased inmate's relative and, with her husband, purloined this inmate's clothes. They had also kept two of their children in the hospital, and replaced the contracted tallow chandler, and painter, with others of their own acquaintance. Additionally, they had allowed inmates to be taken out, permitted some to dine out with friends, and illicitly charged friends of pauper inmates for mending, and other services. Finally, they had converted the straw chimney into a pigsty:

.....it further appears to them that instead of using the Chimney in the Yard for the Purpose of burning the Waste Straw they have left the Straw a Dunghill in the Yard to the great Detriment & Health of the Patients in a Place where the Air and Room are already too much confined & have converted the Chimney from the Purpose for which it was intended into a Hogstye.⁷³

The Pearsons were dismissed, the governors' damaged ethos having been repaired by holding an inquiry, locating "bad apples", and ejecting the problem along with the miscreants.

Both cases can, perhaps, be seen as belonging to a transitional phase in public office, in which a tradition of milking such positions for personal gain was being replaced by an obligation to act for the public good. Notably, in neither case, were institutional failings which allowed such behaviour to take place clearly addressed.

5.9 Poor Commercial Practice

Despite relatively sophisticated systems for monitoring, and control, of finances and staff, these were not always effectively implemented through error, incompetence and inattention. Practices could also become established which made life easier for staff, but impaired the commercial efficiency of the organisation, and sometimes verged on fraudulence.

Auditing accounts, or investigating malpractice, depended on regular, accurate book keeping. This was not always the case, for example, in November 1814, the Bethlem governors admonished the steward for not clearly separating, in his accounts, regular payments made by him, and those made quarterly, by the treasurer:

The Governors present observing that the Steward in his weekly account mixed the account of articles paid by him, together with other articles only delivered in by the butcher baker & milkman through the week, but which are paid by the Treasurer once a quarter, directed that in future the account should be regularly kept distinct by the Steward.⁷⁴

More significantly, in 1801, a Bethlem sub-committee reported on possible economies in the consumption of bread. It had compared the quantity of bread delivered, and putatively consumed, with the probable consumption over a year, finding consumption which could not be accounted for. It reported that the steward, Peter Alavoine, had hampered its enquiries by making erasures in his accounts, but would not explain why. The implication was that staff members were purloining supplies, or that deliveries were being claimed which had not occurred:

.....our examinations have been peculiarly disturbed by Mr. Peter Alavoine, the Steward, who has made many erasures in the number of Patients since his Book was first produced to us, as authentic, but he is unwilling, or cannot explain, why he has so done.⁷⁵

Poor commercial practice was also evident in bad investments. For example the Bethel governors, in 1733, unwisely invested over £2,000 in South Sea stock which, eighteen months later, had to be sold at a loss of just over £60.⁷⁶

Arrears of rents, inmate charges, and other regular payments, could be allowed to build up through poor record keeping, monitoring or collection, with consequent problems recouping the debts, which, sometimes, were never fully collected, or were written off. Similarly, other money owing to the hospital could be allowed to remain unpaid, with consequent losses, or prolonged and expensive legal action to recoup it.

An example of the mess governors could get themselves into is illustrated by the case of the elderly John Freeze, who inhabited a house in the Bethlem precinct. In February 1646 Freeze was ordered to vacate his house, which was decayed, and at the end of its lease, so that it could be demolished.⁷⁷ By October, matters had reached crisis proportions as Freeze was apparently forcibly resisting eviction, and adjacent empty houses were being colonised by undesirables. Freeze was ordered to be arrested for his arrears of rent, and other, unspecified, damage.⁷⁸ However, the matter ended, not by legal means, but by an act of God, as his decayed house blew down, and he and his wife were forced, cap in hand, to go to the governors for aid. No doubt with a sigh of relief, the governors gave them forty shillings to re-establish themselves elsewhere, on condition that they did not return.⁷⁹

Contracts attempted to balance price against quality, but failure to monitor quality over time could result in suppliers gradually degrading it, leading to complaints by consumers. For example, at St. Luke's there were frequent complaints that the beer was bad. On one occasion, in September 1767, it was, again, very poor, and the brewer was summoned to explain himself. One suspects that the brewer may have got the better of the governors as he managed to sell them a more expensive variety:

The Small Beer of late having been very bad and Mr. Salmon the Brewer attending and acquainting this Committee that from the present Dearness of Malt & Hops he could

not afford to serve the Charity with better Beer at 8s a Barrell and that he would advise the Charity to have Beer at 10s a Barrel as that sort is bunged down and not so great a waste therein as in the other.

Resolved That the Charity be at present served with Beer at 10s a Barrell.⁸⁰

The final sanction for exasperated governors was to find another supplier. In September 1782, the beer at St. Luke's was again so poor that it had the unwitting effect of purging the inmates. Consequently it was ordered that the steward should be asked to find another brewer.⁸¹

Waste was a common problem and, at St. Peter's Hospital, in 1784-5, was reduced by a series of reforms after it had been found that the inmate population was regularly overestimated when purchasing supplies, there were inmates who should not have been there as they were able-bodied, and the quantity of goods was regularly below contracted requirements as they were not weighed on delivery. The oddest discovery was that inmates were selling surplus food back to the hospital:

The fourth reform revealed the most startling abuse: bread and cheese had been supplied so much in excess of demand that the inmates, forbidden to dispose of provisions outside the Hospital, sold back the surplus to the Matron at 1d. a loaf. In twenty months this second-hand trade showed a turn over of 65,342 pound loaves, and in one year it cost the House nearly £1,000, not counting the first-hand purchase of the food.⁸²

5.10 Conflict between good commercial practice and the exercise of charity

The institutions were simultaneously businesses, which needed to remain financially viable, and charities which, in the eyes of their governors, dispensed care and cure. This caring function frequently came into conflict with purely commercial considerations, leading to practices which, although kindly, were, strictly, un-commercial.

Relatives and parishes commonly attempted to have the normal maintenance charges reduced by presenting petitions alleging hardship, to which governors frequently succumbed. For example, in December 1670, the churchwardens of St. Leonard, in Foster Lane, achieved a reduction in their charge, and arrears, in respect of Mary White, a Bethlem inmate:

Alsoe upon the humble peticon of the churchwardens of the pish of St Leonards Foster Lane for a mittigation of the payment of fower shillings a weeke towards the charge of keepinge Mary White a poore lunatike woeman of that pish in Bethlem there now being eight pounds & sixteene shillings arrears due for the same and the petitioners heveing now here paid sixe pounds pcell thereof in respect of the greate losses of the inhabitants of that pish & their greate burden of other poore Itt is thought fitt & ordered by this courte that the said sixe pounds shalbe accepted and the fifty sixe shillings residue thereof shalbe abated unto them.⁸³

Staff could plead hardship on account of sickness, financial loss, bereavement, decrepitude and so on, and might be granted a sum of money to “relieve” them, or given leave to have a spell in the country to recuperate. Similarly, long-serving staff might be given a small pension when they became too frail to continue. Others might be provided with an assistant to aid them. For example, in June 1759 Joseph Mansfield, the keeper of St. Luke’s, was allowed a stay in the country, as he was ill. His wife was given leave to accompany him, and a deputy to substitute for her.⁸⁴

Discharged inmates were also often relieved with small amounts of money, or clothing, to help them on their way. For example, in March 1671, John Sutton, a Bethlem inmate, was to be discharged “*cured*”, with half a crown for his relief:

...Itt is ordered that John Sutton a poore lunatike man lately sent to Bethlem from the Greencloth being now cured of his lunacy be delivered & discharged thence with twoe shillings sixe pence for his releife if the Greene Cloth shall approve thereof....⁸⁵

5.11 Governor and Staff misconduct

Governors, and officers, could behave in ways seen as bringing “dishonour” on the governing body, though such challenges were rare. Normally repair was effected by expelling the offender from the governing collective, removing the threatening alternative ethos. The resignation of the governor Thomas Horne outlined in section 5.3.2 was an example of this. More commonly, it was misbehaviour by paid staff which breached the governor’s managerial ethos, necessitating repair.

Incompetent staff were normally dismissed. For instance, in April 1619 Thomas Jenner the keeper of Bethlem, was dismissed for unspecified misbehaviour and incompetence:

The Keepe shippe of Bethlem became voyde by the displacinge of Thomas Jenner, late keep there for misgoveninge and misbehavinge himselfe in the governmen^t thereof, beinge altogether unskilfull & unfitt for the same.⁸⁶

However, even competent staff might carry out their duties with minimal effort, or attention. For example, in June 1772, complaints about John Harris, the newly appointed apothecary at St. Luke's, resulted in an inquiry. Though his competence was not questioned, the inquiry report radiated an air of disapproval at his lifestyle, as well as his neglect of duty:

The Committee having met at the Hospital to inquire into the Conduct of Mr Harris the Apothecary, and Mr. Mansfield being called in and acquainting this Committee that Mr. Harris frequently goes out in the forenoon, and does not return again till after 1 o'Clock in the Morning, and that very often in Liquor, and that he never leaves word with any Person where he is gone to that in Case he is wanted he might be sent for, and instead of giving the Key of the Shop to him, he leaves it with Joel Dance one of the Incurable Patients in the Hospital and that he frequently has Company to Dinner and Supper and keeps very late Hours which greatly disturb the Patients.⁸⁷

The inquiry ended in his dismissal.⁸⁸

Disagreements between staff members also interfered with the smooth application of the governors' managerial ethos. A good example was the lengthy dispute between Richard Langley, the Bethlem steward, and Humphrey Withers, its porter, or possibly their wives. Part of the problem appeared to be that the Wither's maidservant was going between their two houses, via a connecting passage, and carrying tales to Mistress Langley, inflaming disagreements between the two couples. The maid had been warned to keep away from the Langley's house, and to find herself another position, and the door between the two houses had been ordered to be locked to keep the couples apart. However a later inquiry found:

...the said middle doore hath not beene kept locked & bolted in Mr Langleys default whereby mure discords hath lately been occasioned & made. And forasmuch as a former meetinge & endeavour herein have not taken that goode & full effect as was desired. Therefore now upon our further deliberate examination & hearing all parties and their witnesses we finde the said Humfrey Withers hath carryed himselfe honestly dilligently & faithfully in his place and the greivances complayned of in his petiton have growen and arisen by abuses in words blowes assaulte & fowle carriages offred & done unto him by Mr Langley and his wife as was testified unto us by credible witsnesse....⁸⁹

Staff could carry out their duties unwillingly, or be insubordinate. For example, in October 1768, two St. Peter's Hospital servants were punished for drunkenness and abusive behaviour:

Ann Burnell for cursing the Deputy Governor and Committee and Elizabeth Williams for getting drunk and being abusive are ordered to be confined in the House, having been punished by being confined for some time in the Penn.⁹⁰

The female pennis were small, unheated wooden closets, just large enough to contain a person, and commonly used to confine disturbed lunatics.⁹¹

Motivated misconduct, in which staff feathered their own nests, was more serious. The magnitude of the breach tended to depend on their position, abuses by senior staff generally being seen as causing public dishonour, and as considerable breaches of trust. Challenges to the governors' ethos from lower level staff were generally smaller in scope, and to some extent anticipated, as staff of greater status were commonly charged with monitoring their behaviour.

Legitimate use of hospital resources could be carried beyond a normal limit, and verge on misconduct. For instance, the committee of inquiry into waste at Bethlem Hospital, referred to in section 5.9, found unexplained excessive consumption of most regular hospital supplies, and came close to accusing the senior staff of misuse of the provisions, and candles, allowed as perquisites. Repair involved abolition of these allowances and their replacement by agreed salary increases.⁹²

Staff could steal hospital property, particularly food, and other easily portable items. Junior staff, being poorly paid, lacking the allowances granted to their superiors, and farthest from the influence of the governors' managerial discourse, were the most vulnerable to the temptation of alternative agendas which could materially improve their lot. For example, in October 1768, at St. Peter's Hospital:

Margaret Slowman one of the Nurses of the House having been detected in selling the Provisions out of the House Ordered that She be whipped in the Yard in the presence

of all the Family who are able to attend, immediately and that she receive one Dozen Lashes, and that she be confined to the Penn till she behaves better.⁹³

Staff could take bribes, for instances from suppliers, for turning a blind eye to short measure, or inferior quality, or from grateful relatives for services provided to them, or their lunatic inmates. They could also solicit “gratuities” from visitors for showing them the hospital, or for other services. Frequent efforts were made to stamp out backhanders, prohibitions against illicit payments becoming enshrined in the rules of the institutions, for example at the Newcastle Lunatic Hospital.

VI THAT no Person do at any Time presume (on pain of Expulsion) to take of any Tradesman, Patient, Stranger, Servant, or other Person, any Fee, Reward, or Gratuity of any Kind, directly or indirectly, for any Service done or to be done, on any Account of the Hospital.⁹⁴

When making contracts, staff or governors might also ensure that contracts went to businesses in which they had some interest. Specific examples were not noted in the material examined, but are likely to have occurred, as several institutions had rules forbidding such practices. The rules of St. Luke’s, for instance, prohibited members of the general committee, which made contracts, from becoming suppliers to the hospital.⁹⁵

Staff could also illicitly charge inmates, or their relatives, for goods or services provided free by the institution. For example, the charge levied by the keepers of St. Luke’s for mending, and other services, referred to in section 5.8, was an example. Similarly, at the French Hospital, in 1760, it was discovered that, for many years, male inmates had been paying an illicit demi-sou per week to each of the domestics to bring coal to their rooms. It was ordered that this should stop and the Steward was charged with putting the order into practice.⁹⁶

Illicit business activities by staff could go further than such petty corruption, particularly in the case of senior staff, who had more freedom. For instance, in April 1730, Colwell Champion and his wife, the keepers of the lunatic house at Guy’s Hospital, were found, after an inquiry, to have:

...greatly misbehaved themselves for some time by Changing the Patients cloths and misusing them & carrying on a Pawn broking Trade in the House⁹⁷

As was usual these culprits were dismissed, taking the bad with them and securing repair of the breach to the governors' ethos.

While most staff misconduct was small scale, in some circumstances a larger group of staff might collectively flout the rules of the institution for personal gain. In such cases there would commonly be an acceptance of the misconduct as part of institutional life, almost as a right, and staff might cover for each other to avoid detection.

For instance, in May 1727, at Bethlem, it was alleged that the nurse and upper gallery servants were taking money from visitors to show them the chequers, the upper part of the building. The customary inquiry resulted in a welter of accusations and counter-accusations, with even an inmate being blamed. Lydia Mother and Susan Roe emerged as the principal culprits, and were dismissed, though more widespread misconduct seems likely. The dismissals effected a degree of repair to the governors' managerial ethos and, on this occasion, they immediately prohibited the practice, and required higher level permission for visits to the chequers:

The committee are of opinion that the asking people to see the patients in the Chequers & then demanding money of 'em for it, is an abuse upon the house & ought to be remedyed and therefore It is order'd that no persons be permitted to see the patients in the Chequers without leave of the steward if he be in the way or in his absence without leave of the porter & that no money be demanded for the same.⁹⁸

Importation of dangerous objects was another way in which staff could misconduct themselves, the most extreme example occurring at Bethlem, in October 1804. Edward Watkins, a keeper, had previously entrusted an inmate with a pair of pistols. Although he had already been admonished by the steward, and reminded of orders forbidding such behaviour, he had again given them to the inmate, apparently to have them cleaned:

Edward Watkins one of the Keepers of Bethlem Hospital having entrusted a Patient in the Hospital with a pair of Pistols though admonished by the Steward on returning the Pistols to him of the extreme Danger of leaving any Instrument with the Patients by

which they might do mischief and of the orders of the Governors of the Hospital on that subject yet he had again given the Pistols to the Patient.⁹⁹

Surprisingly, Watkins was simply reprimanded, told to attend to his duty and made to apologize.

5.12 Misconduct by Relatives, Parishes, Tenants, Visitors and Neighbours

Repairs to breaches in the governors' ethos by the misconduct of relatives, parishes, tenants, and visitors could generally be dealt with by attribution of blame to the perpetrator, within the framework of an assumed contractual relationship, followed by punitive measures to force the miscreant into conformity, or termination of the contract. Neighbours were an exception, however, as there was no clear contract, necessitating a less confrontational approach.

Relative and parish misconduct could include falsification, or obfuscation, of admission details, evasion of charges, and failure to take back inmates. Threats, admonishments, and refusal to accept, or retain, an inmate were the first line of repair, though legal action was pursued for serious non-payment.

For instance, in June 1796, the Bethel Hospital governors resolved that, if Benjamin Drawater did not pay the arrears he owed for his wife, she would be returned to the parish:

Ordered that Benjamin Drawater having neglected to pay his proportion of the expence for his wife in Bethel the parish of Carbrook be informed that unless they augment their proportion of allowance to two shillings and sixpence a week Fra's Drawater must be sent home to the parish.¹⁰⁰

More drastically, in May 1652, the Bridewell and Bethlem court ordered Francis Moore, a recovered inmate, to be taken away, and threatened to sue his sureties for the arrears of his charge:

Item Itt is ordered by this courte that unlesse Francis Moore in Bethlem lately distracted and now well recovered bee forthwith taken thence and the moneyes due to the said hospitall for him duely paid till his taking thence the bond concerning him shalbee forthwith sued.¹⁰¹

Tenant misconduct involving non-payment of rent was dealt with in a similar way. For instance, in November 1667, Ann Jones, a widow dwelling in the Bethlem Hospital precinct, had paid no rent since she moved there, and was viewed by the governors as a bad lot. Consequently, a decision was made to evict her:

Alsoe itt is ordered by this courte that Anne Jones dwelling in a house in Huswives Alley in Bethlem about twoe yeares past att sixe pounds rent p Annum and never having paid any rent for the same. And that shee is a loose and disorderly person be forthwith ejected out of the same by due course of law.¹⁰²

Tenant misconduct could also comprise objectionable, or dangerous, behaviour which affected other tenants. Such a situation occurred in September 1640 in the case of William Woodcocke who had turned his house into a tavern. On petitioning to renew his lease it was ordered that the house should be let as a private dwelling to somebody else, no doubt with a clause prohibiting its use as a tavern.¹⁰³

When visiting was allowed, bad behaviour by visitors was seen by governors as degrading the reputation of their institutions. For instance, at the Bethel Hospital, in 1725 the master was found to have been allowing in too many visitors, which had been disturbing the lunatics. In consequence, it was ordered that a notice should be affixing to the front gate:

...that for the time to come the Master of this house or any other under him shall not admit any person or persons thereinto to view the same but the space of the hours following in every fore noone on weekdays from nine to eleven & in the afternoon in the summer half year from two to five & in the winter half year from one to four & likewise the master is obliged not to admitt at any time more persons than ten or twelve at the most to be in the house together & that no more be admitted until the others are gone out & than none be suffered to stay in the house above one quarter of an hour at any one time & no person whatsoever to be admitted on Sundays to view this place.¹⁰⁴

At Bethlem visitor misconduct led to the virtual abolition of visiting in the 1770s. Before that, however, the expedient of providing enough muscle in the galleries to control the visitors was used at holiday periods:

Mr President acquainted this Committee that Great Riots & Disorders have been Committed in this Hospital during the Holidays at Christmas Easter & Whitsuntide It is order'd that the Steward Do provide four Constables and also four stout fellows as assistants who are to be placed in the Gallerys one Constable and one Assistant in each

Gallery in Order to suppress any Riots or Disorder that might happen on Monday & Tuesday in Next Week.¹⁰⁵

Neighbours could, sometimes, cause an actual, or potential, nuisance, but a gentler approach through negotiation, was generally used, at least at the outset. For example, in July 1686, Daniel Man had apparently erected a small building adjacent to Bethlem hospital, and asked permission to place chimneys on it. The governors requested the hospital committee to report on any possible nuisance this could cause.¹⁰⁶ In September 1686 the committee reported back to the court that these chimneys would present a fire-risk, and that the smoke would be unpleasant for the lunatics:

Att this courte the committee for the hospitall of Bethlem reported that they viewed the roomes of Mr Daniell Man at the end of the yard belonging to the said hospitall of Bethlem And that they conceive that if any chymnyes be erected or made to the said roomes That the smoake thereof wilbe prediudiciall and inconvenient to the poore lunatikies in the hospitall of Bethlem besides the dainger of fire that may thereby happen to the strawhouses in the said yard.¹⁰⁷

Presumably Man's petition was rejected at that time, though, subsequently, in January 1700, he was given permission to erect a chimney on London wall, which formed one side of the eastern exercise yard of the hospital, where he had built a shop.¹⁰⁸

5.13 Challenges from the Public or Press

Criticisms by the public, or press, were particularly difficult to deal with, and caused quite serious breaches to governors' ethos of good management by implying that it was not shared by influential sections of the community. To effect repair, the credibility of the accusations, or their source, had to be attacked. This could occur through an inquiry which exonerated the governors and staff from wrongdoing or, in the case of newspaper allegations, by publishing a notice denying any wrongdoing and, sometimes, demanding a retraction and apology, backed by threats of legal action. In the case of anonymous press accusations the identity of the accuser might also be demanded, with a threat of legal action if it was not forthcoming.

For example, on 12th December 1764, the Bridewell and Bethlem general committee was informed of anonymous accusations in the press. Repair, in this case, was attempted by ordering the clerk to demand the identity of the accuser from the printers of the papers involved, to be followed up by legal action if this information was not forthcoming:

Upon reading a letter Signed Mechanicus in the London Evening Post of the 4th day of December instant highly reflecting on the Conduct of the Governors of Bethlem Hospital in their Management thereof and also a paragraph in the Public Ledger of the 8th Instant relating to Bridewell Hospital It is ordered that the Clerk do forthwith apply to the Printers of those papers respectively to learn who was or were the Author or Authors of the aforesaid letter & Paragraph and to inform them Severally that if they do not discover such Author or Authors and desist for the future from Censuring the Management of the Governors of these Hospitals a prosecution shall be forthwith commenced against them.¹⁰⁹

5.14 Conclusions

This chapter has examined practices used by the governors to transmit their ethos downwards, and to implement it, through sub-committees and paid staff. Further, it noted that multiple systems of monitoring and control were developed to ensure that the governors' wishes were correctly carried out. Although the present account was not chronologically organised, these systems are likely to have resulted from the accumulated experience, and management, of problems of implementing the governors' agendas. In the second part of the chapter a range of challenges to the governors' discourse of good management was examined, both in terms of its inadequate transmission, and in its inadequate implementation. Its inadequate transmission was marked by rarely occurring direct resistance to the right of the governors to manage their institutions, and by more frequent examples of its partial, or weak, transmission, so that, in its practices, it was easily overcome by local contingencies of self-interest. Much of the material presented could be seen as illustrating events from which the governors learned, and from which their systems of control and monitoring developed. Overall the account presented would suggest a learning process in which the governors' ethos developed from events from within the institutions, as well as external events. The institutions also seem likely to have learned from each other, though the present material did not allow such influence to be tracked.

Although untoward events could be seen as fuelling institutional development they were also damaging to the governors' ethos of good management. The chapter also examined methods typically used by the governors to repair damage done to this ethos. First, the location of an individual wrongdoer could ensure that institutional failings need not be directly acknowledged. The culprit could then be ejected, taking the bad with them, or subjected to reformative practices. Second, an official inquiry could exonerate the governors and locate a "bad apple," or enable those promulgating external allegations of bad management to be discredited.

The institutions could sometimes be seen as planning for the future, particularly by expansion of their facilities in the face of increasing demand. Their governors also attempted to materially improve conditions in their institutions. Much of what has been described could apply to modern institutions, and it is clear that the governors' pursuit of their managerial responsibilities was by no means primitive, or unsophisticated.

Notes to Chapter 5

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CHAPTER 6

THE DISCOURSE OF CARE AND ITS CHALLENGES

I. The Discourse of Care

6.1 Introduction

In chapter 4 a distinction was made between the rhetoric of care, which obscured the confining nature of the institutions, and their actual care of their inmates. It is with this actual inmate care that the present chapter is initially concerned. However, the institutions went further than dispensing care to inmates and could be seen as caring for their own staff, for relatives and others placing inmates in them, for their tenants, and for their neighbours. These aspects of care will also be considered.

As with the preceding chapters the account will then turn to challenges to the caring ethos of the governors, and to their attempts to rectify matters and repair the damage to this.

6.2 Care of Inmates

6.2.1 Introduction

To coercively confine their inmates the institutions had to provide a basic level of care, if only to keep them alive. They had to be accommodated, fed, clothed, warmed, given bedding and exercised. However, the governors' ethos required that the institutions were places of care, and it is care exceeding that necessary for confinement which this section addresses.

6.2.2 Provision of Material Necessities

Inmates could be cared for by being adequately, and nutritiously, fed, and those needing special diets due to illness, or infirmity, could be provided with these. One means of achieving this was by means of dietary table listing the food to be provided

each day. For instance, the rules of the second Bethlem Hospital included a daily dietary which, the governors thought, would “*much more condure to their recovery then the former dyett given unto them,*” suggesting that diet was seen as having some curative potential. For instance:

Itt is ordered by this courte that they have every Sunday to their dynners boyled Beoffe and broth and bredd And that soe much broth be made every Sunday of the said Beoffe that there might be enough for the said lunatikes their suppers And that the said broth be then heated againe a messe thereof with a peece of bread bee delivered to every of the said lunatikes every Sunday night for their suppers.¹

As well as the general diet, special diets could be provided for inmates who were sick, or unable to manage the normal provisions. The rules of the Newcastle Lunatic Hospital, for instance, made its matron responsible for the provision and recording of special diets:

THAT she keep a Diet-Book, by which the Number of Patients on each Diet may be known....²

Inmates could also be cared for by being given adequate clothing and footwear, particularly in cold weather. This was normally the responsibility of those paying the maintenance charge. However, they often failed to meet their obligations, and there were also inmates for whom neither relatives, nor a responsible parish, could be located. Therefore, most institutions had some mechanism for providing clothes, or shoes, for those in need. Kitting out the lunatics, before the onset of winter, seems to have been a regular event at Bethlem as, in October 1672, its steward was ordered to provide clothing for nine lunatics “*having noe friends or kith to provide for them as is usually done att this tyme of the yeare.*”³

Donations were often directed to ameliorating this problem and, in April 1692, the Bethlem court decided to use a legacy to establish a “wardrobe” to meet these needs:

Also upon report made by a committee of the hospitall of Bethlem concerning the laying out of a legacy lately given by Mrs Margaret Hampton widow for cloths for the poor lunaticks in the said hospitall And the converting and setting a part one of the cells or roomes in the said hospitall for a repository or wardrobe for cloths for the lunaticks this court doth approve thereof and order the same accordingly.⁴

Beds, and warm bedding, were normally provided to inmates, particularly as the institutions were unheated at night. However, inmates who were incontinent, or deliberately soiled, slept on straw, possibly with a blanket to cover them. Nevertheless, attention was given to the quality of the straw and to its regular change to maintain reasonable hygiene. For example, in May 1719, the visiting commissaires of the French Hospital noted that the lunatics' straw was changed weekly, and that this was insufficient to keep them clean. It was ordered that the straw was to be changed twice-weekly, and more often if required.⁵

Beds were infrequently purchased, as they were virtually indestructible. However, in December 1779, the house committee for St. Luke's ordered the purchase of a dozen beds, two dozen rugs and three dozen pairs of blankets for inmates, and six coverlets for servants beds, perhaps suggesting that the provision of coverlets was restricted to the servants.⁶ Another item considered necessary, at least for some inmates, was a rug, perhaps lending a degree of refinement to utilitarian sleeping arrangements. For example, the master of the Bethel hospital, in March 1758 was ordered to buy blankets and rugs for inmates:

Ordered that the master provide six pair of blankets and four rugs for the use of the lunatics in this hospital.⁷

Inmates' cells were unheated, but "warming rooms" were provided which they could use during the day and, at a later date, heated "parlours," or day rooms, were provided. At Bethlem the warming rooms, up to 1710, apparently contained open fires at which inmates could burn their hands. To prevent this it was ordered that they should be replaced with stoves.⁸

Institutions could care for inmates by keeping them clean, shaving them, cutting their hair and washing their clothes. Keeping the institution, and the inmate's cells, free from vermin, cleaning privies and removing night soil could also be seen as caring, though everybody in the institution could benefit. Attention to hygiene could also have a bearing on the reputation of the institution. A missing element was any reference to self-care by inmates, though this probably occurred, particularly by those recovering.

At St. Luke's rules for the maidservants indicated that they were expected to wash the inmates, apparently on a daily basis, as well as undertaking general cleaning duties:

That they clean the House every day before Ten of the Clock, dress the Victuals, Wash & assist in the Care of the Patients.⁹

Shaving and hair-cutting occurred on a regular basis, and there was generally an annual contract for this. At Peter's Hospital, in 1699, shaving, and hair-cutting, was part of the contract with the hospital surgeons, who were to have £10 a year for their services:

.....that the chirurgeons have ten pounds per annum paid them for their attendance in this house, and looking over the people that want their assistance, and likewise for medicines that shall be used in chirurgery, and also for shaving the men, and cutting the boys' hair.¹⁰

Apart from medical intervention directed at the amelioration of madness, lunatic inmates were given care for physical disorders by medical staff. The major evidence for this came from the establishment of sick rooms, or infirmaries, in which the sick could be nursed. These sometimes had dedicated staff and night "watchers" to keep inmates under observation. For instance, Bethlem seems to have had an infirmary from 1741 "*for the Conveniency of such Patients as happen to fall sick of a Feavor or other Distemper.*" This was partly funded by a specific donation, and was built abutting the washhouse at the east end of the hospital. It had male and female apartments holding six beds each, and only a single new maidservant was thought to be required to provide necessary care.¹¹

Another aspect of medical care was the management of contagious conditions by isolating, or removing, those afflicted, the welfare of the sufferer and those who could, potentially, succumb having to be balanced. For example, on 10th February 1786, at St. Luke's, Phebe Revell, who had "*the itch*" (possibly scabies) was ordered to be discharged. Her securities were to be notified to take her away, but with permission to bring her back for readmission when it had been cured.¹²

More serious was the management of smallpox, and the St. Luke's governors, in 1775, began using the London Smallpox Hospital, founded in 1746, which was apparently prepared to accept lunatic patients. For instance, Frances Hall was despatched there in April 1775:

Mr. Mansfield having acquainted this Committee that Frances Hall has got the small
pox
Ordered That she be sent to the small pox Hospital in order to her Cure.¹³

Shortly after, the Bethlem governors took the same course and, by October 1780, were making an annual ten guinea subscription to the Smallpox Hospital.¹⁴

Care also required that buildings should be safe and in repair. For example, in July 1767, at the French Hospital, the report of the visite generale found the madhouse in good order, though the ceilings needed to be whitened as they were dirty, and the plaster was cracked:

...les petits maisons sont assés propres a la reserve des plats fonds qui sont fort sales, et dont le plâtre est fort crevassé et noir, et decroit etre recommodé et reblanchis.¹⁵

[...the cells are quite clean, with the exception of the ceilings which are extremely dirty and of which the plaster is very badly cracked, black and decrepit – to be made good and whitewashed.]

Hygiene was another concern, particularly as some inmates were incontinent. Keeping the French Hospital's lunatic house clean must have been particularly difficult as, in February 1660, the Commissaires de Quartier ordered that a woman was to be employed at least twice a week to clean it, and keep it in better order:

La Compagnie a donné ordre a M^r. Roumieu d'avoir une femme pendant 2 jo. de la semaine au moins, p^r nettoyer la maison des fols & a fin qu'elle soit tenue en meilleur ordre....¹⁶

[The Company has given an order to Mr. Roumieu to have a woman in for at least 2 days a week to clean the madhouse so that it will be kept in better order...]

To minimise smell, privies were regularly cleaned, and night soil removed. For instance, in June 1676, the St. Luke's house committee ordered the "necessaries" to be emptied and, in September, the night soil to be removed, at a cost of £6.8.0.¹⁷

Privies were also an area of continuous improvement, as at Bethlem Hospital in September 1796, when it appeared that water closets were to be installed:

....respecting the improvement of the privies, and the Surveyor being of Opinion that previous to making any Alteration of the same, it would be necessary to pull down the defective Walls, to open and cleanse the drains and to sink a Well for supplying a Reservoir for the use of the new Privies...¹⁸

Controlling vermin, such as bugs and rats, was another hygienic concern. Bugs could easily bite inmates, leading to infected sores. For example, St. Luke's had a regular, annual, contract with Mr. Noyes, the "*bug man*" who undertook to keep the hospital free of bugs for the period of his contract.¹⁹

Hygiene was an area of technical innovation, and the introduction of water closets has been mentioned. An earlier innovation was the installation of running water from the "new river" which brought a regular water supply into London. For instance, in October 1757, the general assembly of the French Hospital agreed to pay £10 to the New River Corporation to supply running water to the hospital, and £10 p.a. thereafter.²⁰

Bethlem Hospital, in 1781, also purchased a washing machine, presumably for clothes, for 18 guineas. This included a "*Guarantee*" to keep it in repair for a year, following which a guinea a year was paid for seven years maintenance.²¹ Another innovation was the replacement of wooden bedsteads, in which vermin could lurk, with easily cleaned iron ones. This was done in several of the institutions examined, for instance at Guy's Hospital in October 1785.²²

It was noted in the preceding chapter (section 5.10) that needy inmates could be given clothing, shoes, travel warrants, or small sums of money, to assist them in returning home, or establishing themselves outside the institution. Some institutions acquired specific legacies from which small payments could be made. For instance, the Bethel Hospital used an 1810 donation of £100 from William Foster, a deceased governor, to make such payments.²³ On 10th October 1810 Elizabeth Neave was ordered to be relieved with £1 from the Foster Donation, this becoming the usual sum paid out until 1813, after which it was generally 10s:

Order'd that one pound out of the donation of the late William Foster Esq be paid to the Rev Mr Bowman for the benefit of the said Elizabeth Neave she being deemed a proper person to be relieved from such donation.²⁴

6.2.3 Protection from Abuse, Freedom and Work

Care could be taken by protecting inmates from physical abuse, exploitation, and insult from casual visitors, and staff. They could also be allowed out of their cells during the day for exercise and recreation. In rare cases, they could be allowed out of the institution, and recovering inmates could be permitted home leave. Additionally, inmate work was a feature of most of the institutions.

Casual visiting could be seen as abusive, but also as providing a public gaze inimical to abuse, as well as a diversion for the inmates. However, its abusive potential led to increasing control. It was specifically prohibited at St. Luke's, at the outset, and tightly controlled elsewhere. Even at Bethlem, famous for its visiting, it had been virtually eliminated by 1770 when it was ordered that visitors would only be admitted by presenting a ticket signed by a governor.²⁵ Other Bethlem material hinted at visitor prurience and, possibly, sexual abuse. For example, in April 1769, the Bethlem committee put forward stringent regulations concerning male access to female inmates. No male was to be admitted to the female side "*under the pretence of visiting the Patients or otherwise,*" suggesting that male visitors might have used subterfuge to gain access to the women. Relations were also only to see female inmates in the committee room, with a chaperoning nurse present, unless visits had been sanctioned by the physician.²⁶

However, staff members were in a better position to abuse inmates, and many institutions had rules requiring them to behave non-abusively, suggesting that it was common. For instance, at the Newcastle Lunatic Hospital, nurses and other servants were required to behave with "*Tenderness to the Patients.*"²⁷ Senior staff were also expected to report abuse. For example the Bethlem apothecary was "*to acquaint the Stewards and Committees respectively of any neglect or abuse and to suggest necessary reforms*".²⁸

Sexual abuse of female inmates by male staff was also hinted at. This was prevented by placing the women inmates in female hands, and barring male staff from female areas. The initiation of female care of women inmates can be seen at Bethlem Hospital in January 1662 with the appointment of a matron to look after them, coupled with the separation of males and females. However, such spatial segregation was achievable without placing the women in female hands, and there was a covert suggestion that their abuse by male staff was being controlled:

Alsoe itt is ordered by this courte that the distracted woemen in the hospitall of Bethlem shalbe continually kept from the distracted men there and that a discreete carefull and able single woeman be provided and kept in the said hospitall to looke to and take care of the distracted woemen there. And that shee may call to her helpe and assistance any one or more of the manservants where shee cannot rule any distracted woemen herselfe to helpe her therein.²⁹

Care also involved allowing inmates freedom of movement. Both Bethlem and St. Luke's had galleries in which inmates could spend their day and, at Bethlem, 1765 rules for the matron indicated an attempt to activate the depressively lethargic:

.....that such of the Patients as are low Spirited or Inclivable to be Mopish be obliged to get up and that they be Turned out of their Cells, the Doors locked, that they may not creep back again to their beds.³⁰

Day Rooms, sitting rooms, or parlours for daytime use were also common. For, instance, in November 1781, at St. Luke's, medical opinion was that a greater degree of ventilation was required in the "*Mens parlour & Great Room & in the Womens Great Room.*"³¹

Airing courts, or gardens, were also provided. For example the women's "*yard*" at the Bethel, in 1797, appeared to have been adapted by the master for his own use and was ordered to be reinstated:

Ordered that the womens yard be restored to its former state namely grass plat and gravel walk round without shrubs or flowers. No pigeons or Poultry of any description to be kept by the Master within any part of the hospital premises.³²

Trusted inmates were sometimes allowed out. For instance, at the French Hospital, lunatics could sometimes go out with a trustworthy non-lunatic. However, this went

awry in the case of one Le Large, a lunatic in the charge of Jean Castain as, in June 1742, both were recorded as returning to the hospital drunk. Consequently Le Large was banned from going out, while Castein was gated for three months.³³ Allowing recovering inmates home leave was also common. For example, on 10th January 1757 Johanna Fuller, a Bethel inmate, was granted leave with friends for a month or two on the doctor's advice.³⁴

Inmate work was a feature of most of the institutions, though many inmates did not work. Work could be seen as exploitative, as it benefitted the institutions, but could also be caring, as it relieved boredom and earned small rewards, and a degree of status. It mainly embraced domestic tasks, and women were likely to have formed the majority of workers, though tasks such as gardening were done by men.

The Bethlem governors clearly thought that inmates capable of work should be productively occupied, rules for the matron including the following requirement:

That she shall distribute the Patients in their proper Cells that each Gallery Maid may have a proper number of such hands as are fit to work to assist her and Employ such of the Patients at their needle as are capable when not otherwise Busied rather than let them walk Idle up and down the House Shewing it to Strangers and Begging Money.³⁵

Although social contact, diversion and status could result from work, the major tangible benefit was additional food. For instance at Bethlem, in December 1796, an inmate assisting the cook was rewarded with a pint of porter and, in May 1804, female inmates assisting the gallery maids were given extra bread and cheese.³⁶

6.3 Care of Staff

The institutions cared for their staff, reflecting their caring ethos but, also so staff would be satisfied, and work effectively.

They probably received free medical care, though this was only explicit in the case of Bethlem and the French Hospitals. The 1778 rules for the Bethlem physician, for instance, included the requirement "*To attend the Officers and Servants when ill.*"³⁷

Staff could also be cared for by the provision of comfortable, well decorated accommodation, commensurate with their status. For instance, by the late eighteenth-century, machine printed wallpaper was probably cheap enough to enter the institutional environment and, in April 1793, the master's room at the Bethel Hospital was wallpapered:

Ordered that the Treasurer pays Mr William Burt Two pounds four shillings and eightpence in discharge of his bill now produc'd & allowed for papering the master's room.³⁸

Bethlem staff were supplied with work clothing. For example, with the completion of the new hospital, in 1676, its servants were to be clothed in blue. Inmates clothed by the hospital, were also to be in blue, as were the figures holding the poores boxes. The porter, greeting visitors, was to be particularly splendid, having a blue gown, and a staff with a silver tip bearing the hospital's arms.³⁹

Staff could also be cared for by being given gifts, or monetary rewards, for special services, or as a sign of esteem. For instance, in September 1710, the bedchamber of the Bethlem nurse was to be furnished in a thoroughly feminine way, apparently as a reward "*for her good service*":

Ordered that the Bedchamber belonging to the Nurse of this Hospital be furnished with the severall things following for the better accommodation of the Nurse for her good service Viz. A bedstead feather bed Boulster pillow blankets Counterpain Valence 4 Chaires Table Looking Glasse and a couple of Window Curtains....⁴⁰

Sick employees might be given convalescent leave. For instance, in May 1706, the St. Luke's apothecary was granted a fortnight in the country, presumably for his health, one of the governors acting as locum for him:

Mr. Meadowes desiring leave to go into the Country for a fortnight Mr. Prowting having undertaken to attend for him. Ordered that he have Leave accordingly.⁴¹

More comprehensive relief was provided, in August 1782, to the retiring gardener at the French Hospital. Aged 75, and infirm, he was given a cabin in the grounds, and food, provided he comported himself satisfactorily.⁴²

While staff could not, routinely, expect a pension, long and faithful service was often rewarded in this way. For example, on 26th July 1755, five shillings a week was granted to William Hart, a sick Bethlem basketman:

William Hart one of the Basketmen of this Hospital upon account of his bad state of health desired to resign his place and prayd the governors be pleased to grant him such weekly allowance as they did to Margaret Dedman late Cook of this Hospital. Which resignation was accepted And ordered that the Steward do pay unto Thomas William Hart 5s p week till further order of the Committee.⁴³

Staff unable to fulfil their duties due to infirmity, could be provided with an assistant. For instance, in July 1761, Mrs. Mansfield, the female keeper of St. Luke's, due to her poor health, was given someone to assist her with female inmates.⁴⁴

6.4 Care of Relatives and Parishes

Relatives, and parishes, were mainly cared for by abolishing, or mitigating, the institutions charge, or accumulated arrears.

Bethlem's financial situation had improved so much by 1702, that the governors made a major caring gesture by ordering that, from the following January, all admitted inmates would be kept "*at the charity of the hospital except for their clothes and burial*".⁴⁵

Abatement of the charge could also be achieved by pleading hardship. For instance, in May 1756, an abatement was granted for Sarah Crotch, a Bethel inmate, due to her husband's poverty:

That Sarah Crotch be permitted to remain in this Hospital and that for the future the payment for her be reduced to three shillings p week her husband being a poor man with a family of five children.⁴⁶

Again, arrears could be mitigated following a suitable "hard luck" story. An example was noted in chapter 5 (section 5.10) when, in December 1670, the churchwardens of St. Leonard, in Foster Lane, had their arrears reduced, in respect of Mary White, a Bethlem inmate, having pleaded "*the greate losses of the inhabitants of that pish & their greate burden of other poore*".⁴⁷

6.5 Care of Tenants

Although a number of the sampled institutions derived income from leasing land and property only Bethlem, particularly in its first building, provided detailed information on its governors' activities as landlords. The following account draws entirely on this material.

Tenants could be given leases which were more favourable than purely commercial considerations would dictate, commonly following claims of hardship. For example, in August 1791, those leasing Lincolnshire farm land petitioned for the individual renewal of their leases, rather than being made under-tenants of a single lessee, who would have sub-let the farms at higher rents than the hospital's. They successfully presented a narrative of hardship and risk, asking for new rents to be set by an experienced surveyor acquainted with their markets, their danger from the sea and the nature, and situation, of their lands.⁴⁸

Tenants were sometimes allowed to have their lease re-assigned to some other person, apparently without charge, although a certain amount of administrative work was involved. For instance, in November 1654, William Dickenson and his wife were given licence to assign their lease to Benjamin Turner, a barber surgeon.⁴⁹ Leases also occasionally got lost and, in July 1671, Robert Finch petitioned along with Isabell, his wife, that their lease of a messuage in Bethlem was lost "*soe that they know not what covenants on their partes therein to be performed.*" The court ordered the lease to be written again and given them, apparently without charge.⁵⁰

Bethlem governors had to ensure that tenants' property was properly maintained, safe, and modernised when necessary, a financial contribution to required work sometimes being made. For example, in August 1663, they contributed to the cost of bringing New River water into the hospital precinct. This was, perhaps, not entirely unselfish, as an adequate water supply was important in case of fire.⁵¹

The governors were also concerned to remove nuisances for the benefit of the precinct's tenants, as in the case of the building operations of one Mr. King. These were delayed due to the refusal of the previously mentioned John Freeze to vacate

his house on the site and, in March 1648, the governors urged King to proceed, as tenants were complaining of the smell and filth the site was producing:

.....itt is much complayned of by the inhabitants of Bethlem to bee a very great hindrance of passengers that passe that way and very noysome and offensive by the pales stoping of filth and sayle.⁵²

Care also included a consideration of the character of petitioners for leases. In April 1643, John Casseele was refused a renewal of his lease of three tenements, which he sub-let, as he was considered an absentee landlord simply out to exploit others:

And this courte being informed that the said John Casseele is a stranger bourne and a man of evill life and conversation and intendeth not to inhabite in any parte of the premisses himselfe butt to make a profitt thereof by letting them out to others and to goe and live beyond the seas.....⁵³

Bethlem tenants commonly fell into rent arrears. If misfortune could be claimed, the governors would often reduce the amount demanded. Widows, having the obvious misfortune of no husband and, often, little income, were commonly treated with great leniency. For instance, in March 1625, Elizabeth Mould was granted a part abatement of her rent arrears, on account of the recent death of her husband, and her straitened circumstances:

Upon the peticon of Eliz. Moulte widowe showing the greate lose her late husband sustayned in building certen newe tenements at Bethlem and that thereby the death of her husband and other crosses is much impoverished and indebted & praying an abatement of arrearages of the said houses this court thought fitt and soe ordered that shalbe forgiven x1 l. of the said arrearages so as shee discharge the rest before our Lady Day nexte.⁵⁴

6.6 Care of Neighbours

Governors related to their neighbours at individual, and parish, levels. Although records of such interactions were sparse they suggested that they attempted to maintain good relationships with them, and to minimise nuisances.

An example arose at Guy's Hospital in March 1743 when the night work of the Brewer renting the vault under the central building was disturbing the neighbourhood:

Mr Treasurer acquainting the Court that the servants of Mr Collinson the Brewer who rented the vault under the centre Building at £8 p ann frequently worked there in the night time and gave great disturbance to the neighbourhood. Ordered That Mr Treasurer be desired to give Mr Collinson notice to quit the said vault at Michaes next.⁵⁵

Governors also cared for neighbours by contributing, financially, or materially, to local facilities. For instance, in February 1752, the French Hospital governors contributed £15 to St Luke's parish, towards the laying, and paving, of the road from Old Street to Blue Anchor Alley, which ran by the hospital site. A year later a further £5 was given as the hospital's contribution to the charge on St. Luke's parish for paving the road.⁵⁶

Smaller contributions to local convenience were also made. For example, in October 1679, the Bethlem governors ordered a lantern to be provided at the hospital gate:

Alsoe it is ordered by this courte that a good substantiall large lanthorne be bought and provided for the gate of the hospitall of Bethlem And that two candles be put therein every night at sixe of the clocke till Our Lady day next to give light to the people that pass through the streetes there.⁵⁷

II Challenges to the Discourse of Care, and their Repair

6.7 Lack of Care of Inmates

6.7.1 Lack of Material Care

Inmates could, sometimes, be inadequately clothed and this could, occasionally, be caused by visitors. For instance, a 1770 investigation of visiting at Bethlem Hospital noted:

.....it appearing that great Irregularities are daily Committed the Patients disturbed and often Robbed of their Provisions and Cloaths by the admission of improper Persons in the Hospital.....⁵⁸

However, lack of clothing generally arose by failure of relatives, or securities, to provide it. For example, at St. Luke's, in November 1751, the governors threatened to discharge Mary Griffith if her securities did not send in adequate clothing:

Ordered That the Secry do again send letters to her securities that she will be peremptorily discharged next Fryday unless they send her Suff^t Cloathing.⁵⁹

Inmates rarely lacked bedding, probably because relatives were required to provide, or pay for, this on admission. Consequently it was expected to be returned to them on an inmate's discharge. Nevertheless, there was a danger of it being purloined and, as noted earlier, in section 5.3.2, at Bethlem, the Matron was required to ensure that gallery maids kept written records of linen provided by relatives to prevent this. The same regulation applied to male basketmen and, implicitly, implied that such theft had been an earlier problem.⁶⁰

Evidence that the institutions were cold, particularly at night, was more forthcoming, though this has to be seen within a social context in which bedrooms were not normally heated, multiple fires were rare, and glazing expensive. Early in the life of Bethlem heating was sparse and, in July 1663, perhaps for economy, the governors ruled that both Bridewell and Bethlem Hospitals should each keep only one fire going which, of necessity, should be in the kitchen.⁶¹ Again, the full heating capacity of the hospital may not to have been used, to avoid hearth tax. In December 1677, the court was visited by one of the collectors of this tax, to assess its liability. The governors produced a narrative of hardship in an attempt to evade payment, and this incorporated a claim that few of the chimneys had been used, and most never would be.⁶²

Later evidence indicated that heated day-rooms, were provided, though sleeping rooms were unheated and, until later in the eighteenth-century, often unglazed. Those sleeping on straw could become extremely cold and susceptible to infections, and frostbite, which could lead to gangrene and loss of limbs. At St. Luke's, for instance, female keepers were to:

Carefully to examine the feet of every Patient who is under personal restraint or in Straw, to rub and cover the same with flannel every night and morning during the

Winter Season and give immediate notice to the Apothecary if there be any complaints which require his or the Surgeon's Assistance....⁶³

Turning to diet, only one piece of evidence of near starvation of inmates was found, at Bethlem Hospital, in 1630. Visiting governors found that:

....the poore there had noe victualls but some smale scrapps and that they thought, and so it was complained unto them, that the poore were likely to starve.

The court ordered immediate action to remedy the matter.⁶⁴

More frequent were complaints of poor food quality, generally caused by suppliers not meeting quality standards. For example, at the French Hospital, in October 1781, the commissaires reported that the "pauvres" [paupers] had complained volubly about the quality of the beer, and that they would make arrangements to rectify the problem.⁶⁵

Overall, there was little evidence that inmates were routinely kept in intolerable physical conditions. The only reference to what seems to have been thoroughgoing neglect was at a time when Bethlem was managed by semi-autonomous keepers. In November 1598, just after the departure of the keeper, Rowland Sleforth, a group of inspecting governors reported:

We do find divers other defaults in the sayd house in such sorte that it is not fitt for anye man to dwell in which was left by the keeper for that it is so loathsomly and filthely kept not fit for anye man to come into the sayd house.⁶⁶

Evidence of a poor, unhealthy or dangerous environment was generally lacking, though there was a regular catalogue of minor dilapidations noticed by visiting governors. These necessitated minor repairs which, in general, appeared to be carried out.

Institutions for the mad were excessively noisy, if contemporary accounts are to be believed. However, noise was virtually never mentioned in the institutional records, the closest to such claims being in a letter from Samuel Wiggett, a Bethel Hospital trustee who resigned, in June 1757, as he could no longer "*bear to hear*

and see, these melancholy Objects.” though he attributed the problem to his own “*weak*” spirits rather than any inadequacy of care.⁶⁷

If the records are to be believed, the mad suffered more from noisy staff, or neighbours, than vice-versa, as shown in the proposal to build a watchtower near Bethlem Hospital, in 1763. This was considered, by the medical staff, likely to cause excessive noise for inmates, it being “...*absolutely necessary in all cases of lunacy and acute diseases that the patients should be kept extremely quiet.*”⁶⁸

6.7.2 Abuse of Inmates, Restriction of Freedom, and Exploitation through Work

It was mainly from Bethlem material that evidence emerged of the abuses that casual visiting could cause and, as early as 1650, attempts were being made to reduce the admission of undersirables:

Item this courte being informed that divers abuses are committed on the Sabbouth day by young men and maids coming into the hospitall of Bethlem and there idely and profainly spending their tyme on those dayes and molesting and troubling the poore lunatiques there in under the pretence of doing them good and releiving them for avoyding of which abuse it is ordered by this courte that the porter of the said hospitall doe hereafter on every Sabboath day keepe the doores of the said hospitall shut and suffer none to come therein but such as bring releife to the said poore lunatiques or come to doe them goode. And that he suffer not young men maides boyes or girles or other loose or idle people to come into the hospitall on Sabboath dayes or to abide there idley or profanely spending there tymes or to disturb the poore lunatiques there.⁶⁹

Relatives could also import objects with which inmates could harm themselves, or others and, in 1779, it was ordered to be inscribed on the visitor’s tickets that knives or other dangerous instruments were not to be given to them.⁷⁰

Inmates could also be harshly handled, or assaulted, by staff though this was indicated more by rules requiring inmates to be kindly treated, than by specific reports of abuse. Allegations of physical abuse seldom got very far, as illustrated by an incident at Bethlem, in December 1647, when Katherine Goodfellow alleged that Humfrey Withers, the hospital porter, had abused an inmate, Bridgett Martyn, in an unspecified manner. The usual inquiry was held, and Withers was exonerated, the accusation being attributed to Goodfellow’s madness and malice, both Withers and the hospital being presented as wronged. The attribution of malice illustrates the

flexible attribution of agency to lunatics, who could, as circumstances required, be constructed as mad, and without agency, or bad, and deliberately ill-intentioned. Staff collusion in the covering up of the abuse was also not improbable:

Item upon examination of the matters complained of in the petition of Katherine Goodfellow concerning some pretended abuses supposed to have been done to Bridgett Martyn by Humfrey Withers and inquiring of the servants of the house of the truth of the matter therein suggested they cannot finde any of the same to be true but conceive the said Katherine to be a woman crazed in her braine and neither knowing nor caring what she saith of anyone and the hospitall to be much dishonoured and the said Humfrey Withers wronged by the said petition.⁷¹

Goodfellow's accusation possibly hinted at sexual abuse, and the sampled material suggested that abuse of female inmates by male staff was frequent, though usually dealt with very obliquely. Gender separation commonly involved an implication that the major danger of sexual abuse lay in male and female inmates being in physical proximity. For instance, in May 1751, at the first Bethlem Hospital, a guard was proposed to prevent women inmates coming out of their ward, and male inmates going in:

...And a proper person to attend at the iron-gates of the women's ward to prevent the women from coming out and the men from going into that ward...⁷²

However, inmates were generally supervised, and were locked up at night, severely limiting opportunities for sexual impropriety, whereas male staff had relative freedom to move around the institution and encounter female inmates in isolated conditions. A clear example of this occurred in March 1681 when female Bethlem inmates were sexually abused by male staff. The steward's wife, who was "*intrusted to look after the lunatic women*" had, probably by neglect, allowed male servants to gain access to the female inmates, with the result that one was six months pregnant. It was charged that she had allowed the basketmen:

.....to goe among the lunatike woemen when shee was not at present herselfe with them And that shee did not make a sooner discovery of one of the said lunatike woemen that is with child as is within three monethes of her tyme The committee for the hospital are desired to consider the best way of preventing further miscarriages in the said hospital.⁷³

The offending servants were probably discharged as, in April 1681, another minute recorded the admission of a new basketman in place of “*them that were lately expelled*”.⁷⁴

Pregnant women were quite frequently discharged from the institutions and the question of how they came to be pregnant is of interest, particularly as pregnancy generally precluded admission. While some women in the early stages of pregnancy may have been inadvertently admitted, it is possible that some of the pregnancies occurred in the hospital. There is, perhaps, an interesting research project to be pursued in examining the admission dates of women who were discharged pregnant.

Evidence of inter-inmate abuse was sparse but, in August 1772, “*La Ferté*,” the keeper of the French Hospital lunatic house reported that some of the men in the “*chambre de quatre*” [bedroom for four] were amusing themselves in an indecent way with the poor female lunatics. It was decided to empty the room of men by not replacing them as they left, and then put four women in it⁷⁵ Again, in February 1814, William Miller, a Bethel Hospital inmate was discharged for indecency with another, vulnerable, inmate:

At this meeting it was reported by the Master of this hospital that on the 17th day of February instant he found William Miller a patient belonging to this house in a very indecent situation with another patient who is reported by the physician to be in a state approaching to idiotism. Order'd that the said William Miller be discharged from this hospital.....⁷⁶

Turning to inmate freedom, three examples will be presented which exemplified restriction of this, in the service of public appearances, rather than for safety or security.

In 1674 the perimeter wall of the new Bethlem Hospital, facing Moorfields, was originally intended to have been ten feet high, and to enclose an inmate space. However, the building committee proposed that its height should be limited to eight feet, so as not to interfere with the view of the building from Moorfields. To permit the reduced height and, presumably, to avoid sullyng the view, the lunatics were to be banned from this area, and provided with spaces at each side of the hospital with enhanced, fourteen foot, walling.⁷⁷ A further elaboration of the eight-foot wall

consisted of gratings, effectively rendering the wall transparent, to allow the hospital to be admired at close quarters.⁷⁸

Again, the second Bethlem Hospital, was built with fifteen foot wide, impressively long and well-lit galleries, onto which cells opened. Their original purpose was almost certainly for inmate recreation, with a central division to separate the sexes. However, the governors could not bring themselves to spoil the impressive view afforded to visitors by dividing them and, in October 1675, the court ordered:

.....that the long Gallory in the new building for the hospitall of Bethlem to be continued and remain intire the whole length without any particon to be made therein.⁷⁹

In May 1676 it was further argued that, for the safety of visitors, the lunatic inmates should be kept out of the galleries, being relegated to the two outside yards:

And that such persons as come to see the said lunatikes may goe in great danger of their lives if the said lunatikes should be suffered to walk in the same Galloryes and there being other sufficient accomodacons for them to walke in Itt is ordered by this Courte that none of the lunatikes to be kept in the said hospitall be permitted to walke in either of the said Galloryes...⁸⁰

A third example of the possible restriction of inmate freedom occurred at the Bethel Hospital, in August 1769, when a note in the Trustee's minutes indicated that consideration was to be given to preventing the lunatics communicating with the "*common people*" at the front gate. Such communication may have been a diversion for the lunatics, and the locals, and it is possible that the trustees wished to prevent allegations of abuse, demonstrations of protest or, perhaps, danger to the public:

NB to take into consideration how far needful to prevent the Communication of the comon people with the Lunaticks at the Front Iron Gate.⁸¹

The ambivalent nature of inmate work was noted earlier. As it was unpaid, and benefitted the institution, it could be seen as exploitative; as it relieved boredom and earned status, and small rewards, it could be seen as caring, or even therapeutic. The expectation that inmates would work, then, cannot be seen as necessarily uncaring, though the particular circumstances of some inmates could, perhaps, make it so.

Two such circumstances were suggested by the material analysed. The first involved possible avoidance of discharge of inmates because of their usefulness. In fact all inmates who could usefully work raised a question of whether they really needed to be confined. The second involved the admission of inmates with a requirement that they worked, again raising the issue of the validity of their confinement.

Hannah Thompson, a long-standing inmate at the Bethel Hospital, exemplified the first category. She appears to have acted as a servant, and seems to have almost become a staff member as, when she died, her service to the institution was recorded by the governors in terms which make one wonder whether she really needed to be there:

At this meeting it was reported by the Master that Hannah Thompson a patient in this hospital under the care of Dr Reeve died on the 30th day of March last she having been a patient for the space of 53 years during which she was a trusty useful servant to this hospital although a lunatic.⁸²

Only a few examples of admissions with a specific requirement to work were found, though the possibility that these provided a safe institutional niche, rather than being exploitatative, cannot be ruled out. In July 1748 Madelaine Frenot was admitted to the French Hospital with “*l’esprit foible*” [feeble mind] on condition that she worked as a laundry-maid according to the orders of Madame Roumieu, the stewardess:

La Compagnie a admis dans les petites maisons Magd^{ne} Frenot ayant l’esprit foible, mais aux conditions qu’elle travaillera en linge selon les ordres de Mad^e Romieu.⁸³

[The Company has admitted to the petites maisons Magdelaine Frenot having a feeble mind, but on condition that she will work in the laundry according to the orders of Madame Roumieu]

Finally, the behaviour of some inmates suggested that they did not wholeheartedly share the governors’ conception of institutional work. In July 1763, at St. Luke’s, Sarah Furnifall and Ann Gardner, two inmates working in the laundry, escaped while they were not under surveillance. Subsequently Ann Gardner was returned, presumably by her relatives, and the sister of Sarah Furnival visited the hospital to plead that she should not be discharged, suggesting that, in some cases a degree of collusion between relatives and governors may have kept inmates in the

institutions longer than was justified. In this case the usual mechanisms of an inquiry, identification of culprits, whining apologies and reprimands, along with a better lock on the back door served to repair the damage to the governors' ethos.⁸⁴

6.8 Lack of Care of Staff

There were few examples of lack of care of staff, at least according to the practices of the time. What there were fell into three categories, restriction of their social life, inadequate remuneration, and sexual harrassment.

Resident staff had a very restricted social life. For instance, at St. Luke's, the porter and maid servants were not to be absent without the keeper's leave, and the male and female keepers were not to be absent at same time.⁸⁵ Staff below porter level were expected to be single, and could be dismissed if found to be married. For instance, in May 1655, Thomas Freckleton, a Bethlem servant, was warned to find himself another position as he had married and was, therefore, ineligible for his position.⁸⁶

Servants, particularly women, could be very poorly paid and, occasionally, petitioned for "relief" because of this. The Bethlem governors commonly dealt with such breaches of their ethos by buying off dissent with one-off payments, rather than improving pay. For example Mary Howkins, a laundress was particularly badly treated. Having petitioned for relief twice, and been refused, she petitioned, again, in December 1815, along with two male colleagues, the court having ordered reductions in their salaries. The Bethlem committee was asked to enquire into their character and conduct and, if this was satisfactory, to award the males an £8 gratuity and the female £5, for one year only.⁸⁷

Female staff probably suffered sexual abuse from male colleagues. While governors appear to have taken action when such cases came to light, a lack of care might be seen in their maintenance of a culture in which such events occurred. In general they saw practices in their institutions in terms of individual actions and responsibilities, rather than an institutional culture which might support, or discourage, particular

behaviour. For instance, in March 1678, George Inn, a Bethlem Basketman was charged with sexual abuse and theft. It was alleged that he had:

...committed severall miscarriages therein and most wickedly abused severall of the maidservants in the said hospitall and vehemently suspected to have robbed the boxe wherein the money was put for chainge for use of the poor lunatikes.⁸⁸

In a typical “bad apple” repair, Inn was discharged and required to provide bails for his good behaviour, on default of which he would be committed to Bridewell. Additionally, his share of the servants’ box was to be reserved by the treasurer to pay off his debts.⁸⁹

6.9 Lack of Care of Relatives and Parishes

The governors had no specific responsibility to care for relatives or parishes, but two incidents could, perhaps, suggest failure to live up to their caring ethos.

The first occurred in July 1675 when the Bethlem governors were under pressure from the costs of building the second hospital, while demand on the first hospital remained high. Under these circumstances they felt empowered to ban abatements of the five shilling charge, unless the circumstances were exceptional.⁹⁰

The release of a dangerous lunatic might also be considered a lack of care. At Bethlem, in June 1775, Benedicta Gough a “*lunatic*” with “*melancholy disorder*” was discharged as incurable and sent home. However, she remained disturbed and murdered her youngest child. She was tried, and acquitted as mad, with a strong recommendation that Bethlem should be approached with a view to her confinement as incurable. A petition for her urgent readmission was submitted by her brother, and the court agreed to take her back at the next vacancy.⁹¹

6.10 Lack of Care of Tenants and Neighbours

Governors also had a contractual relationship with tenants and little in the way of a general duty of care for them outside this. Such duty as they had was to ensure that

tenants were not subject to unreasonable danger or nuisance, allowing this to occur being a dereliction of this duty.

For instance, in March 1645, Peter Dodsworth, a Bethlem tenant reported that his house was so unsafe that he was afraid it would fall on him. In consequence, he had decamped to another house in the precinct. It appears that the court felt some responsibility, as he was excused the quarter year's rent which should have been due.⁹²

Again, lack of care could be shown by allowing inmates, or staff, to cause a danger, or nuisance, to neighbours. For example, in October 1644 Bethlem hospital was causing offence to its neighbours by creating smoke and smell through burning the foul straw on which incontinent inmates slept. The porter was ordered to ensure that the straw was burned a little at a time so as to minimise this nuisance:

And Humfrey Withers the Porter is commanded to cause the servants to burne the straw from time to time by little & little in the chimney & not to suffer any to bee burnt out of the Chimney or soe much together as shall make annoyance to the neighbours there neere inhabiting.....⁹³

6.11 Conclusions

This chapter has suggested that, generally, the governors tried to care for their inmates, staff, tenants and neighbours, though we only have their word for this. Clearly less caring accounts, particularly by ex-inmates, can be found, though, again presenting a one-sided case. Ultimately there can be no "true" account of life in these institutions.

Together with chapters 4 and 5 it has illustrated two important aspects of the institutions. First, they were evolving systems, both learning from their mistakes and initiating improvements. During the period considered, the physically sick were placed in infirmaries, day rooms and gardens increasingly provided exercise and recreation, and the physical environment improved in warmth, hygiene and the provision of facilities such as running water. It also seems that attempts were made to treat the inmates humanely, prevent abuse, and allow them freedom of movement,

and practical work. The institutions, as described, while fundamentally coercive, certainly bore little resemblance to very negative picture which has been a common feature of the historical literature.

Second, the compendium of practices which has been presented illustrates the construction of the governors' ethos from below, as well as from external influences and personal predilections. Day to day practical problem solving became represented in an evolving system of beliefs, rules and practices as the institutions constructed themselves and their governors.

Notes to Chapter 6

1. BBCM 30/3/1677.
2. NUTRHL.
3. BBCM 10/10/1672.
4. BBCM 22/4/1692.
5. FPHJCQ 25/5/1719.
6. SLHCM 16/12/1779.
7. BHTMB 6/3/1758
8. BethlemHSCM 14/10/1710.
9. SLHCM 25/9/1751.
10. Johnson, J. *Transactions of the Corporation of the Poor in the City of Bristol during a Period of 126 Years, Alphabetically Arranged, with Observations and a Prefatory Address to the Guardians of 1826*. Bristol: P. Rose, 1826, p. 112.
11. BBCM 30/7/1741, 17/2/1741.
12. SLHCM 10/2/1786.
13. SLHCM 21/4/1775.
14. BethlemHCM 28/10/1780.
15. FPHGAM 8/7/1767.
16. FPHJCQ 16/2/1760.

17. SLHCM 21/6/1776, 13/9/1776
18. BethlemHGCM 20/9/1796.
19. SLGCM 2/7/1777.
20. FPHGAM 5/10/1757.
21. BethlemHCM 23/6/1781.
22. GHCCM 18/10/1785
23. BHTMB 1/1/1810.
24. BHTMB 1/10/1810, e.g. 1/11/1813 Sarah Phillips.
25. St. Luke's Hospital. Original Rules and Orders 1751. Reproduced in French, C. N. *The Story of St. Luke's Hospital 1750-1948*. London: William Heinemann, 1951, Appendix II, and in handwritten form in the hospital archives; BBCM 21/11/1770.
26. BBCM 27/4/1769.
27. NUTRHL.
28. BBGCM 15/7/1795.
29. BBCM (Rough) 21/1/1662.
30. BBCM 20/6/1765.
31. SLHCM 30/11/1781.
32. BHTMB 6/11/1797.
33. FPHJCQ 12/6/1742.
34. BHTMB 10/1/1757.
35. BBCM 20/6/1765.
36. BethlemHCM 31/12/1796, 5/5/1804.
37. Bridewell & Bethlem Hospitals. *General Orders Concerning Bethlem Hospital* 1778.
38. BHTMB 1/4/1793.
39. BBCM 21/7/1676.

40. BethlemHSCM 30/9/1710.
41. SLHCM 24/5/1776.
42. FPHJCQ 3/8/1782.
43. BethlemHSCM 26/7/1755.
44. SLGCM 1/7/1761.
45. BBCM 6/11/1702.
46. BHTMB 3/5/1756
47. BBCM 12/12/1670.
48. BBGCM 8/6/1791.
49. BBCM 6/11/1654.
50. BBCM 28/7/1671.
- 51 BBCM 28/8/1663.
52. BBCM 30/3/1648.
53. BBCM 20/4/1643.
54. BBCM 11/3/1625.
55. GHCCM 13/3/1743.
56. FPHJCQ 22/2/1752, 24/2/1753.
57. BBCM 10/10/1679.
58. BBCM 21/11/1770.
59. SLHCM 8/11/1751.
60. BBCM 20/6/1765.
61. BBCM 3/7/1663.
62. BBCM 7/12/1677.
63. *Rules and Orders to be Observed by the Officers and Servants of St. Luke's Hospital.* Undated but probably late eighteenth century. Handwritten document in the hospital archives.

64. BBCM 18/2/1630.
65. FPHGAM 3/10/1781.
66. BBCM 4/12/1598.
67. BHTMB 27/6/1757.
68. BBCM 27/1/1763.
69. BBCM 7/9/1650.
70. BethlemHCM 22/5/1779.
71. BBCM 24/12/1647.
72. BBCM 22/5/1751.
73. BBCM 30/3/1681.
74. BBCM 15/4/1681.
75. FPHJCQ 22/8/1772.
76. BHTM 21/2/1814.
77. BBCM 23/10/1674.
78. BBCM 23/10/1674.
79. BBCM 10/9/1675.
80. BBCM 5/5/1676.
81. BHTMB 7/8/1769, note at bottom of page.
82. BHTMB 1/4/1811.
83. FPHJCQ 16/7/1748.
84. SLHCM 29/7/1763.
85. SLGCB 12/2/1752.
86. BBCM 16/5/1655.
87. BBGCM 6/12/1815.
88. BBCM 27/3/1678.

89. BBCM 12/4/1678.

90. BBCM 30/7/1675.

91. BBCM 18/4/1776.

92. BBCM 8/3/1645

93. BBCM 18/10/1644.

CHAPTER 7

THE DISCOURSE OF PIETY AND ITS CHALLENGES

I The Discourse of Piety

7.1 Introduction

The literature on madness has sometimes suggested that lunacy was commonly explained within a Christian belief system. Some of the sampled institutions certainly had Christian origins, some had Christian practices, and requests for funding could appeal to Christian charity. This chapter examines the degree to which Christian beliefs were evident in the institutions' practices.

7.2 Pious Foundations

Some of the institutions were founded by pious individuals, who gave buildings and money for this purpose. Bethlem Hospital came into being with an act of piety when, in 1247, Simon FitzMary granted land and property to found a priory which would provide hospitality for the Bishop of Bethlem, and a place of worship for the resident order. However, by the time Bridewell took control of it in 1557, it was a secular institution for the mad. The Bethel Hospital was established in 1713, at her own expense, by Mary Chapman, from pious motives, and she inscribed it with biblical texts. The French Hospital, and its small lunatic house, was also founded by the legacy of a pious man, together with donations from the French Protestant community.

The other institutions cannot be said to have been founded from religious motives. Thomas Guy, though a charitable individual, was not described as a particularly religious man. Similarly, John Cary, the prime mover in the establishment of St. Peter's Hospital, seems to have been more bent on establishing an institutional solution to poverty than articulating pious motives. The founders of St. Luke's Hospital, in their publicity documents seemed, almost deliberately, to avoid any

expression of religious motivation. Finally, though information on the foundation of the Newcastle Lunatic Hospital is sparse, there no reason to suppose that it arose from any specifically religious impulse.

7.3 Religious Explanations of Madness and Recovery

Some of the literature discussed in Chapter 1 suggested that, within the period considered, madness, and recovery, were commonly explained within a Christian belief system. That the mad were often considered as demonically possessed was a particular feature of early psychiatric histories.¹ Again, madness as a divine trial, or punishment, and recovery as a sign of God's grace, was a theme for those recording their own experience of madness.² Given these themes, it might be expected that evidence of such explanations would have emerged in the material considered here. However, that was not the case and, in general, God was conspicuous by his absence as far as explanation of madness, or its amelioration, were concerned. Recovery was, in the main, attributed to medical procedures and the prevailing system for understanding madness, even in institutions with Christian foundations, was a rational, medical one.

The only references to divine involvement in madness were in early material for Bethlem Hospital, the latest of these being from 1683, by which time inmates clearly received medical attention, and physick, and were admitted for "cure". This suggests that a clear explanation in terms of medical procedures had, by then, crystallised.

Furthermore, mentions of God were more in the manner of a customary invocation of the deity as governing all things, than any real attempt to account for lunacy supernaturally. Only five examples emerged from the first Bethlem Hospital material, all referring to recovery being in God's hands. For instance, in September 1626, Elizabeth Rathbone informed the court of her recovery "*by god's grace,*" and was discharged:

Elizabeth Rathbone an old lunatique in Bethlem presented herself to this court and affirmed that by gods's grace she is cured of her lunatiquenesse is by order of court discharged....³

Again, in May 1642, Tobias Hume was admitted to Bethlem and was to be discharged “*if it shall please god he shalbee recovered of his senses.*” There was a clear reference to the provision of “physicke” in this minute, hence some level of curative intent.⁴

The second Bethlem Hospital produced two further examples, both from the early 1680s by which time inmates were typically admitted “for cure.” The latest, from May 1682, appears to represent the last gasp of divine involvement in recovery, and attributed this both to God and the hospital’s ministrations:

Whereas Prisilla Cambell about sixe moneths since was admitted into the hospitall of Bethlem for cure of her lunacy An now the said Prisilla having by the blessing of God and the meanes that hath beene used is recovered and restored to her former senses. It is ordered that shee be discharged out of the said hospital.⁵

Turning to material unconnected with admissions and discharges, one of the rules accompanying the opening of the new Bethlem Hospital, in 1677, attributed recovery to God’s grace, though, again, suggesting a ritualistic incantation, particularly as the governors, by this time, saw the hospital as dedicated to cure. One of the treasurer’s duties also required:

And that an accompt thereof be by him kept how much is given to every lunatike person that the same may be restored to him or them againe when it shall please God such lunatike person or persons shalbe recovered of his or their former senses....⁶

That references to recovery being in God’s hands were little more than a customary form was also suggested by a later document, produced by Thomas Bowen, chaplain to Bridewell and Bethlem, in 1783, probably to attract donations. Bowen, predictably, attributed madness to “*the visitation of God,*” and recovery to the ministrations of the hospital which, however, was made efficacious by God’s blessing.

HAPPY is it for the individual, for his friends, and, for society when thus the divine blessing gives efficacy to the means used for his restoration!⁷

7.4 Religious Observances

Some of the institutions had chapels, and employed chaplains, or made other provision for prayers, or clergy visits. All, however, had facilities for Christian burial. Nevertheless the material suggested a dearth of religious attention to lunatics, who may not have been thought sufficiently mentally accessible for this to be beneficial, but also, perhaps, due to medical suspicion of religious enthusiasm which could cause, or exacerbate, madness.

Three of the institutions, the Bethel, St. Luke's and Newcastle Lunatic Hospitals had neither a chaplain, nor a chapel, and, apparently, no arrangements for Christian visiting, divine service, or prayers. In the case of the Bethel Hospital this seemed at variance with its pious foundation. In the case of the St. Luke's, there may have been a deliberate avoidance of religious observation, at least in regard to the inmates, because of the importance William Battie, its first physician, gave to managing madness through a regime which may have seen religious enthusiasm as a factor to be avoided.⁸

The two general hospitals catering for lunatics Guy's and the French Hospital, had chaplains, and chapels. Guy's chaplain was appointed to read prayers, visit the patients daily and preach twice every Sunday. Presumably these services could extend to the lunatics, particularly as, from December 1763, Stephen Swaine, the lunatic keeper, received a supplementary salary as "*Clerk of the Chappel.*"⁹ The French Hospital minister performed divine service in the chapel, conducted prayers, gave a sermon every Sunday, and on public days of devotion, and conducted prayers every Wednesday and Friday morning. Lunatics were not specifically mentioned, but some may have participated, particularly as hospital rules required all able paupers to attend divine service.¹⁰ He also visited, consoled and exhorted those who were sick. However, only one example of a lunatic being visited was found, and it seems unlikely that there was any regular input to the *petites maisons*.¹¹

St. Peter's did not have a chapel and made use of the adjacent St. Peter's church for formal services. Those too sick or infirm to leave the building were reported by Butcher to have had prayers read to them by a layman, possibly a staff member or

inmate. A hospital chaplain was appointed in March 1767, though Butcher suggests that he did not exert much moral and spiritual influence, as his work was rarely mentioned in court records, although the efforts of the curate of St. Peter's, and of visiting nonconformists, were praised.¹²

The first Bethlem Hospital had a church, and a chapel, both being clearly visible on the 1553-9 "Copperplate" map of London (Fig. 1). However, there was no evidence of any religious practices in relation to lunatics and, by the time it came under Bridewell's management, in 1557, nothing in the way of religious activity seems to have remained.

Bridewell had a chapel, and a chaplain who provided services to inmates and staff. Bethlem was not mentioned in his duties, and any ministrations to its staff and inmates would have been an informal responsibility. It was not until March 1677 that it was proposed that Bridewell's chaplain should compose prayers thought to be:

...fitting to be read to the lunatikes at Bethlem by such person as shalbe appointed by the courte.¹³

The result is unknown, but three months later the employment of a curate for Bethlem was proposed, who would have been required to:

...discourse with such of the lunatikes in the said hospitall when occasion shall offer from tyme to tyme as hee shall finde them capable to receive instruction.

This proposal was not proceeded with, due to the hospital's debts, and the fact that Bridewell's minister could already converse with suitable inmates, though there is no evidence that he did.¹⁴ A number of minutes suggested that those outside the joint hospitals were unimpressed with whatever sporadic attention to the lunatics ensued. In January 1681 a lady donated £100 to Bethlem specifically for religious instruction of the lunatics, though there was no evidence of any subsequent change in the status-quo.¹⁵ More positively, in March 1812, Thomas Twigg, Curate and Vicar of St. Stephen Coleman Street, approached the Bethlem committee indicating that he had visited sick patients in the hospital over a 35 year period and begging for financial recognition of this, perhaps for his own church. He was awarded 20 guineas.¹⁶

However, it was not until after the third hospital opened, in 1815, that formal divine worship began in the hospital, and not until 1846 that a formal chapel was opened.¹⁷

Two of the institutions, the first Bethlem Hospital, and Guy's Hospital, had their own burial grounds. That for Bethlem was, presumably, part of the original priory but was later used as a general cemetery for victims of the great plague of 1563.¹⁸

Guy's Hospital burials were initially undertaken by the inmates' own parishes, or at a charge of £19/6 for a burial in St. Olave's parish, in which the hospital was situated.¹⁹ From 1729, however, Guy's had its own burial ground, adjacent to the lunatic house and, in May of that year, the court of committees ordered that unclaimed corpses were to be buried there:

Ordered that the Steward do direct that the next Person dying in this Hospital and left here to be burryed be interr'd in the Burying Ground belonging to this Hospital.²⁰

A week later the court of committees ordered that 20 shillings would be payable for a hospital burial.²¹ As the second Bethlem Hospital did not have its own burial ground, Guy's was the only institution able to offer this service after 1676.

The other institutions required relatives, or sureties, to pay any burial expenses as part of the bond signed on admission. Burial costs typically amounted to between fifteen shillings, and a pound, at this time, and the French Hospital material often provided itemised costs. For instance Esther Vidal, admitted to the petites maisons, aged 74, and "*dérangée dans Son Esprit*" [of deranged mind], died in the hospital in December 1751. Her funeral expenses were listed as "*Coffin No Shroud 5s. Parish Dues &c. 9s. 4d. Total 14s. 4d.*"²² Others had a wool shroud at a cost of 1s., making the total cost £15/4.

Occasionally the institution would pay funeral expenses, as at the Bethel Hospital, in June 1812, when Mary Jackson's burial costs were met, as she appeared to have almost become a member of the hospital's staff:

Order'd that the treasurer pays to James Bullard three pounds seventeen shillings and fourpence for the funeral expences of Mary Jackson as a mark of respect she having

been 22 years a patient in this hospital and during which period been very serviceable.²³

Non-removal of corpses could be a problem, particularly in smaller institutions. For instance, the Bethel Hospital, in October 1763, appeared to be full, and it was ordered that there should be no admissions unless there was a vacancy. Furthermore, dead patients were to be removed within 24 hours.²⁴ The Bethel governors may also have become a little sensitive about the number of dead issuing from the hospital as, in November 1778, they ordered that corpses should no longer be taken out of the front gate:

Ordered for the future the burials from this hospital shall be performed in the most private manner and that the corps be not carried out of the front iron gates.²⁵

7.5 External Appeals to Piety

Institutions seeking funds sometimes made direct appeals to the piety of potential donors, commonly representing inmates as suffering and needy, their institutions as dedicated to their rescue, and donors as doing God's will. Subtly, but effectively, the Bethlehem governors, mounting an appeal for funding their new incurable wing in 1725, did not directly appeal to the pious, but to "*they who enjoy the Blessing of a Right mind,*" inviting contemplation of the divine origin of sanity in order to engage those oriented to this view.²⁶

The French Protestant Hospital governors, being more solidly anchored in a community of believers, could afford to make more blatant appeals to this community for money. In 1752 they circulated a "*memoire*" [appeal] soliciting donations towards a new lunatic house, which constructed a Christian brotherhood of which they, the lunatics, their families, and potential donors, were all members. Potential donors were presented as "*blessed*" as they had received, through God's goodness, refuge from persecution and were, therefore, obligated to those in need. They were asked to contribute of their bounty, which they would not have had if they were not blessed. Their donation was, therefore, the price of their blessedness:

La Corporation souhaiteroit avec ardeur d'être en état de pouvoir par elle même remplir un projet duquel elle reconnoit également l'utilité & la nécessité, mais les

dépences ordinaires, de l'Hopital excédant depuis plusieurs années ses revenus & ses recettes, elle se trouve indispensablement obligée d'avoir recours aux Personnes Charitables. Si la Corporation ne fait pas cette démarche sans quelques peine elle la fait cependant avec confiance persuadée que les Chrétiens, sur tout que Dieu à bény dans leur Refuge, ne refuseront pas de contribuer de leur abondance, pour procurer le logement, la subsistance, & du soulagement à ceux de leurs Freres qui sont dévenus les objets les plus humiliants pour la nature humaine, & tout ensemble les plus à charge dans les familles, sur tout dans celles qui sont elles mêmes destituées du necessaire, ou qui a la sueur de leur front peuvent a peine gagner le quotidien.²⁷

[The Corporation fervently wishes to be in a position to be able to complete a project of which it recognises both the utility and the necessity, but the everyday expenses of the hospital, exceeding for several years its revenues and receipts, it finds itself indispensably obliged to have recourse to charitable people. If the Corporation does not take this step without some reluctance it does it however with confidence convinced that Christians, above all those that God has blessed in their refuge, will not refuse to contribute from their abundance, to procure the accommodation, subsistence, and relief of those of their brothers who have become the most humiliated objects of humankind, and altogether a burden to their families, above all those who are themselves lacking the necessities, or who can, by the sweat of their brow, barely earn their daily living.]

II Challenges to the Governors' Discourse of Piety

7.6 Introduction

Challenges to the Discourse of Piety involved abandonment of existing Christian observances and clergy input, and lack of expected religious observance by inmates, or staff. However, such references were rare, and almost entirely concerned with Bethlem Hospital.

7.7 Abandonment of Religious Practices

An example of the secularisation of Bethlem Hospital was its resistance to the payment of taxes to its parish church of St. Botolph's. For instance, in March 1617, the demand for the payment of a tax of six pounds by the hospital master, Thomas Jenner, was resisted:

It is agreed upon and ordered that the said Thomas Jenner shall be freed from the said tax. And the churchwardens and parishioners beforesaid were required that henceforwardes they lay no tax upon him.....²⁸

7.8 Removal of Clergy Input

After the opening of the second Bethlem Hospital, in 1676, there was, at best, sporadic input to its staff and inmates by the minister of Bridewell. A minute of June 1713 indicated that the minister's position was vacant, due to the resignation of Dr Atterbury, Dean of Christ Church. The court noted that an annual payment of £20 had previously been given to him in consideration of attending and instructing those Bethlem inmates capable of receiving instruction. However, the governors decided that there was now no occasion for such attendance, and deemed the allowance unnecessary, though without making clear why it was no longer required. Possibly it was a service which had largely lapsed, and the opportunity was taken to save £20 per annum.²⁹

It is uncertain how long the provision was curtailed, but a later minute, of April 1745, recorded that the post of chaplain was, again, vacant. Samuel Masters was elected as the new incumbent and, as well as his official duties at Bridewell, he was to be given an annual gratuity of £20 *“for visiting & instructing such poor Lunaticks in Bethlem that are fit to receive any Benefit thereby.”*³⁰

7.9 Inmate Neglect of Religious Observance

At the French Hospital inmates were expected to attend divine service, and prayers, on threat of punishment, unless they had just cause not to, and this requirement was enshrined in one of the hospital's rules.³¹

A single example of this rule being breached was found. This occurred on 12th June 1742 when the non-lunatic Etienne Laborde was complained of for not attending prayers and the sermon, and for bringing *“Liqueurs fortes”* [strong drink] into the hospital. His right to go out of the hospital was removed for three months as a punishment.³²

7.10 Conclusions

The major conclusion is that, although some institutions had pious foundations, and some maintained Christian practices, there was little evidence that madness, or its treatment, was conceptualised within a Christian belief system. The only evidence was from Bethlem Hospital, and solely consisted of statements that recovery lay in God's hands, and that God might make curative practices efficacious. This was not evident after 1683, by which time madness, and its treatment, was constructed within a rational, medical system.

Similarly, there was little evidence, even in institutions founded in piety, of systematic provision of clergy visits to lunatics, though this happened sporadically. However, some institutions showed no evidence of such visits, and may have even discouraged them. Lunatics might, perhaps, have been thought not to have a mental state receptive to such visits. Alternatively, they might have been seen considered too receptive, as excessive piety could cause madness, and clergy visits could inflame religious delusions, excite inmates, and be antithetical to recovery.

While Christian practices impinged minimally on lunatics, institutions were not shy about publicising any pious credentials for fund-raising purposes, and there were several examples of large sums of money being raised by appeals to pious individuals outside the institutions.

Notes to Chapter 7

1. e.g. Zilboorg, G. & Henry, W. *A History of Medical Psychology*. New York: W. W. Norton & Company Inc, 1941. Chapters 5 & 6.

2. e.g. Porter, R. *A Social History of Madness: Stories of the Insane*. London: George, Weidenfeld and Nicholson Ltd., 1987 (a) Chapter 5; Ingram, A, ed. *Patterns of Madness in the Eighteenth Century: A Reader*. Liverpool: Liverpool University press, 1998 pp. 12-17. 30-35, 209-212.

3. BBCM 2/9/1626.

4. BBC 27/5/1642.

5. BBCM 26/5/1682.

6. BBCM 30/3/1677.
7. Bowen, T. *An Historical Account of the Origin, Progress and Present State of Bethlehem Hospital. Founded by Henry the Eighth for the Cure of Lunatics and Enlarged by subsequent Benefactors, for the Reception and Maintenance of Incurables*. London: Bridewell & Bethel Hospitals, 1783 p. 15.
8. Battie, W. *A Treatise on Madness*. London: Whiston & White, 1758. Reprinted in Hunter, R. and Macalpine, I. *A Treatise on Madness By William Battie, M.D. & Remarks on Dr. Battie's Treatise on Madness by John Monro, M.D. A Psychiatric Controversy of the Eighteenth Century*. London: Dawsons, 1962. e.g. pp. 83-4.
9. GHCCM 11/5/1726; GHRB 24/12/1763: H09/GY/D/023/004.
10. FPHGLA General Rules, 8/10/1718. Chapter III Article I.
11. FPHJCQ 5/10/1776.
12. Butcher, E. E., ed. *Bristol Corporation of the Poor. Selected Records 1696-1834*. Bristol: Bristol Record Society, Bristol Record Society Publications, **III**, 1932, pp. 20-21.
13. BBCM 30/3/1677.
14. BBCM 20/6/1677.
15. BBCM 20/1/1681.
16. BBGCM 4/3/1812.
17. O'Donoghue, G. *The Story of Bethlem Hospital from its Foundation in 1247*, London: T. Fisher Unwin, 1914, p. 366.
18. Christie, J. *Parish Clerks: Some Account of Parish Clerks, more Especially of the Ancient Fraternity (Bretherne and Sisterne) of S. Nicholas. Now known as The Worshipful Company of Parish Clerks*. Privately Printed, 1893, p. 134.
19. GHCCM 7/12/1725.
20. GHCCM 15/5/1729.
21. GHCCM 20/5/1729.
22. FPHJCQ 17/2/1749; Marmoy, C. F. A. Applicants to the French Protestant Hospital 1718-1957. *Huguenot Society Quarto Series Vol. LIII*. 1977. Entries for Esther Vidal, Jacques Viger.
23. BHTMB 1/6/1812.
24. BHTMB 3/10/1763.

25. BHTMB 2/11/1778.
26. BBCM 17/12/1725.
27. Printed Appeal for Rebuilding Petites Maisons, 1752. Huguenot Society Library, H/F1a/1.
28. BBCM 7/3/1617.
29. BBCM 26/6/1713.
30. BBGCM 9/4/1745.
31. *The Statutes and By-Laws of the Corporation of the Governor and Directors of the Hospital for Poor French Protestants, and their Descendants, Residing in Great Britain.* 1761. Huguenot Society Library, 26.d. Chapter VI.1.
32. Marmoy. 1977. op. cit. Entry for Etienne Laborde.

CHAPTER 8

THE INFLUENCE OF THE INSTITUTIONS

8.1 Introduction

This chapter will consider the impact of the sampled institutions on each other, and on the design, and management, of later public institutions for the mad. However, the records of one institution rarely referred to another. Nevertheless, similarity in their practice, their similarities to later institutions and, in London, their physical proximity, suggested that new institutions were likely to have learned from earlier ones.

Smith's 1999 account of the asylums of the first half of the nineteenth-century was analogous to the present study and was used to indicate later institutional practice. Additionally, the 1844 national institutional survey by the Metropolitan Commissioners in Lunacy, their annual reports, and their "*Suggestions and Instructions*" for the construction of asylums (1856) were used as an index of official advice. Tuke's "*Description of the Retreat*" (1813), Browne's "*What Asylums Were, Are and Ought to Be*" (1837), and Conolly's "*The Construction and Government of Lunatic Asylums and Hospitals for the Insane*" (1847) were also drawn on as representative of practitioner advice on later asylum construction and management.¹

It will be suggested that no major developmental shift in institutional practices took place in the latter part of the eighteenth-century, as has often been suggested, and that later institutions have to be seen as part of a continuous line of development from the sampled institutions.

8.2 Development and growth of the institutional solution to the management of madness.

The confinement of lunatics in dedicated public institutions for the mad began with the first Bethlem Hospital and a striking aspect of the sampled institution was their

popularity, their capacity expanding to meet continuously increasing demand, which outstripped population rise. For instance, between 1600 and 1790 the population doubled² while Bethlem's capacity, alone, rose from 20 to over 300, an increase of 1500%. (Appendix 2).

Two indications of mutual influence were found in the present sample. First, Thomas Guy noted Bethlem's lack of provision for 'incurables' when he specified that his new hospital should accommodate twenty 'incurable' lunatics.³ Second, the 1750 prospectus for the new St. Luke's Hospital also referred to Bethlem's inability to meet existing need.⁴ Smith, in his post 1800 sample, noted that this demand continued to grow and was met, as in the present sample, by the initial adaptation of existing space and, subsequently, by major building projects.⁵

8.3 Institutional Design

8.3.1 Sites.

With the exception of St. Peter's Hospital, and the first Newcastle Lunatic Hospital, the site of which is unknown, all the institutions were built on open land, close to city boundaries. Even St. Peter's Hospital, though in an urban setting, backed on to open water, giving a degree of airiness.

Except for the second Bethlem Hospital, and the second French Hospital Lunatic House, which were rebuildings, there were no direct indications that any of the institutional sites were influenced by the position of any of the others. Criteria for choosing sites were also rather opaque, the clearest being those of the second Bethlem Hospital, for which the governors specified "*health and aire*", and "*a more convenient place.*"⁶ These criteria implicitly referred to the old Bethlem site which, by 1674, had become too cramped to allow necessary expansion. Further, according to Stow it was unhealthily "*near unto many common Sewers*" and, in an urbanised precinct, pernicious interactions were arising between hospital inmates and staff, and nearby residents.⁷ The only other criteria for the choice of site which could be discerned were for the first St. Luke's Hospital, the chosen site for which was a disused foundry described as "*convenient for this purpose,*" though the hospital's

founding prospectus also emphasised cure, and public safety.⁸ Somewhat similarly the second Newcastle Lunatic Hospital was on open land, outside the city walls, the first building having become “*too small and very inconvenient.*”⁹

Thus, the only discernible criteria for the sites were a healthy, airy position, adequate size, convenience and, possibly, the separation of inmates from the surrounding community. Whether by accident, or design, these various criteria seem to have been met by placement on reasonably priced sites, in open land, near the urban boundary. Smith noted the use of ‘urban fringe’ locations into the nineteenth century, and such sites became virtually mandatory for subsequent institutions in the eyes of the Commissioners in Lunacy, and others advising on asylum design, though their motives also included greater concern with public security, the production of prestigious buildings, classification, recreation, productive work, ease of expansion and the value of country views.¹⁰

Conolly, for example, advised:

There can be no doubt that the best site for an asylum is a gentle eminence, of which the soil is naturally dry, and in a fertile and agreeable country, near enough to high roads, a railway, or a canal, and a town, to facilitate the supply of stores, and the occasional visits of friends of the patients, and to diversify the scene without occasioning disturbance.¹¹

Such requirements could be seen as a further elaboration of the rhetoric of cure, in which the institutional buildings moved from necessary containers, to therapeutic machines.

The urban fringe site, then, could be seen as originating in the institutions of the present sample and to have continued, in an elaborated form, into the nineteenth century. This was, however, a doomed solution, as urban encroachment inevitably engulfed the institutions.

8.3.2 External Design.

The building housing the first Newcastle Lunatic hospital is unknown, the first Bethlem Hospital was probably not built to house lunatics and St. Peter’s Hospital

was housed in an adapted Jacobean residence. The other institutions were purpose-built, though Guy's lunatic house, and the two "petites maisons" of the French Hospital do not appear to have had any influence elsewhere. Of the remaining institutions the Bethel Hospital and the second Newcastle Hospital, can be seen as domestic in character, though neither building appeared to have owed anything to earlier institutions, nor to have specifically influenced later ones.

The second Bethlem Hospital, and the first St. Luke's, were institutional in style. In terms of design Bethlem's layout of a central administrative and service block, long wings allowing gender separation, stacked storeys, segregated airing courts, and orthogonal wings allowing further inmate categorisation, became ubiquitous in later asylum design, where they appeared in a wide variety of juxtapositions. For instance, Conolly, discussing exterior design in 1847 advised:

I believe there is none so convenient as one in which the main part of the building is in one line, the residence of the chief physician or other officers being in the centre, and also a chapel, and a large square room in which the patients may be occasionally assembled from either side of the asylum on the occasion of an evening entertainment, and which may also be capable of division for schools; the kitchen, laundry, workshops, and various offices, being arranged behind these central buildings. To this main line, wings of moderate extent being added at right angles in each direction, the building assumes the H form.¹²

The first St. Luke's Hospital clearly incorporated these elements within a smaller, simpler, more austere format. Surprisingly, its design has not been seen as deriving from Bethlem's, and it has been its derivative, successor, the second St. Luke's, which has been credited as influencing county asylum design.¹³

8.3.3 Internal Design and Therapeutic Space.

This section considers four elements of internal design and their influence on later institutions:

- Cellular confinement.
- Galleries.
- Inmate classification.
- Therapeutic spaces.

The first Bethlem Hospital probably had a central corridor with cells on either side, an arrangement applicable to many institutions housing unrelated individuals.¹⁴ In the second Bethlem Hospital individual cells were taken for granted, and were a feature of all subsequent institutions in the sample though, increasingly, sharing took place.¹⁵ By the mid-nineteenth-century, the Commissioners in Lunacy were recommending that only about a third of inmates should be confined in cells.¹⁶

A major innovation occurred in the second Bethlem's cellular arrangement when the governors' rejected Hooke's first, more domestic, design in favour of a "*single building not double*" This, in interaction with a long site, produced an elongated building with two floors, each with a long row of cells opening onto a wide corridor with windows overlooking Moorfields.¹⁷ This gallery blended cellular confinement, recreational space, and easy surveillance. Although there was no direct evidence of influence, galleries were incorporated into the Bethel Hospital, the second French Hospital lunatic house, and St. Luke's Hospital, and seem likely to have derived from Bethlem's.¹⁸ Subsequently, they became a common feature of lunatic institutions and, by the mid-nineteenth-century the Commissioners in Lunacy saw galleries as a regular feature of new asylums.¹⁹ Browne saw the gallery as having a variety of benefits:

This, besides subserving to ventilation, may be used as a common hall, as a work-room, as a place where the night keeper or nurse may watch, and for other purposes equally useful.²⁰

The third influential design feature was the spatial categorisation of inmates. The first, and most obvious, categorisation was that of gender which appears to have started at Bethlem Hospital in January 1662 when it was ordered that "*the distracted woemen in the hospitall of Bethlem shalbe continually kept from the distracted men there.*"²¹ It was a feature of the second Bethlem from the outset, but was not instituted at the Bethel Hospital until 1747, over thirty years after its inception.²² At St. Luke's complete gender separation may not to have occurred until 1754, three years after its opening, when another room was ordered to be provided "*in order that the Men and Women Patients be kept Separate.*"²³ As a workhouse St. Peter's Hospital may have had gendered accommodation from its beginning, though detailed

information was not available until 1820 when Johnson gave a list of its wards, which were clearly gendered, and included a “*Womens Bedlam*” ward.²⁴ At the French Hospital an undated ground plan, probably dating from the mid-eighteenth-century, showed gendered refectories and infirmaries and it seems likely that the male and female lunatics were separated.²⁵ It is unclear whether the male and female inmates of the Guy’s Hospital lunatic house, or those of the second Newcastle hospital, were spatially segregated, though their buildings would have allowed this.²⁶ Such segregation was mandatory in later institutions and can be seen, at least partly, as having its origin in the sampled institutions, though it was also a feature of other institutional types. By the mid-nineteenth-century the Commissioners in Lunacy required all new buildings to keep male and female inmates “*distinct on either side of the centre*” a view also expressed by Conolly.²⁷

A second categorisation separated offensive inmates from the quieter, more tractable, or convalescent. Offence might be caused by dirtiness, noisiness or violence, and such inmates were often segregated, sometimes in inferior accommodation, establishing a spatial hierarchy. Such a division took place at Bethlem, in July 1645, a couple of years after it had been enlarged. The governors were:

.....of opinion that itt will be necessary to keepe the distracted people in Bethlem which are most quiett and orderly in the new building of that hospitall and those that are most unquiett in the old building.²⁸

There was no direct evidence of this division at the second Bethlem, but, at the Bethel Hospital the trustees, in 1749, fitted up a cellar for the “*worst*” inmates, who, presumably, fell into this category.²⁹ At St. Luke’s too, in June 1763, it was decided that the “*governable*” and “*unruly*” should be separated and, in October 1764, that a ventilator should be installed in the women’s room for “*the bad patients*.”³⁰

There was no evidence of such categorisation at the French Hospital, Guy’s Hospital, or the Newcastle Hospital though St. Peter’s developed an early version of seclusion, violent and refractory lunatic inmates being temporarily confined in “*pens*,” small wooden closets about three feet wide, with a hole in the ceiling for ventilation.³¹

The incorporation of this category in later institutions could reasonably have derived from these early institutions. Browne, in 1837, argued that:

It contributes greatly to the quiet of an asylum during the night, and to the remedial effects of sleep, if the noisy and furious can be placed at a distance from the other classes of patients. This is the first, and perhaps the most important, step in classification.³²

Similarly, Conolly, at Hanwell, described the wings most remote from the centre as being for the “*noisy, the refractory and the dirty.*”³³

The final categorisation was the spatial separation of “curable” and “incurable” inmates. As noted in section 4.5.3 this category first emerged at the second Bethlem Hospital in 1681 and developed sufficiently for specific incurable wings to be added to the hospital.³⁴ St. Luke’s, in 1754, began taking back inmates discharged as “*uncured*” at five shillings per week and, by August that year had allocated a specific area for them. By November 1755 they were described as “incurable,” as at Bethlem.³⁵ At the Bethel, by 1773, the “incurable” categorisation was used in relation to discharged inmates, though no specific space appeared to be devoted to them, and they were not taken back after discharge.³⁶

Guy’s Hospital lunatics were all “incurable” and there was no evidence that the categorisation was used at St. Peter’s, most of its lunatic inmates probably being of this type. The same was probably true of the French Hospital which showed little in the way of a curative policy. Its 1752 appeal for funding a new lunatic house stated that an attempt at cure would be made but, if unsuccessful, inmates would be kept for the remainder of their life.³⁷ One of the aims of the first Newcastle Lunatic Hospital, was “*to make a proper provision for incurables,*” though it is unclear whether they were spatially segregated. The category presumably continued to be used in the second hospital, though there was no direct evidence of this.³⁸

Although direct mutual influence was not demonstrable within the sampled institutions the curable-incurable categorisation became increasingly relevant in later asylums as the initial spatial separation of curable and incurable inmates broke down

when they silted up with ‘incurables,’ to the detriment of their putatively therapeutic regimes. A number of spatial solutions were proposed including boarding out harmless incurables, separate incurable asylums and dedicated workhouses.³⁹ Again, although the direct influence of early institutions on later asylums, cannot be demonstrated in respect of the curable-incurable categorisation, it is difficult not to see a clear line of development from early to later institutions, particularly as Bethlem’s incurable wings were notable features of its building.

The final issue to be addressed concerns the development of therapeutic space, and its subsequent importance. In section 4.4.3 the development of space for medical activity was discussed and, in section 6.2.2, the emergence of sick rooms and infirmaries was noted. In the present discussion, the concept of therapeutic space will be widened to include space for activity and recreation, comprising galleries, yards, and day rooms.

Galleries have already been discussed, and yards can be seen as performing similar functions, with the added benefit of fresh air. The first Bethlem Hospital had at least two yards in the 1640s,⁴⁰ and the second hospital had yards at each end.⁴¹ St. Peter’s had an exercise yard, though whether it was available to lunatics was unclear.⁴² The Bethel Hospital and St. Luke’s also had yards for the inmates.⁴³ The French Hospital had a garden for inmate recreation and for vegetable production, though its availability to lunatics was unclear. There was no evidence of any such facilities for the Guy’s Hospital lunatic house, but the second Newcastle Lunatic Hospital, according to its ground plan, had a small internal yard for its inmates.⁴⁴

Day rooms, warming rooms, sitting rooms and parlours probably had a similar recreational function and have been mentioned in section 6.2.3, which also noted that inmates who worked had greater access to institutional space and some inmates were allowed out, or granted home leave.

Again, there was no evidence that the early institutions directly influenced each other in respect of these provisions but, by the mid-nineteenth century, these spaces had become virtually mandatory, and it is difficult not to see this as a development, and elaboration, of the provision described above. The 1856 *Suggestions and*

Instructions of the Commissioners specifically mentioned the need for “*Airing Courts*” which should be “*planted and cultivated,*” together with heated galleries and day rooms. Baths were also considered important. Specific spaces for medical activities were not mentioned, however, though infirmaries were required, if possible with small day-rooms.⁴⁵

Conolly noted the need for infirmaries, and devoted a good deal of space to airing courts, which he saw as having moved from prison-like monotony to garden-like spaces with plants and small animals. He also saw facilities for outdoor sports as important.⁴⁶ Browne made similar observations and described the ideal airing ground as follows:

These places should be planted, have a fountain; a portion of ground prepared as a bowling green; they should be stocked with sheep, hares, a monkey or some other domestic or social animals.⁴⁷

Baths, a feature of the present sample, were also noted by both Conolly and Browne as necessary asylum attributes, both for hygienic and therapeutic use. Conolly advised a warm weekly bath for all inmates, and showers for both hygiene, and ‘*gentle excitement.*’⁴⁸ Browne saw baths as necessary for cleanliness ‘*At certain seasons,*’ though for treatment at all times.⁴⁹

8.4 Managerial Structure and Practices

8.4.1 Managerial Structure

As noted in Chapter 5 the managerial structure of the sampled institutions was a tripartite one of governors and their sub-committees, paid staff headed by a master, or steward, and a body of coercively confined inmates. Smith suggested that this managerial structure was adopted by many later-eighteenth-century lunatic hospitals though, subsequently, the County Asylums Act of 1808 placed the governance of lunatic institutions in the hands of local justices of the peace, their day-to-day management being in the hands of a superintendent, with small groups of justices visiting regularly.⁵⁰ Thus, nineteenth century asylums could be seen as managed by a relatively distant gubernatorial body with a visiting committee of justices

transmitting its ethos to a superintendent, equivalent to a master, or steward, who managed a subordinate body of staff, and a further body of inmates. The evidence, then, is again consistent with a gradual evolution of the structure of the early institutions into that of the later ones.

8.4.2 Managerial Practice.

Chapter 5 considered management processes in the sampled institutions, discussing their monitoring and control of staff, income and expenditure, financial monitoring and control, planning, development and improvement. Smith, in his account of early nineteenth-century asylums also noted these aspects of their management.⁵¹ He discussed rules and regulations as “*a mixture of principle, directive, obligation, direction and exhortation*” which could be alluded to “*when there was a dispute as to their proper fulfilment.*”⁵² He reported that the physician’s responsibilities included inspecting the institution, and monitoring the conduct of staff, and that the duties of superintendents:

included purchases of goods and equipment, payment of bills, and account keeping, maintenance of inventories, keeping registers of patients and of admissions and discharges, the preparation of annual accounts and reports, and acting as secretary to the committee of visitors and house committee, to whom he was directly responsible.⁵³

The superintendent was also responsible for hiring, firing and directing staff, maintaining standards, reporting misconduct, inspecting inmates, organizing the wards, and ensuring their order and cleanliness, diet, safety and security. In a similar way the matron had responsibilities for supervision and inspection of female staff and inmates, as well as food preparation, cleaning and laundry.⁵⁴

Smith’s account indicated considerable similarity between the sampled institutions and those of the nineteenth-century. In fact, it suggested that managerial practices in the early institutions had reached a point where little change was necessary. The picture, again, was one of the persistence of managerial processes developed in early institutions into the later ones, without any late eighteenth-century developmental rupture.

8.5 Inmate Management

8.5.1 Introduction

Chapter 4 outlined three justifications for confinement; public protection, care and cure. It suggested that claimed ‘cures’ were likely to be spontaneous remissions, and that institutions developed processes which extruded those unlikely to spontaneously remit as ‘unfit objects, placing the responsibility for the lack of “cure” on the inmate. The following discussion will be structured in terms of the three justifications for confinement public protection, care and cure.

8.5.2 Public Protection

Chapter 4 (sections 4.2 & 4.7) examined public protection as a justification for confinement. However, there was no direct evidence that the sampled institutions influenced each other in this respect, though it can be assumed that those which were rebuilt carried over existing policies into their new buildings. Nevertheless, it is difficult to suppose that later institutions in the sample did not build on the experience of earlier ones.

Turning to the influence of the sampled institutions on later ones Smith noted the persistence of the justification of public protection, alongside those of care and cure:

The prevalent philosophy determining the physical nature of the institution was to combine reasonable comfort and the pursuit of ‘cure’ with the maintenance of adequate security for the staff and for the public at large. The resolution of these conflicting objectives remained problematic. The creation of a forbidding environment, though perhaps not the deliberate intent, was the frequent consequence.⁵⁵

Conolly, while asserting the importance of public protection, felt that security could be tempered by a cheerful appearance:

Although the first thing demanded by society, when we undertake to relieve it of the presence of those who cannot be at large consistently with the safety of themselves or others is their perfect security; it must be remembered that this security does not require gloom, or a frightful apparatus.⁵⁶

While not directly protecting the public, the use of personal restraint protected inmates, and staff, from violence, and hindered escape. Despite the spread of moral treatment, and the development of the non-restraint movement from the late 1830s, restraint continued to be used in most asylums, even at *The Retreat*.⁵⁷

Chapter 4 (section 4.7) described ways in which inmates protested against confinement. Smith, too, reported protest as a feature of later institutions, recording self-neglect, refusal to eat, destruction of clothing and bedding, bad language, violence, damage to property, suicide and escape, all of which were similar to those found in the present sample of early institutions.⁵⁸

To summarise, there was, again, no direct evidence that the sampled institutions influenced each other, though their common concern with material aspects of security, and escapes, would suggest that they did not, individually, discover the need for security afresh. This concern, and the justification of confinement in these terms, continued in later institutions for the mad, though sometimes more covertly. Overall the material would, again, suggest that later institutions learned from earlier ones, adapting their practices to meet their particular needs.

8.5.3 The Rhetoric of Care, and actual Care

In chapter 4 (section 4.3), a distinction was made between the rhetoric of care, which obfuscated the fact of confinement, and actual care. Smith's account, though not directly using this concept illustrated its continuation into later eighteenth-century, and early nineteenth-century institutions:

The lunatic hospital or asylum was portrayed as providing for a particularly unfortunate and deserving group of people. The Manchester trustees spoke of 'unhappy Wretches' and 'miserable Objects'; no objects could be 'more truly deplorable.' The Exeter Asylum was intended 'to relieve the most helpless and pitiable Class of Mortals'. Dr. James Currie, the Liverpool physician who piloted the establishment of the city's asylum, argued that men were subject to no evil 'so dreadful as insanity.'⁵⁹

Actual inmate care, in chapter 6, was conceptualised, first, as the provision of adequate diet, clothing and bedding, the maintenance of personal hygiene, a clean, warm and wholesome environment, adequate care when physically sick, and a safe,

well-maintained building. Once more, there was little evidence that the sampled institutions influenced each other in these respects, though their similar preoccupations with these matters would make this likely.

Tuke advocated a '*liberal, nourishing diet.*' Conolly, similarly, thought insanity could result from poor nutrition, making a good diet therapeutic, as well as improving the death rate. Browne castigated asylums in which all the inmates were given the same diet, and counselled that this should be governed by individual physiological and therapeutic needs.⁶⁰ Browne was also relatively forthcoming about clothing, arguing that there should be:

.....not only warm and clean clothes, but changes of these adapted to the different seasons and variations of temperature and weather, and resembling as closely as possible, those to which the individual had been accustomed; and, if practicable, there should be no uniformity of costume. It may have advantages, but it reminds of the workhouse, the prison, the galley-slave.⁶¹

Conolly was tolerant of uniformity in the dress of male inmates though, for therapeutic reasons, less so in the case of females.⁶² He also advocated the liberal provision of washrooms, bathrooms, water closets, urinals, and clean bed-linen, and stressed the role of attendants in ensuring inmate hygiene.⁶³ Washrooms were to be open to the inmates of quiet wards who were held to enjoy "*a clean face and hands, and the refreshment of washing when fatigued, or after various occupations.*"⁶⁴

More generally care could imply a clean, warm, safe and wholesome environment. The 1856 *Suggestions and Instructions* of the Commissioners in Lunacy noted the necessity of a healthy, elevated, site with good water and drainage and land for agricultural employment, exercise and recreation. Adequate warmth and ventilation were necessary, dayrooms and galleries being warmed with open fires and having opening windows for moderating the temperature. Ventilation flues were also to be provided for extracting foul air.⁶⁵

However, in the period leading up to the dissemination of the Commissioners' requirements, Smith reported that heating and ventilation systems were frequently ineffective, and that "*Cells were frequently deficient in ventilation and heating.*"

Galleries were noisy, and ‘refractory’ and ‘dirty’ inmates constantly threatened the tranquillity and cleanliness of the institution, consequently being placed in separate accommodation, which became offensively smelly. Water and sewage arrangements, too, were often inadequate, making a wholesome environment hard to achieve, and leading to concerns about epidemic disease and mortality.⁶⁶ In summary he concluded:

An unavoidable picture emerges of public asylums as unwholesome and disease-ridden places, resulting from increasingly overcrowded conditions in buildings that were damp, cold, cramped and ill-ventilated.⁶⁷

Overall, his account hardly suggested any improvement over the provisions of the sampled early institutions.

Provision of facilities for the sick was another aspect of care in the present sample and, by 1856, the Commissioners included infirmaries, in their requirements.⁶⁸

A less tangible aspect of inmate care, identified in the present sample, was protection from physical abuse, exploitation, and insult from visitors, fellow inmates and staff. Casual visiting was not mentioned by Conolly, Browne or Smith and, presumably, was no longer a feature of public asylums, though relatives clearly visited. The Commissioners’ 1856 *Suggestions and Instructions* indicated that ‘visitors’ rooms’ were expected and it is likely that visitors and relatives met inmates under supervised conditions.⁶⁹ Visitor abuse was, then, unlikely.

Chapter 6 (sections 6.2.3 and 6.7.2) of the present account noted that rules prohibiting abusive treatment of inmates were common in early institutions, though this did occur, and inmates could abuse each other. The regime at the *Retreat*, as would be expected, required their gentle handling, attendants, as in the present sample, being forbidden to use excessive force:

The common attendants, are not allowed to apply any extraordinary coercion to the patients, by way of punishments, or to change, in any degree, the usual mode of treatment, without the permission of the superintendents.⁷⁰

Violence between inmates, and between staff and inmates, was noted in Smith's sample, along with inmate destruction of asylum property. Staff members were likely to be recipients of violence as they trod an uncertain course between maintaining order, and behaving kindly, as the rules required. They had many opportunities to use force, particularly when applying restraining instruments, and, as in the present sample Smith noted the inherent conflict between kindness and coercion within these custodial institutions.⁷¹

One type of abuse noted in the present institutions, but not recorded by Smith, Browne or Conolly, was the sexual abuse of inmates, and female staff, though it seems likely that this occurred. Browne noted sexual abuse of inmates in asylums before his day, but either assumed that it had been eliminated by proper classification by his time, or avoided mentioning it.⁷²

Chapter 6 (section 6.2.3) noted the availability of exercise and recreation for inmates and, for some, the ability move about inside the institution, to spend time outside it, or to have home-leave. A concern with recreation and diversion was noted by Smith as increasing from the late 1830s as 'moral management' took hold and:

Asylum managers increasingly promoted leisure and recreational pursuits as an alternative or supplement to work. By the early 1840s, there was a certain amount of vying between asylums as to which could offer the most imaginative activities for patients.⁷³

Conolly felt that, daily, inmates should be out of doors for an hour or two, and he praised the conversion of airing courts to gardens. He recommended swings, see-saws, roundabouts, rocking horses, small animals and birds, and games such as bowls in outdoor areas and, indoors, the provision of books, journals, board-games, cards, puzzles, soft-balls, musical instruments, concerts and dances.⁷⁴

Chapter 6 (sections 6.2.3 and 6.7.2) also indicated that inmate work was a feature of the early institutions, and this also became an increasing preoccupation in later institutions. The ability of judiciously chosen work to improve self-esteem, inculcate self-control, stimulate the body, and divert the mind was broadcast in

Tuke's 1813 *Description*⁷⁵ and Browne was equally enthusiastic, describing his ideal asylum as:

.... a hive of industry. When you pass the lodge, it is as if you had entered the precincts of some vast emporium of manufacture; labour is divided, so that it may be easy and well performed, and so apportioned, that it may suit that tastes and power of each labourer.⁷⁶

Chapter 6 (section 6.3) described the care of staff in the sampled institutions, and Smith's sample showed many of the characteristics of staff conditions which were noted there. Pay was poor, but gratuities, Christmas bonuses and one-off payments could off-set low pay, and he also noted the development of a career structure, which had not been evident in the early institutions. As in the present sample bed and board could ameliorate poor pay, though accommodation was commonly associated with the galleries, and subject to the asylum's noise and smell. Allowances of food, and beer, were liberal, and uniforms were provided, in Smith's view, deriving from those of Bethlem. The social life of lower level staff, as in the present sample, was severely limited.⁷⁷

Chapter 6 (section 6.4) discussed care provided to relatives and parishes in the sample of early institutions, through the abolition, or mitigation, of charges and arrears. Tuke reported that the charge for poor inmates of the *Retreat* was lower than those who were better off. Smith, too, noted attempts of his asylum visitors and governors to keep the charges for charity patients low by drawing on the subscription fund, and by adjusting charges to fit the means of the patient or his family.⁷⁸

8.5.4 The Rhetoric of Cure

In Smith's later institutions "cures" continued to be claimed, and comparative statistics presented. Browne, Conolly and Tuke all presented comparative cure rates, though Tuke used the term 'recovered' rather than 'cured' as he did not know "*what degree of sanity is generally thought sufficient to warrant the application of the term 'cured.'*"⁷⁹ Furthermore, sceptically, he accepted that the most which was achieved at *The Retreat* was to assist natural remission.⁸⁰

More generally, Smith noted:

By 1840 most of the county asylums were publishing detailed statistical tables as part of their Annual Reports. The numbers and proportions of claimed cures continued to form a central focus of these reports. Comparisons, if favourable, were highlighted. If unfavourable, explanations were offered which usually attributed poor results to the chronic state of patients sent off to the asylum long after the onset of their disorder.⁸¹

These factors suggest that most later institutions were exploiting a strong rhetoric of cure, while also justifying confinement in terms of public protection and care. This uneasy amalgam of the three justifications for confinement could be partly unified by suggesting that confinement itself was an essential component of cure. Both William Battie, and John Monro, physicians of St. Luke's and Bethlem, for instance, agreed that removal to a place of confinement was an essential component of a curative regime.⁸² The same view of confinement was also evident in Smith's sample::

The process of cure was seen to begin with the act of committal. If the lunatic's disorder was to be tackled, he or she had to be removed from its 'exciting cause'.⁸³

'Exciting causes' could cover an enormous range of factors, for example, lack of insight, advanced civilisation, nervous system damage, alcohol, strong passions, excessive concentration, grief, despair and gluttony.⁸⁴

As to what produced 'cures' the records of the early institutions were not forthcoming. No particular rationale for intervention could be discerned, though the impression was that physical remedies were administered in a trial and error effort to see if anything worked. A similar approach was also noted by Smith in his later sample:

Treatment regimes continued to be dominated by the empiricism characteristic of many eighteenth-century practitioners. There was still nothing resembling an agreed set of remedies to be implemented for particular mental conditions.⁸⁵

For the present sample of early institutions the closest one can get to therapeutic statements is to examine the writings of their physicians. William Battie's *Treatise*

on Madness (1758) saw insanity as resulting from disorders of nervous conduction which produced “*deluded imagination*” characterised by the perception of objects “*not really existing or not really corresponding to the senses.*” Nervous system disorder was divided into “*original*” and “*consequential,*” the first being hereditary, or otherwise without obvious cause, the second acquired through accident, infection, sunstroke, tumours, gluttony, and so on.⁸⁶ Both types were physically caused and there are no grounds for assertions that Battie distinguished between functional and organic disorders.⁸⁷

Despite Battie’s novel model, his approach to treatment was a conventional medical one and his innovative reputation, to modern eyes, probably lay more in his observation that “*management did much more than medicine.*”⁸⁸ He advocated a calm environment, away from home, in which unruly appetites were checked, fixed imaginations diverted, the inmate’s body and residence kept clean, his air fresh, his food simple and easy to digest, his amusements brief and unexciting and his occupations neither anxiety provoking, nor pleasurable.⁸⁹ Some elements of ‘moral therapy’ as practised at the *Retreat* might be read into this regime, though essential components were missing, in the form of a domestic, familial ethos, engagement in useful occupation, the inculcation of self-control and religious observance.⁹⁰

Monro’s response to Battie’s provocative *Treatise* presented a tenable alternative position. He argued that the characteristic feature of madness was not deluded imagination, pointing out that this occurred in drunkenness, and in hypochondriacal, and hysterical, conditions. Furthermore, in conditions such as mania, the imagination might be perfectly normal although the person behaved quite irrationally. The true basis of madness, for Monro, lay in vitiated judgement. As he put it the mad “*see right, but judge wrong.*”⁹¹

Turning to ‘management’ Monro was in general agreement with Battie’s position, though he made a number of additions and modifications to it. His major elaboration concerned the relationship between the inmate and the physician, and he stressed that the physician should be honest with the patient in order to foster trust and confidence in the physician’s ability. While he should have authority over the patient, he should treat him with kindness, tenderness and affection, as should attendants, who should

not use fear to influence him.⁹² Finally Monro saw knowledge of the cause of the patient's condition as important, so that the physician could approach the inmate in a suitable manner:

.....every one is not to be accosted in the same manner, some are to be commanded, others are to be soothed into compliance, but we should endeavour in every instance to gain their good opinion.⁹³

Monro's observations on management, as Battie's, cannot be said to approach those of the moral management regime at the York Retreat, but did anticipate the doctrine of separation of inmates from their previous milieu, and their placement in supposedly therapeutic institutions. However, in stressing the therapeutic use of the inmate-doctor relationship, Monro advocated at least one element of moral therapy as practised in the public asylums sampled by Smith.⁹⁴ Further, his approach could indicate a conception of the inmate as having at least some residual degree of self-control, another essential part of the Moral Treatment regime at *The Retreat*.⁹⁵

Both John Haslam, and Bryan Crowther, respectively the apothecary and surgeon at Bethlem Hospital, also published work on insanity. Haslam clearly saw the Bethlem inmates as amenable to gentle treatment:

I can truly declare that by gentleness of manner, and kindness of treatment, I have never failed to obtain the confidence, and conciliate the esteem of insane persons, and have succeeded by these means in procuring from them respect and obedience.⁹⁶

This view of inmate treatment clearly influenced practice at *The Retreat* and it was Haslam, not Battie, who was referred to in Tuke's 1813 *Description*.⁹⁷

Haslam also advocated the use of punishments, at least for recovering inmates:

Where the patient is in a condition to be sensible of restraint, he may be punished for improper behaviour by confining him to his room, by degrading him, and not allowing him to associate with the convalescents and by withholding certain indulgences he had been accustomed to enjoy.⁹⁸

Crowther took the same view, advising that:

If a patient offers violence to any officer, servant, or to each other, let him be confined until he is made sensible of his bad behaviour, and makes apology for his conduct.⁹⁹

This was not dissimilar to practice at The Retreat, where an analogy of disciplining children was used.¹⁰⁰

Surprisingly, and contrary to the general opinion that it was pointless to address inmates' delusional ideas, Crowther suggested:

Mad persons are frequently capable of being reasoned with; and it is sometimes on the power of the physician to remove false impressions from the patient's mind, by a well directed reply and judicious reasoning.¹⁰¹

Porter rejected the idea of an epistemological break around 1800, in which management of the mad shifted from treating them as animals, to a conception of them as people. He argued for a slow transition to moral therapy, though largely outside the public institutions considered here.¹⁰² Smith, too, was at pains to point out that moral therapy did not begin at the *Retreat*, nor did the moral management practised in his institutional sample necessarily derive from practice there, but from a variety of earlier influences. The Tukes, he suggested, simply “*adopted the best existing practice.*”¹⁰³

While the views of Battie, Monro, Haslam and Crowther can be seen as indicating that conceptions typical of moral management, were not uncommon in public institutions, the conception that inmates had human agency, was also implicit in their more general treatment. The conversion, in 1749, of the old straw room at the Bethel Hospital into a cellar for the “*worst of the lunatics*”, could, for instance, be seen as a moral judgement of their bad behaviour, and as attributing agency to them.¹⁰⁴ Again, the employment of some inmates in useful work would also suggest that they were seen as being in control of themselves.

8.6 Christian Observance

Chapter 7 of the present account concluded that there was scant evidence that madness, or its management, was conceptualised within a Christian belief system or

that inmates were regularly involved in divine service, or visited by clergy. Rather, madness was managed within a rational, medical system of belief. To obtain any consistent medical view of religious practices it is, again, necessary to examine the published views of the medical officers of the sampled institutions. Neither Battie, nor Monro made any specific observations on the matter, though Haslam saw religious terror as a cause of insanity, and Crowther suggested that “*enthusiasm and madness are not very distant relatives.*”¹⁰⁵

Religious observation, then, was an area of substantial change as, by 1856 the “*Suggestions and Instructions*” of the Commissioners in Lunacy specified a central chapel “*capable of comfortably accommodating at least three fourths of the patients.*”¹⁰⁶

As would be expected the importance of a religious life was recognised at *The Retreat*, and religious books, conversation, readings and attendance at Quaker meetings formed part of the regime there.¹⁰⁷

Tuke implied that Haslam and Crowther, had been unnecessarily pessimistic about role of religion in causing madness, noting that only three cases of this type had been admitted to *The Retreat*, of which two had recovered completely and the other considerably improved.¹⁰⁸ Conolly was more ambivalent, asserting that “*nearly one half of the cases of derangement of mind arise from this perversion of religion alone.*”¹⁰⁹ Nevertheless, with proper medical oversight, religious observance and discussion could be beneficial.¹¹⁰ Browne was more circumspect, favouring religious engagement on an individual basis.¹¹¹

Nevertheless, despite such medical qualifications Smith noted that:

Organized religious practice became a standard element of asylum life. Its benefits were recognised not only as being directly therapeutic, but also as being functional by promoting order and regularity, key elements in the return to normality.¹¹²

To conclude, in contrast to most aspects of institutional life considered in this section, the early institutions of the present sample cannot, in general, be seen as

having formed a credible base for the group worship, and clergy involvement with individuals, which developed in those which followed them.

8.7 Diffusion of Practices and Ideas

The preceding discussion showed little direct evidence that the sampled institutions influenced each other. Nevertheless their design and practices were more similar than would be expected from separate development, and the similarity of these elements to those of the later institutions suggested a gradual developmental process rather than a major late eighteenth-century shift in design and practice. Smith also noted *"the clear continuities, rather than any fundamental breaks, between contrasting eras in the treatment of insanity."*¹¹³ The argument that the sampled public institutions learned from each other and influenced later ones requires the specification of mechanisms for this mutual influence, and the following discussion will attempt to do this. The account will be largely speculative but will, at least, open up some possibilities for future research.

First, Bethlem, St. Luke's, The French Hospital, and Guy's, were all London hospitals and, as group, were accessible to anybody with an interest in them. Again, Bethlem (at least until 1770), and the Bethel, hospitals were open to public visiting.

Second, transfers of inmates occurred, requiring governors to acquire some knowledge of each other's institutions. For instance, in June 1704, Abraham Tompson was ordered to be transferred from St. Peter's Hospital to Bethlem, the advice, and agreement, of Dr. Tyson, the Bethlem physician, having been obtained.¹¹⁴

Third, the medical officers of, at least, the London Hospitals, were likely to be known to each other. Membership of their colleges and companies would have brought them together professionally, as would their everyday work. For example John Monro, the Bethlem physician, and William Battie, the St. Luke's physician were well known to each other, as Battie was a governor of Bethlem, and they also met over particular cases.¹¹⁵ The Monro family also kept a private madhouse, and Battie took over James Newton's Islington madhouse in 1754.¹¹⁶ John Haslam, the

Bethlem apothecary, was also involved with Miles' madhouse in Hoxton.¹¹⁷ Thus, they would have been acquainted with colleagues in the private mad business. Again, St. Luke's, initially, appointed six volunteer apothecaries, working in rotation, who were given governorships. Clearly they would have been in regular contact with each other, with members of their professional group and with other governors.¹¹⁸

Fourth, there was probably a degree of staff movement between the institutions, particularly in London. Although there were no clear examples in the present sample there was a regular turnover of staff, and experience of lunatics would have been a marketable skill.

Fifth, the governors of the London institutions were likely to be acquainted. Many were of similar social status, and probably met on other occasions, particularly if active in other areas of public life (see Appendix 1). Some governors would have held this position in a number of institutions and been especially able to compare them.

Sixth, institutions occasionally communicated with each other at a formal level. For instance, in June 1809 the Bethlem governors took exception to several passages in a printed book of rules and orders published by St. Luke's Hospital and diplomatically asked for the offending passages to be expunged. In October 1809, the secretary of St. Luke's attended the Bethlem general committee and agreed to the amendment of the next edition of the rules to obviate the governors' objections. More directly, in March 1728, prior to building the hospital lunatic house, the Steward of Guy's Hospital was given a gratuity for, among other things "*making Enquiries into the method of Lunatic Houses.*" This, presumably, involved communication with those in London and, perhaps, further afield.¹¹⁹

The seventh area of possible influence was the diffusion of institutional rules. Clearly, from the previous example, Bethlem was aware of the rules for St. Luke's, and the similarity of rules in different institutions makes it likely that one institution's rules were often a basis for those of another. For instance St. Luke's had a rule that the keeper:

.....do not permit any strong Beer, Spirituous Liquors, Tea or provisions of any kind to be brought into the House to the patients from their friends or any person whatever.¹²⁰

The Newcastle Hospital had a very similar rule for its nurses and servants:

THAT no Liquors, or Provisions of every Sort, be brought into the House to the Patients, from their Friends, or any others whatsoever.¹²¹

This rule also occurred elsewhere and, while it could be argued that it dealt with a common problem, the similarity of wording does suggest mutual influence.

Other printed material was also in circulation, forming an eighth area of influence, The writings of Battie, Monro, Haslam and Crowther were available to interested parties and, by the later eighteenth-century, there was an expanding literature on the causes, classification and treatment of madness.¹²² Again, diarists and other visitors to institutions recorded their impressions, for example, the unenthusiastic account of St. Peter's Hospital by Sir Frederic Morton Eden in 1797 which reported that it was "infested with vermin" and that there was "a want of cleanliness".¹²³

Accounts of the institutions were also to be found in city guides and 'surveys' produced during the eighteenth-century of which the most notable were those of Stow. Stow's 1754 'Survey' of London described Bethlem, St. Luke's, Guy's and the French Hospitals and, for Bethlem, presented a history, descriptions of the exterior and interior, its rules, benefactors, numbers of inmates, governance, diet, admission and discharge procedures, and cure rate.¹²⁴ Finally, details of the institutions appeared in the newspapers and in government reports.

In conclusion, while there were only occasional examples of direct communication, and of movement of inmates between the sampled institutions, there were clearly many routes through which information about their practices, and their gubernatorial ethos, could have been acquired. It is difficult to believe that the governors of new institutions, particularly in London, were unaware of what went on in existing institutions, and that they did not model their institutions on what they saw as best

practice, leading to a gradual evolution of institutional organisation which continued into the nineteenth century.

Notes to Chapter 8

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13. Smith, 2007. op. cit. pp. 47; Stevenson, C. *Medicine and Magnificence: British Hospital and Asylum Architecture, 1660-1815*. London: Yale University Press, 2000, p. 99; Andrews, J. & Scull, A. *Undertaker of the Mind: John Monro and Mad-Doctoring in Eighteenth-Century England*. Berkely: University of California Press, 2001, pp. 45-46.
14. Bridewell and Bethlem Hospital Muniment Book 1553-1732 Part II. Fol 208; BBCM 9/7/1656.
15. E.g. at the Bethel Hospital a bedroom was turned into a room “*for the reception of two Lunatics*”: BHTMB 28/5/1750. Again, the French Hospital’s second lunatic house had a ‘*chambre des quatre*’ in which up to four lunatics could be kept: FPHJCQ 17/9/1768.
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22. BHTMB 27/4/1747, 1/6/1747.
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26. Guy's Hospital: Agreement for building Lunatic House 9/9/1727: London Metropolitan Archives H09/GY/A/304/001, Plan and Elevation of Newcastle Lunatic Hospital by William Newton. c. 1765. Northumberland Archives Service. Ref ZBL 269/69.
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32. Browne, 1837. op. cit. p. 185.
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34. BBCM 1/7/1681, 17/12/1725, 26/7/1728, 28/6/1733, 13/7/1733, 11/2/1735.
35. SLGCB 13/2/1754, 14/8/1754; SLGCM 5/11/1755.
36. BHTMB 7/6/1773.
37. E.g, on 29th August 1741, Jacob Lardant was admitted to the French Hospital lunatic house "derangé dans son Esprit" having apparently been discharged from Bethlem as incurable. He left the hospital on December 15/12/1744 and was readmitted on 26/5/1750, dying in the hospital on, or about, 27/3/1754: See Marmoy, C. F. A. *The French Protestant Hospital: Extracts from the Archives of "La Providence" Relating to Inmates and Applicants for Admission 1718-1957 and to Recipients and Applicants for the Coqueau Charity 1745-1901*. Huguenot Society Quarto Series Vol LII. 1977; Printed Appeal for Rebuilding Petites Maisons 1752: French Protestant Hospital Library, H/F1a/1.
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43. BHTMB 27/4/1747, 6/11/1797; SLGCM 4/7/1764; Plan and Elevation by William Newton. c. 1765. op. cit.
44. FPHJCQ 12/1/1719, 13/10/1750.
45. Commissioners in Lunacy: *Suggestions and Instructions*. 1856. op. cit.
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47. Browne, 1837. op. cit. p. 190.
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57. Smith, 1999. op. cit. Chapter 8; Tuke, 1813. op. cit. pp. 163-176.
58. Smith, 1999. op. cit. pp 119-125.
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60. Tuke, 1813. op. cit. p. 125; Conolly, 1847. op. cit. pp. 65-66; Browne, 1837. op. cit. 170-171.
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63. Ibid. pp. 39-42; pp. 87-88.
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CHAPTER 9

THE CONTEXT OF THE INSTITUTIONS

9.1 Introduction

This chapter will give a brief account of three aspects of the broader context within which the sampled institutions existed. First, by considering other institutions in which the mad were detained, in relation to those of the present project. Second, by estimating the capacity of the overall range of institutions housing lunatics, and the proportion of the mad contained in them. Third, by presenting a variety of visual, literary, dramatic and poetic representations of the sampled institutions and, where evident, the role of their governors in producing, and responding to, such representations.

9.2 The sampled institutions, and other institutions accommodating the mad

9.2.1 Introduction

In relation to their confining and corrective functions, the sampled institutions could be seen as having something in common with prisons, bridewells, houses of correction, workhouses, private madhouses and hospitals. That this relationship could be close is evident from the fact that two of the sampled institutions were within general hospitals, one within a workhouse, and one was associated with Bridewell, a prison.

9.2.2 Prisons, Bridewells and Houses of Correction

Before the later eighteenth-century prisons were commonly placed in town walls, gates, or other adapted buildings. They were highly permeable, goods, persons and information passing freely in and out, under the control of a keeper appointed by local magistrates and aldermen. This keeper prevented escape in return for an opportunity to run the prison as an exploitive hostel.

Prisons were largely for containment rather than punishment, felonies being punished by transportation, or execution, and cellular confinement was rare. Their major internal classification was of class, measured by ability to pay.

However, by the later eighteenth-century, the need to control “gaol fever” reduced overcrowding, and improved hygiene and ventilation. The idea of moral contagion justified the separation of the criminal from society, and the classification of prisoners to minimise their mutual contagion. Imprisonment became both punitive and reformatory, and led to solitary confinement, in which the prisoner was punished by his conscience, received spiritual guidance, and did reparative work. Bentham’s concept of the “panopticon” also emphasised the internalisation of continual surveillance within a specially designed structure.

Bridewells resulted from sixteenth-century legislative moves proscribing wandering, and idleness, and aimed to punish, and reform the disorderly, immoral, and petty-criminal. Bethlem’s managing institution, was the first such establishment, and gave its name to those which followed. Houses of Correction also punished and reclaimed through work, though they gradually declined into general imprisonment.¹

Only law-breakers could be placed in these institutions and their lunatic inmates were largely those found guilty of vagrancy, or petty offences. While the wealthy could look after their own lunatics, those from poor families were often forced into vagrancy, coming to legal notice in this way. Except for rare cases of criminal insanity, which could involve life imprisonment, the mad were confined only for their lunacy’s duration, and were set free during lucid intervals to be a further danger, or nuisance.²

Lunatics were problematic in these institutions and appear to have commonly been kept separate, to avoid disturbing and frightening other inmates.³ Those in Bridwell Hospital were normally sent to Bethlem and, in the present sample, there were also examples of transfers between other prisons and the sampled institutions. For instance, in June 1670, Daniel Neave who had been sent to Bethlem from the Woodstreet Compter was returned there, having recovered. Again, Jonathan Morley was taken from the Bethel Hospital to Norwich castle gaol after mortally wounding

the master, in April 1814. Having been found guilty of murder he was subsequently removed to the new facility for criminal lunatics at Bethlem Hospital in 1816.⁴ Bethlem acquired a number of notable cases of this type, for instance the would-be regicide James Hadfield, and his accomplice Bannister Truelock.⁵

The managerial pattern of a “keeper” running the institution on behalf of a distant governing body was common to both prisons and public lunatic institutions. However, institutions for the mad were never penetrated by the public to the extent prisons were, and public presence in prisons was not generally motivated by a desire to “view” the inmates.

9.2.3 Workhouses

During the sixteenth-century the parish replaced the manor, religious houses and craft guilds as the core of poor-relief. Tudor legislation culminated in a 1601 Act by which parish overseers and churchwardens maintained the poor and set them to work, generally leaving them in their own homes. This system was funded by a tax on householders, collected and distributed by overseers of the poor.

However, towns resisted giving outdoor relief and, by the mid-seventeenth-century, were developing residential “hospitals” for children and the aged, and employing the able-bodied in non-residential “working houses,” or with local employers. Such arrangements were commonly linked to a Bridewell, or house of correction, for the punishment of the work-shy. Poverty came to be increasingly blamed on idle and indulgent habits, and seen as requiring reformatory programs. These were to be residential to minimize evasion, prevent the dissipated wasting their relief, provide a regulated regime, and ensure that inmates paid for their relief. Under local acts parishes amalgamated into “unions” to establish workhouses which commonly took in children, the aged, and the mad, as well as able-bodied workers.

Administratively, overseers of the poor normally appointed a workhouse master with a limited budget to run the institution. Materials were provided, from which inmates produced goods, sold for the profit of the master, or union. Workhouses also undertook sub-contracted work, rented out workers, and arranged apprenticeships.

Some provided basic education for children. The sexes were accommodated separately for convenience, and to reduce pregnancies which would swell the volume of poor. The mad, if present in any number, were generally segregated, as they were disruptive.⁶

One of the sampled institutions, St. Peter's Hospital, was an early workhouse and, by 1820, had twenty-two "wards" for different classes of inmate.⁷ It accommodated lunatics, exemplifying the general workhouse pattern and, by 1767, had dedicated lunatic wards⁸ containing, by 1826, seldom less than thirty inmates.⁹ These were not only paupers, some having payments made by relatives, or others.¹⁰

There was some evidence of transfers between workhouses and the sampled institutions. In June 1765, for instance, a rule for Bethlem Hospital required incurable "mopes" and "consumptives" to be transferred to parish workhouses.¹¹ Material for Bethel Hospital also recorded frequent transfers to, and from, the local workhouse.¹²

9.2.4 Hospitals

Hospitals had bodies of governors which, like those of Guy's and the French hospitals in the present sample, appointed management committees, and a steward, to see to day-to-day matters.

The prototypical English medieval hospital had a long hall with beds down the sides and a chapel at one end, in sight of the inmates. This space gradually became cubicalized to give more privacy and warmth.¹³ However, during the eighteenth-century a more domestic pattern also emerged, with hospitals placed in converted houses, or built in a domestic style.¹⁴

An analogy might be drawn between rows of lunatic cells off a corridor, or gallery, and the hospital pattern of rows of beds, or cubicles, down a ward. However, in hospitals, this arrangement derived from the need for inmates to see the altar, for easy staff access, and for greater comfort and privacy. In institutions for the mad, cellular confinement was a matter of coercive control and there seems no reason to

see any special relationship between rows of lunatic cells, and rows of hospital beds, other than the need to accommodate relatively large numbers of inmates.¹⁵

More cogently, institutions for the mad resembled hospitals for the physically sick in their provision of infirmaries, apothecary's shops, examination rooms, and so on, and in the provision of staff carrying out medical and nursing procedures aiming to 'cure' madness. They were commonly presented by their governors as specialist hospitals for the cure of madness by the application of medical expertise. The perceived closeness of physical and mental disorder can be seen in the fact that, in the present sample, Guys and the French Hospitals had lunatic houses, though their inmates were largely 'incurable'. This link was also apparent in the later eighteenth-century tendency for subscription hospitals to spawn associated lunatic hospitals.¹⁶

While in-house medical facilities would have been available to lunatics in the sampled institutions, both Bethlem and St. Luke's transferred occasional inmates to general hospitals as shown in Chapter 6 (section 6.2.2) which noted the transfer of inmates to London's Smallpox Hospital.

9.2.5 Private Madhouses

Private madhouses, in part, derived from the seventeenth-century practice of boarding out individual lunatics by parishes, or more affluent families.¹⁷ For instance, about 1630, Dr Crooke, the Master of Bethlem, maintained a lunatic in his own house.¹⁸ Specialist houses also accommodated a number of lunatics and, during the eighteenth-century, increased in number. Admission was initially uncontrolled, but allegations of brutality, and wrongful detention, eventually led to the 1774 Act for regulating madhouses which established medical certification as an admission requirement for non-paupers, and a licensing and inspection system for houses with more than one lunatic.¹⁹

The majority held between 6 and 25 inmates, though a few reached 100 or more.²⁰ Few were purpose built, and houses, often of imposing appearance, were generally adapted to accommodate different classes of lunatic. Commonly, private patients resided in the main house, while paupers were in converted outbuildings.²¹ Some

private madhouses accommodated criminal lunatics and chancery lunatics found unable to manage their own affairs.²²

Private madhouses had no governors, simply individual proprietors, commonly physicians. For instance, William Battie the physician of St. Luke's, and successive members of the Monro family, who were Bethlem physicians, ran private madhouses. John Haslam, the Bethlem apothecary, was also involved with Miles' madhouse in Hoxton, and there were frequent exchanges of inmates between it and Bethlem.²³ Others were clergymen, or laymen, some were 'empirics,' or other healers, and family businesses were common. Before 1828 there was no legal requirement that private madhouses had any medical input and lay proprietors were free to manage their institutions as they wished.²⁴ However, it tended to be medical men who wrote about their madhouse practice giving an impression that they were more medically organised than was the case.²⁵

Transfers occurred between private madhouses and the sampled institutions. For instance, in March 1750, Judith Dervoine was admitted to the French Hospital 'petite maisons' from a madhouse in Hoxton.²⁶ Movement also occurred in the other direction, presumably because of relatives' dissatisfaction. For example, in January 1755 the minutes of the Bethel Hospital recorded an order:

...that the friends of Elizabeth Sallow a lunatic now in this hospital have leave to take her out, in order to place her in a private house.²⁷

9.3 Statistics

In 1807 a House of Commons Select Committee reported the first county returns of the number of criminal and pauper lunatics in England.²⁸ By then the overall capacity the institutions in the present sample was about 790 places.²⁹ However, by 1807, there were additional institutions for the mad at Manchester (1766), York (1777), Liverpool (1792), Leicester (1794), Hereford (1799), and Exeter (1801).³⁰ It is unlikely that these provided more than an average of 150 places each and that the total public provision in 1807 exceeded 1800 places, or 0.02% of a population of about 9 million.³¹

The 1807 report was concerned only with provisions for criminal and pauper lunatics, and the numerical returns were in three categories covering, first, gaols, second, houses of correction and, third, poor-houses, houses of industry and workhouses, the total being 1,915 inmates.³² These returns probably seriously underestimated the true situation as, of 54 counties, 12 claimed to have no lunatics at all, and a good many very few. Even the accuracy of returns which had been made were doubtful, as those for Suffolk and Norfolk were subsequently amended by Dr. Andrew Halliday, who corresponded with the committee.³³ However, despite the deficiencies of this information, it does suggest that the majority of the pauper and criminal lunatics were in poor houses, houses of industry and workhouses (1,765 of the 1,915).

The number of inmates in private madhouses was not recorded, though the report indicated 17 metropolitan licensed madhouses and 28 more in the counties, totalling 45, though there would also have been unlicensed establishments operating.³⁴ Figures given by Parry-Jones for 1819, suggest that the maximum capacity of private houses at that time would not have exceeded about 2,600 inmates.³⁵

In conclusion, in 1807, the capacity of public asylums was unlikely to have exceeded 1800 places, and the number of places in private madhouses was probably below 2,600. If the Select Committee figure for workhouses and related institutions was increased to 3,000, to compensate for unreported cases then the capacity of the three major categories of institution in which the mad were placed in 1807 was probably no more than 7,400, or 0.08% of the population, and the capacity of public institutions for the mad was no more than 0.02% of the population.

Goldberg and Huxley's modern (1992) estimate of annual psychiatric in-patient prevalence for greater Manchester was 0.34%, seventeen times greater than the capacity of the sampled public institutions for the mad.³⁶ Although modern conceptions of mental disorder cannot be directly compared with those of the early nineteenth-century this does, nevertheless, suggest that the sampled institutions dealt with a relatively small proportion of seriously mentally disordered individuals.

9.4 Public Representations of the Sampled Institutions

9.4.1 Introduction

This section will present a variety of contemporary representations of the sampled institutions in order to place them in context and because, in the absence of significant archival research on them, published histories of madness and its management were often influenced by such representations.

These representations commonly recruited the institutions for particular purposes such as the projection of them as places of care, criticism of officialdom, lampooning of medical practice, or the projection of an individual as possessing sensibility, or as persecuted. A small sample of these will be presented, without any sophisticated analysis, as many lie within other areas of research which are outside the scope of the present project.

As might be expected Bethlem Hospital was the most commonly represented institution, and will figure strongly in the present account. However, an attempt will be made to do justice to the other institutions, insofar as material was available.

9.4.2 The Governors, Directing and Impotent.

Positive depictions of the institutions were often those which governors could control. Visual depictions almost invariably showed their building's best aspect, suggesting gubernatorial involvement in their production. For instance White's 1677 print, commemorating the building of the second Bethlem Hospital (Fig.1) was tightly controlled by the governors. Its inscriptions praised them, and two prints were handsomely framed, and presented to the King and the Duke of York.³⁷



Figure 1: Robert White’s 1677 Commemorative Print of the second Bethlem Hospital

Another such representation was on the seal of the Bethel hospital. (Fig. 2).³⁸



Figure 2: The Bethel Hospital seal, 1724, showing its street elevation.

Other positive visual representation, again under gubernatorial control, depicted founders. For example, Figure 3 shows Sheemaker’s statue of Thomas Guy, founder of Guy’s Hospital, which was commissioned by the governors.³⁹

Within a different modality Figure 4 shows a 1744 broadsheet poem, which was almost ludicrously positive about Bethlem’s regime and was, putatively, written by an inmate. This presumably had gubernatorial approval, as a note at the bottom of the sheet read *“Proper to be had and Read by all when they go to see Bedlam. Price 3 pence.”*⁴⁰

Governors actively used the press to advertise for supplies, staff, and donations, and to publicise new initiatives, all of which allowed them to portray their institutions positively. For instance, the future governors of the first Newcastle Lunatic Hospital promoted their fledgling project by regularly advertising donations and subscriptions in the local press.⁴¹



Figure 3. Sheemakers' statue of Thomas Guy, 1731. Original in colour.

The press could also be used to counteract damaging newspaper reports. For example, in October 1777, the Bethlem governors informed St. Luke's general committee of a newspaper report alleging abuse of inmates in both hospitals, and sent them a copy of their own response. The St. Luke's committee resolved to place a newspaper advertisement to refute the allegations, and restore the hospital's reputation:

Resolved That the following Advertisement be inserted in the Publick Papers Vizt.

St. Lukes Hspl for Lunaticks Oct 22d 1777

A False and Scandalous Paragraph having appeared in the Morning Post of the 14th instant highly reflecting on this Hospital with respect to the usage of the Patients. The Committee think it a Duty incumbent on them in justice to their servants and to prevent the uneasiness that such a Malicious Insinuation may occasion to the Friends of the Unhappy Objects under their Care to assure the Publick there is not the least Foundation for such a Charge. On the Contrary that the Patients are treated with the Greatest Tenderness and Humanity.⁴²



Figure 4: J. Clark. *Bethlem A Poem*. 1744.

However, the governor's control was limited. They were, for instance, unable to control published accounts of visitors such as Ned Ward, whose 1770 description of Bethlem was less than flattering:

Tis an Alms-House for Madmen, a Showing Room *for* Whores, a sure Market for Leachers, a dry Walk for Loiterers.⁴³

Again, the lunacy reformer Edward Wakefield, in 1815, gave damning evidence to the parliamentary select committee on the regulation of madhouses, concerning a visit to Bethlem on 2nd May 1814, accompanied by the artist G. Arnold.⁴⁴ During their visit they observed the plight of James Norris, who was confined in a complicated iron harness because of his supposed dangerousness, and Arnold sketched him (Fig. 5).



Figure 5. James Norris. Sketched by G. Arnold and mass produced as an engraving. The caption read "*William Norris Confined in this Manner in Bethlem Hospital. Sketched from the Life May 2. 1814 & Etch'd by G. Arnold. A.R.A.*" Original in colour.

9.4.3 Visitors.

Although governors could not control visitors' accounts, these were not necessarily negative. Jane Harvey, for example, in her *Sentimental Tour Through Newcastle*, of 1794, was complimentary of the architecture of the second Newcastle Hospital for Lunatics, describing it as:

An elegant and extensive brick building, with a neat pediment in the centre, and the whole well finished according to the rules of modern architecture....⁴⁵

In contrast, Zacharias Conrad Von Uffenbach, describing a visit to Bethlem in 1710, was distinctly underwhelmed:

The building is large and fine but nowhere near as handsome as it is made out to be, and, moreover, it is kept in a rather slovenly manner. I was not able to discover why this madhouse is called Bedlam, and whether it received this name from its founder or builder. On one side are the females, who look utterly repulsive, and on the other the men; each sex has an open green space, since most of them can be together, as they are not mad but only deprived of their wits or simple.⁴⁶

9.4.4 Sensibility

While some visitors were bent on diversion, others took pains to demonstrate their natural sympathy with the plight of others. Jane Harvey, for example, expressed how moved she was at the sight of the Newcastle lunatics and, additionally, constructed their plight as an opportunity for others to be charitable and compassionate.⁴⁷

Sensibility was also a literary theme and, in relation to lunacy, can be seen in the description of a visit to Bethlem in Henry Mackenzie's novel "*The Man of Feeling*." This questioned self-interest as the basis of social relationships and, against them, pitted natural sentimentality and benevolence. At the end of his visit the hero, Henry Harley, speaks to a young woman, made mad by the death of her lover. Her plight drives Harley to sympathetic tears, blurring the distinction between them:

.....I love you for resembling my Billy; but I shall never love any man like him.' She stretched out her hand to Harley; he pressed it between both of his, and bathed it with his tears.

Nevertheless, their difference was reasserted when she was turned into a commodity, sold for the public gaze, as she departed to her “*little apartment*”, and Harley and his friend paid the keeper for their visit.⁴⁸

9.4.5 Inmates.

Only two accounts by inmates were found, both concerning Bethlem, and hardly complimentary. The first was James Carkesse's 1679 series of poems “*Lucida Intervalla*” partly written in Bethlem Hospital while under Dr. Allen's care. In them Carkesse protested against his confinement, asserted his reasonableness and satirised his treatment. For example, “*The Riddle*” lampooned Allen's regime and drew a commonly made analogy between madness and poetry:

Doctor, this Pusling *Riddle* explain;
Others your *Physick* cures, but I complain
It works with me the clean contrary way,
And makes me *Poet*, who are Mad they say.⁴⁹

The second was Urbane Metcalf's 1818 pamphlet *The Interior of Bethlem Hospital*, which described his stay at the second hospital in the most negative terms:

During the years of 1804, 5, and 6, I spent twenty-two months in that dreary abode, Old Bethlehem Hospital; not more I believe than six weeks during that time I was incapable, through indisposition, of judging of the occurrences that daily took place. From the supineness of the then physician, the cruelty of the apothecary, the weakness of the steward, and the uncontroled audacity of the keepers, such scenes passed, that if the hospital had stood in a solitary place, where only six sensible and humane persons could have access in the course of a year, it would even then, have been astonishing that they remained unexposed...⁵⁰

Inmates could also be visually depicted and Figure 6 shows a print of Margaret Nicholson (Mad Meg), who attempted to assassinate King George III on 2nd August 1786. After long interrogation she was pronounced mad and committed to Bethlem, where she remained until her death.⁵¹



Figure 6. Margaret Nicholson's attempted assassination of George III (1786) from a contemporary print by Robert Dighton. c. 1786. Original in colour.

9.4.6 Referrers and Donors

Increasing demand for places in the institutions could also be seen as indicating a positive opinion of them, and the pathetic petitions of those seeking their relative's confinement reflected this. An example was that of Madeleine Guichet, to the directors of the French Hospital, in November 1762. This was probably professionally written, and sought the admission of her husband who had twice been in St. Luke's Hospital, and three times in a private madhouse. Madame Guichet was in danger of her life, unable to work, and the family was in great distress:

Il est ouvrier en Soye à quoi il gagnait sa vie: mais depuis long-tems est Aliéné Il a été mis 2 Fois à l'Hopital de St. Luc & 3 fois chez Mons Potter aux petites Maisons à Bethnal Green, & va en empirant & devient si dangereux: que s femme est en danger de sa vie incapable d'aucun travail & sa Famille reduite dans la derniere détresse.⁵²

[He is a silkweaver by which he earns his living: but for a long time has been mad. He has been put in St. Luke's Hospital twice and three times with Mr. Potter at his madhouse at Bethnal Green, and is deteriorating and becoming so dangerous that his wife's life is in danger, incapable of any work and his family is reduced to the ultimate distress.]

Subscriptions, donations and legacies also indicated a positive view of the institutions. Though generally monetary they could take other forms, one of the most unusual being a 1787 donation to the French Hospital of 63 bottles of Champagne, which were sold for £10.15.6.⁵³

9.4.7 Satire

Bethlem was a particular vehicle for satire. For example Jonathan Swift, later a governor, made a number of references to Bethlem in his satire, *A Tale of a Tub* (1704). In its *Digression concerning the Original, the Use and Improvement of Madness in a Commonwealth* he argued that both genius, and madness, arose from vapours rising to the brain, producing extravagant fantasies. Whether genius, or madness was ascribed to these depended on context, consequently, using the common analogy of a college, the inmates of Bethlem should be carefully examined to select out those whose fantastic ideas could be of use to the state.⁵⁴ For example a “Student” found “Swearing and Blaspheming, biting his Grate, foaming at the Mouth, and emptying his Pispot inn the Spectator’s Faces” could be given “a Regiment of Dragoons” and sent to war.⁵⁵

Figure 7 shows a visual satire, by Richard Newton, from 1794, in which the Bethlem madmen are in control, and the visitors’ faces, showing horror and surprise, resemble theirs. The female visitor on the left is being accused of immoral behaviour and is calling the inmate a mad dog, while her husband, dropping his stick in surprise, is being called a cuckold.

9.4.8 Bedlam and Bedlamites

The term “Bedlam” came to have a number of meanings other than referring to Bethlem Hospital. First it was used as a general term for a madhouse, as shown in Middleton and Rowley’s *The Changeling* (1653) in which Isabella, the young wife of Albius, a madhouse keeper, asks his assistant, to afford her “*the pleasure of your bedlam*” so she can look at Franciscus, a young man who had been admitted by pretending to be a madman.⁵⁶



Figure 7 Richard Newton: A Visit to Bedlam (1794)

Second it could refer to a general state of tumult or chaos and was, for instance, used as an analogy for the general foolishness and disorder of society. For instance, Michael Drayton's poem "*To my Noble Friend Master William Browne*" (1627) likened England to Bedlam:

This Isle is a mere Bedlam, and therein,
We all lye raving, mad in every sinne.⁵⁷

Third, it could represent a madman, as in John Ford's play *The Lover's Melancholy* (1628), in which Cuculus, a foolish courtier, was described as entering "*like a bedlam, singing*."⁵⁸

Bethlem inmates, in poetry and drama, were commonly depicted in terms of particular "types" such as the ruined merchant, the mad poet or intellectual, or the zealot driven mad by religion.



Figure 8. Crazy Kate by Henri Fuseli 1806-7. Original in colour.

A frequent visual, and literary, image, was that of Crazy Jane, or Kate, a young woman driven mad by her lover's desertion. Typically she was depicted with straw in her hair, garlands of foliage, dress dishevelled and in a mournful, or abandoned posture. For instance, Figure 8 shows an 1806-7 depiction by Henry Fuseli, painted for Cowper's poem *The Task*.

Added to the above types were the drunkard, and the lecher, suffering the consequences of their addiction. John Rutter's "*Bethlem Hospital: A Poem in Blank Verse*" (1717) presented a tour of Bethlem's "types" including a dismal portrayal of the lecher:

Not far from these the Letcher wan appears,
Dragging with feeble Limbs a nasty Corps,
Diseas'd all putrid and corrupt, inflam'd
His baleful Eyes sunk in his harpy Hands
Reeking with grime of Stews, not to be cleans'd:
Nor must I here describe his brutish Soul,
Of Reason void, or to what loathed Acts
It urges him, that wou'd pollute my Song,
Offend the modest Ear, that would detest
To listen to, what Eyes to see abhorr'd.⁵⁹

9.4.9 Summary

This section has presented a range of representations of the sampled institutions, and their inmates, and has emphasized that the governors initiated positive representations of them, and attempted to modify negative ones, as far as this was in their power. However, many representations, both positive and negative, were not under their control and were not, overtly, acknowledged.

Those who placed lunatics in them, or donated to them, presumably also saw them in a positive light, while others used representations of them for a variety of purposes. Visitors could present them as places of diversion, as an opportunity to demonstrate their sensibility, or as a vehicle for social comment, or satire. Inmates could represent them as places of unjust confinement, and themselves as abused, and artists, poets, novelists and dramatists could people them with a variety of fictitious, but dramatic “types.” Their real inmates could also be represented as mad, bad and dangerous, or as shamefully abused. In short there was no single, outside perception of the institutions, and their inmates, rather they were depicted in a wide variety of ways, to suit the particular needs of those representing them.

Notes to Chapter 9

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CHAPTER 10

SUMMARY, CONCLUSIONS, METHODOLOGICAL CRITIQUE, AND SUGGESTIONS FOR FUTURE RESEARCH.

10.1 Summary and Conclusions

The project originated in what were felt to be inadequacies in the depiction of early English public institutions for the mad in the secondary literature. In particular primary archival research was generally lacking, and the institutions were commonly used as a negative baseline from which a narrative of scientific and humanitarian progress could be constructed, which justified modern management of mental disorder. Although some of the literature avoided such a Whiggish narrative these early institutions were, nevertheless, presented in a very negative light.

Somewhat ameliorating these inadequacies were a small number of accounts of individual institutions which, sometimes, drew on their records. These could usefully elucidate their internal practices, but were often written by those associated with the institutions, and their accounts were often unreasonably positive, and uncritical. Although a few were reasonably balanced, and scholarly, they were, nevertheless, confined to a single institution, and what was lacking was a general overview of all early public institutions for the mad in England.

Accounts of the development of these early institutions also tended to be simplistic, commonly relying on the operation of a particular external variable, or a small number of variables, to explain changes, rather than seeing these as the result of a complex of interacting variables and events. Any contribution of the internal practices of the institutions to their own development was generally absent, and it was as if the direct experience of the institutional management of madness produced no learning, and no change. While interactive models, in which internal and external events influence each other, would seem to be appropriate, they were not in evidence.

The present project attempted to remedy these deficiencies by providing the first general account of the internal practices of all early English institutions for the mad. This was based, almost exclusively, on their own records and organized around two general research questions which asked what the governors of the institutions saw as their role, and how the institutions functioned.

What emerged from the project was, first, an account of the formation of the governors' ethos, mechanisms by which it was protected from untoward influence, and mechanisms by which it underwent agreed change. Although the governors would have had individual conceptions of their role, these had to be welded into a collective ethos in order to run their institutions effectively. An important element of this lay in the prescriptions left by the founders of the institutions, in the form of expressed intentions, rules, buildings and practices. Founders could also maintain a lasting presence in the institutions through depictions in portraits, statues, and other material forms. Significant benefactors or officers might also be memorialised to construct a creditable history, and legitimise the governors' ethos. In some cases Charters of Incorporation legally welded the governors into a collective body, symbolised by an official seal.

Regular meetings assisted the formation of the governors' ethos, and controls on the conduct of meetings protected this against infiltration by dissident, factional, ideas. Again, collective practices in the form of prayers, or dinners, bound the governors into a cohesive group with a common purpose. Additionally minute books and other records formed a collective a memory which legitimised their current activities.

New governors were subject to selection processes which ensured their positive disposition towards the prevailing ethos, and which symbolically inducted them into this, for instance by providing them with a symbolic staff, or book of rules. Finally, institutional buildings represented and contained the governors, their inmates, staff, and practices and, materially, "remembered" changes in their ethos.

Despite mechanisms which ensured a stable ethos the need to adapt to unforeseen events required changes to this. Such changes could be monitored through the

governors' resolutions, and orders, and mechanisms were in place to ensure that such decisions were collectively made and binding on all members of the collective.

Second, the content of governors' ethos was conceptualized within three major discourses which were broadly concerned with presenting the institutions as caring and curative, with their effective management, and with the actual provision of care. Clearly the governors saw their role as caring for, and curing, their inmates, as caring for their staff, and for others with whom they were concerned, and as managing their institutions as effectively as possible. A fourth "discourse" concerned the relative absence of various aspects of Christian belief and practice which one would have expected, from the literature on madness, to have been present in the institutions.

During the analytic phase of the project, from which these discourses emerged, considerable attention was given to material aspects of institutional practice, to routine practices, and to terminology. A "challenged" version of each discourse was also presented, which detailed unanticipated events, mistakes, resistances, and protests, with which the governors had to deal, and which could lead to changes in practice, and in the gubernatorial ethos. Essentially, they recorded a process of learning from experience which drove the internal development of the institutions. Such "bottom up" learning is an element which has been missing from secondary historical accounts of madness, and its management. The implication is that explanations of institutional development need to become more interactional, and take account of both internally driven changes, and external influences.

As well as elucidating internally driven change, the challenged versions of the discourses also illustrated ways in which the governors managed untoward events, and repaired the damage to their ethos they caused. At the most basic level a simple repair could be made, for instance faulty equipment could be replaced. At the most serious level an enquiry, or report, could be ordered which, generally, exonerated the governors and located culprits, who could then be admonished, disciplined or sacked. While changes to rules, or practices, could result from such events there was seldom any overt acknowledgement of institutional failings. External attacks on gubernatorial competence appear to have been dealt with in much the same way, an

enquiry being followed by an attempt to discredit the sources of any accusations, and have them retracted.

The challenged versions of the discourses also enabled the voice, and viewpoint, of the inmates, who were otherwise mute, to be expressed. It was suggested that, although some accepted their confinement unprotestingly, and some adapted positively, others protested against it using whatever means were at their disposal. Protests could range from lack of co-operation, through violence, or destruction of property, to escape or suicide. Again, relatives, and others, could sometimes be seen as protesting against the treatment of inmates. The challenged versions of the discourses also revealed something of the under-life of the institution, a particular instance being the sexual abuse of female inmates and staff.

Turning to the individual discourses, it was argued that the institutions coercively confined their inmates and, up to about 1550, this was openly justified in terms of public protection. Subsequently, it was argued, this justification was progressively supplanted by the sequential development of “rhetorics” of care, and then cure, which represented inmates as needy, suffering and sick, and the institutions, their staff and practices, as dedicated to their protection, care and cure. It was suggested that the rhetoric of cure progressively became dominant, though public protection, and care, could be used as justifications for confinement when necessary. The first Bethlem hospital was noted as the site of emergence of these three justifications for confinement and, in the maintenance of its separateness from Bridewell Hospital, as initiating the English pattern of confining the mad separately from other disturbers of the peace.

A more controversial argument was that the institutions did not actually cure their inmates, and that their spontaneous remission was increasingly represented as cure, supported by an apparatus of cure in the form of personnel, practices, equipment, “therapeutic” spaces, and an increasing ability to select inmates likely to spontaneously remit. In the view of the present writer, the issue of cure has not been adequately addressed and, if the institutions are presented as curative, an account of mechanisms by which cure was achieved must be presented.

Representations of the institutions as caring and curative could be seen as mechanisms through which the reluctance, and guilt, which families, and others, might have felt about locking up lunatics, could have been overcome. This could have contributed to an increasing demand for places, and the consequent institutional expansion which was notable.

Turning to the discourse of control and commerce, the institutions appear to have become, managerially, highly sophisticated as a consequence of the accumulated experience of dealing with day-to-day problems of implementing the governors' agendas. The challenges which confronted the governors included direct resistance to their right to manage their institutions. However, more frequently, the partial, or weak, downwards transmission of their ethos allowed it to be easily overcome by the self-interest of staff and others with which the governors were concerned.

The institutions could also be seen as planning for the future, particularly by expanding their facilities in the face of increasing demand, but also by developing new services for incurables and, in the case of Bethlem, for criminals, and personnel from the armed forces. The governors also attempted to materially improve conditions in their institutions in terms of comfort, efficiency, economy and modernity, for instance by creation of an infirmaries for sick inmates.

A distinction was made between the actual care dispensed by the institutions, encapsulated within the discourse of care, and the "rhetoric" of care which served to obfuscate the fact that inmates were coercively confined. In relation to the former a wide range of caring practices was considered. During the period considered, infirmaries were provided, day rooms and gardens allowed recreation and exercise, and the institutions improved in warmth, hygiene and the provision of facilities such as running water and water closets. Attempts were also made to treat inmates humanely, prevent abuse, and allow them freedom of movement. Additionally there was evidence of care for the institutions' staff, for relatives, for tenants, and for neighbours.

A challenged discourse of care recorded instances of lack of material care of inmates, their abuse, restriction of freedom and exploitation. The sexual abuse of female

inmates, and staff members was considered, as was the rather inadequate response of the governors to this. The issue of the flexible attribution of agency to inmates was also raised. Whereas, to justify their confinement, they could be considered as lacking even the agency to care for themselves, their difficult behaviour was commonly viewed as motivated and could be dealt with in a rather punitive way. Examples of lack of care of staff were also noted, manifesting, for instance, as restriction of their social life, and inadequacy of their pay. Restriction of the abatements normally granted to parishes, and relatives could also be seen as uncaring, and, in one case a family was exposed to danger by the release of a homicidal relative. Failure to care for tenants could, similarly, occur when they were unreasonably exposed to danger, or nuisance.

Consideration of these discourses illustrated two important aspects of the institutions. First, they were evolving systems which learned from their mistakes. Second, this learning illustrated the construction of the governors' ethos from below, as well as from external influences, and personal predilections.

The final "discourse," concerning explanations of madness within a Christian belief system, and practices associated with such beliefs, was largely notable for its absence. There was no mention of the devil, or demonic possession, no evidence of practices concerned with this, and no evidence that madness was seen as a punishment for sin, or as visited on an individual as a trial. The only references to God consisted of early statements that recovery was in God's hands, and that God might make medical practices efficacious. These statements ceased after 1683 and appeared to refer more to God having a hand in the organisation of the world than to any specifically supernatural explanation of madness.

Even in institutions founded in piety, clergy visits to lunatics appeared to be rare, and some institutions may even have discouraged them. Neither was there any direct evidence that lunatics routinely participated in divine worship in such institutions as held Christian services for other types of inmate, though they may have occasionally done so. However, although Christian practices impinged minimally on lunatics, institutions were not slow to exploit any religious credentials for fund-raising purposes.

Finally, Chapter 8 considered the influence of the sampled institutions on each other, and on those which followed them. There was little direct evidence of mutual influence, though the similarities of their design and practice made it likely that they learned from each other, and mechanisms through which this influence could have occurred were discussed. Again, direct evidence of their influence on later institutions was scant, but similarities of practice strongly suggested a continuous line of development from the sampled institutions to their later counterparts. In particular these similarities, and the writings of the medical staff of Bethlem and St. Luke's, suggested that the conception of an epistemological rupture which divided the early institutions from those of the later eighteenth century and nineteenth-century was probably incorrect, continuous development being more likely.

10.2 Methodological Critique

10.2.1 The Sample

A major strength of the present project was its inclusiveness, as it covered all English public institutions for the mad founded up to 1765, including several which were virtually unknown, resulting in a general model of their functioning, and their gubernatorial ethos. However, the institutional sample was restricted in a number of ways. First, its two upper time limits, 1765 and 1815 were somewhat arbitrarily imposed because of time constraints, the volume of material to be analysed, and in order to allow each institution to be examined, either to its demise, or for at least half a century after its foundation. Thus, the end point for sampling differed somewhat for each institution, producing a rather ragged termination. Second, only public institutions were sampled, again because of time, and volume, constraints. While private madhouses of the period have been covered by Parry-Jones, this remains an under-researched area.¹ Third, only English institutions were sampled, again because of time and volume constraints, as well as problems of language and access. Clearly it would be valuable to extend the upper time limit, to include private madhouses and to examine non-English institutions. Finally, four of the institutions, St. Peter's, Guys, the French Hospital, and the Newcastle Lunatic Hospital presented problems of limited data and, though these may be insurmountable, it is possible that other

sources, for instance newspaper reports, could be used to augment this limited data pool.

10.2.2 The Analysis

The analytic method enabled large amounts of material to be consistently processed. It ensured that all the sources were closely scrutinized for their meaning, that material objects and practices were noted, and that mundane processes were acknowledged. As analysis proceeded, material from different institutions was grouped into meaningful categories, which appeared to reflect common practices, leading to a general model of institutional functioning. The analysis also took account of untoward events leading to an account of “challenges” to each gubernatorial discourse. Attention was also paid to the ways people, objects and events were described so as to present the institutions, and their practices, as caring, curative and well managed. This approach prioritized the role of internal events and practices, and provided an antidote to the common presentation of them as simply changing in response to external forces, events and ideas. Rather, it emphasized the development of the institutions through the interaction of internal and external processes. The project could be criticized for this “internal” focus, which took little account of external forces, events and opinions. However, it aimed to fill a conspicuous gap in the literature on madness and its management, and succeeded in doing so.

The backbone of the analysis were the processes of coding, sorting and categorising. Although these processes might be seen as being applied in a relatively dispassionate way, one person’s use of them is likely to differ from another’s, and explanation, as it emerged, represented a particular “take” on the material, rather than having emerged uncontaminated by the researcher. This could leave the project open to the criticism that it was simply the writer’s personal view, particularly as it drew on modern conceptions of organizational management, and modern debates concerning the nature of “cure” in serious mental disorder.

10.2.3 The Model

The model which emerged from the analysis should be easily testable, and modifiable, by further research, and its applicability to other types of institution, both for the mad, and for other types of inmate, could be easily investigated. The model could be used, for instance, as a base from which to explore differences between individual institutions, or differences between practices in dedicated institutions for the mad, and those in other institutions in which the mad were placed. Again, the evolution of particular organizational elements, or practices, could be explored over time. Nevertheless, the production of such a general model could be seen as a weakness, as it obscured the uniqueness of each institution, and tended to represent their practices, and the ethos of their governors as equivalent. Clearly, further research on each institution as a unique entity would be important.

10.3 Suggestions for Future Research

Section 10.2.1 noted a number of deficiencies in the present institutional sample, which was limited, geographically, temporally, and in the range of institutions included. Future research possibilities clearly exist in surmounting these limits. Additionally, a number of the sampled institutions deserve their own, separate, histories and, in particular, the madhouses of Guy's and the French Hospitals are virtually unknown, and would bear individual treatment.

Another path for research would be to refine, or modify, the model which emerged from the present analysis. Normative assertions have been made about the management of the sampled institutions, the discourses of their governors, the conduct of staff, inmates, relatives, and so on, and these could be explored further. In particular, the argument that the justification for confinement in terms of public protection was progressively transformed into a presentation of the institutions as providing care and cure is open to refutation, modification or elaboration, for the period sampled, in later periods, and in a wider range of institutions.

Available sources would also enable other issues to be pursued, for instance the issue of sexual abuse of female inmates, or the institutional "careers" of individual inmates

could also be examined. In relation to this latter possibility, material relating to inmates of the French Hospital has been collated, and alphabetically indexed, by Marmoy,² and exploration of this source could be an inviting research project. Again, a comparison of inmates retained at Bridewell, and those moved to Bethlem would be of interest. The relation of developments within the institutions to related developments outside them could also be explored. For instance the development of water closets, washing machines, vermin control, window glazing or uniforms could be linked to the development of such facilities elsewhere, placing institutional practices in their broader social context and encouraging more complex models of institutional development. Similarly, if institutions leaned from each other, the mechanisms for this need to be elaborated. For instance, a comparative analysis of the rules of institutions for the mad over time could be revealing, as could an in-depth analysis of the social milieu of their governors, or the movements of their staff.

Finally, the institutional records were replete with architectural details. There were images of most of them, and their records made references to their interior spatial arrangements which could be, at least partly, reconstructed. Again, their architectural development over time could be plotted. While moves have been made to examine these early buildings³ architectural accounts have tended to focus on the nineteenth-century, and there is work to be done on earlier institutions.

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Note: From 1155 to 1751 England used the Julian calendar, the first day of the new-year beginning on 25th March. In 1751 a switch to the Gregorian calendar was made, the day after 31st December 1751 becoming 1st January 1752 instead of 1st January 1751. To avoid confusion when searching for references, the dates given below are as given in the documents. Thus, they are in the Julian calendar up to the date of the change, and in the Gregorian calendar afterwards.

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- *Vol 2:1574-1576.
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- *Vol 4: 1598-1604.
- *Vol 5: 1604-1610.
- *Vol 6: 1617-1627.
- *Vol 7: 1627-1634.
- *Vol 8: 1634-1642.
- *Vol 9: 1642-1658.
- *Vol 10: (Rough) 1657-1659.
- *Vol 11 (Rough) 1662-1664.
- *Vol 12:1666-1674.
- *Vol 13 1674-1678.
- *Vol 14: 1678-1684.
- *Vo 15: 1684-1689.
- *Vol 16: 1689-1695.
- *Vol 17: 1695-1701.
- *Vol 18: 1701-1713.
- *Vol 19: 1713-1722.
- *Vol 20: 1722-1737.
- *Vol 21: 1738-1751.
- *Vol 22: 1751-1761.
- *Vol 23: 1762-1781.
- *Vol 24: 1781-1792.
- *Vol 25:1792-1803.
- *Vol 26 1803-1822.

Bethlem Committee Minutes.

- *1756-1783 (Rough).
- *1783-1791.
- 1791-1795 (Rough).
- *1795-1800.

*1800-1805.
*1805-1814.
*1814-1817.

Bethlem Hospital Grand Committee Minutes.

*1789-1793.
*1792-1802

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*Vol 2A 1717-1723
Vol 2B 1723-1726.
*Vol 3A 1726-1732.
Vol 3B 1732-1735.
*Vol 4 1746-1755.
Vol 5 1756-1762.
Vol 6 1762-1770.
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1775-1781.
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MS 25121/837.

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*Deed: Bristol Record Office 09864(6) a.

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*1776-1797.

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1753-1765.

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1723-1738. H09/GY/D/078/001-059.

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1741-1742. H09/GY/D/080/200-230.

1747-1748. H09/GY/D/080/231-262.

Cash Books.

A 1724-1739. H09/GY/D/011/001.

B 1738-1749. H09/GY/D/011/002

C 1749-1765. H09/GY/D/011/003.

D 1765-1794. H09/GY/D/011/004.

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*1750-1779.

*1779-1811.

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*1750-1774.

*1775-1804.

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*1758-1765.

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*1778-1784.

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APPENDIX 1

WHO WERE THE GOVERNORS?

A.1.1 Introduction

Governors were an important interface between the internal practices of the institutions and the world outside, with its varied perceptions of them. This appendix will briefly describe who the governors were, and some possible motivations for their being governors. There has been little systematic research on these matters but this would, for any institution, require a complete list of governors for the relevant period, and biographical information for each governor. For the present sample Bateman and Rye provided a list of Bethel Hospital trustees (governors) from 1724 to 1904¹ and, for the French Hospital, Murdoch and Vigne provided an equivalent list, from 1718 to the present day.² Biographical information was also available for the Bethel Hospital, the French Hospital and, in pre-analysed form, for Bethlem Hospital.³ The following account is based on this material, and will, tentatively, draw some general conclusions. However, the sampled institutions, while showing common characteristics, also met local needs, and their governing bodies are likely to have had unique features, just as the institutions did.

A1.2 Bethlem Hospital

Andrews et. al. described Bridewell and Bethlem's governance as "*a microcosm of London's governance*", and as reflecting "*the ebbs and flows of city affairs*,"⁴ though actual management was largely in the hands of regular court attenders, and Bethlem's management was largely through subsidiary committees controlled by small numbers of governors in which individuals, or small groups, could exert considerable influence.⁵ In the hospital's early days these governors appear to have been largely tradesmen and businessmen, with smaller numbers from the middle and professional classes.⁶ In the decade between January 1685 and January 1695, the 108 governors nominated for election, whose occupations, or titles, were recorded, included fifty-three dealers and victualers, eighteen craftsmen or semi-skilled workers, and seventeen professionals. In terms of title three were styled as knights,

two as close relatives of knights, thirteen as esquires and two as gentlemen, this socially elite group, forming less than five per cent of the total.⁷ This suggested that, initially, governorships were commonly occupied by upwardly mobile individuals from mercantile, manufacturing and professional groups, rather than the landed gentry and aristocracy.

However, during the eighteenth century, lower ranking tradesmen, craftsmen and semi-skilled workers were elected less frequently, “*with MPs, landowners, city notables, the professions, financiers, lawyers and leading tradesmen dominating the Hospitals’ meetings and business.*”⁸ The medical and legal professions were especially well represented, with a good many notable mad-doctors and Anglican churchmen.⁹ Andrews et. al. also suggested that, as Bridewell was a prison, the joint hospitals may have attracted those concerned “*with public order, the extirpation of vice and the reformation of manners and morals.*”¹⁰ A political element was also noted as, during the later seventeenth-century, the joint hospitals were presided over by a Whig group, headed by the president, Sir William Turner. However, by the end of the first quarter of the eighteenth-century Bethlem was dominated by Tories and High Church Anglicans.¹¹

A1.3 The Bethel Hospital

The initial governors (trustees) of the Bethel Hospital were, under the terms of the will of Mary Chapman, the foundress, John Hall, William Cockman, Richard Cooke, John Lombe, John Thompson, William Lombe and Timothy Ganning.¹²

Mary Chapman was the daughter of John Mann, a mercer who was sheriff, and mayor, of Norwich in 1649, and sheriff of Norfolk in 1672. She came from the upper social echelons of the city, and county, and it seems likely that her initial trustees were of similar social standing. Another factor in her choice may, however, have been that she was the widow of an Anglican clergyman and, judging by her instructions for her funeral, a woman of simple piety¹³. She might, then, have chosen pious men as her trustees.

Of these, John Hall was an alderman of Norwich, and twice its mayor. His daughter married Philip Meadows, also mayor in 1734, and a trustee in 1724. Bateman & Rye noted that “*the Governors of this Charity were conspicuous in contracting alliances with each other.*”¹⁴ Hall’s wife was Margaret Lombe and two other initial trustees, John and William Lombe, may have been from the same family, which was reputable and above the simple artisan level. John appears to have been a worsted weaver, but nothing is known of William.¹⁵ William Cockman, also a worsted weaver, was a justice of the peace and alderman, sheriff in 1703 and mayor of Norwich in 1711.¹⁶ Timothy Ganning was the son of a rector, and an upholsterer, and appears to have been a sheriff in 1706.¹⁷ John Thompson and Richard Cooke remain obscure figures though Thompson may have come from an old Norwich family and been a common councillor in 1685.¹⁸ Richard Cooke died before the initial trustees met in January 1724, Sir Benjamin Wrench replacing him.¹⁹ Wrench was a physician, whose father had been sheriff and mayor. He was knighted in 1720, for obscure reasons, and also served as the Bethel Hospital’s first physician until 1746.²⁰

As a group, these men were generally of prominent and respected Norwich families, in some cases associated with weaving and uphostering, and many had held public office, or came from families in which other members had done so. Something can also be said about their religious affiliations. Richard Cooke and John Thompson left bequests to the Presbyterian Schools, as did a later trustee John Lougher. Timothy Ganning, too, was the brother of a Presbyterian Minister.²¹ John Hall was a member of the Presbyterian Octagon Chapel in Norwich, which William Cockman and John Thompson also seems to have attended and, with which, the later trustees, Robert Marsh, Philip Meadows, William Wiggett, and John Lougher were associated. Lougher’s wife donated funds to the chapel and a Mrs. Susannah Cooke, presumably related to Richard Cooke, donated to both the Presbyterian Schools and the Bethel Hospital.²² Although Mary Chapman was not a Presbyterian, a good many early trustees appear to have been of this persuasion, reflecting a strict piety of which she may have approved.

Of the 35 later trustees, and governors, up to 1815, listed by Bateman & Rye, seventeen were titled “Esquire”, one “Gent”, two “Mr,” one “Reverend”, and one “Sir”, the remainder being listed without any title, though two had professional

qualifications. This would indicate that a majority came from the upper sections of Norwich society, though such occupations as were listed suggested origins in trade and manufacturing, the landed gentry being conspicuously absent. Many showed evidence of other public service, ten having been alderman, sheriff or mayor, and another chancellor of Ely. One, Sir. James Edward Smith, established the Linnean Society, and donated Linnaeus' library to it. When any political affiliation was discernable it was Whig, perhaps suggesting an orientation towards social reform. A number were Presbyterians, and promoters of church schools, one was a Quaker, and one was active in the anti-slavery movement. In this respect they differed from the Tory and High Anglican tendency of the Bridewell and Bethlem hospitals. Members of the same family not uncommonly became trustees, or governors, and there was one case of inter-marriage, when W. Foster married the widow of Jehosophat Postle, a deceased governor.²³

A1.4 The French Hospital

Murdoch & Vigne listed four hundred and twenty-one "directors" (governors) of the French Hospital during the period of the present study.²⁴ Of these, nine became its "governor" (president), and fourteen deputy governors. Only seventeen (4%) were titled, or showed evidence of professional training, seven being knights, five earls, three barons, one a fellow of the Royal Society and one a clergyman. Forty-four (10%), (including nine of the seventeen noted above), had an armorial shield, or coat of arms, displayed in the French Hospital, and one had an individual book plate, suggesting a degree of social distinction. Thus, it appears that the majority did not come from the highest social levels, and Murdoch & Vigne suggested that many were successful merchants, manufacturers and craftsmen, the latter group including silk and satin weavers, jewellers, clock-makers, carvers, gilders, modellers and goldsmiths. A number were also distinguished soldiers, or members of the professions.²⁵ Recurrences of surnames suggested that members of the same family not uncommonly served as directors, and the vast majority were of French descent.²⁶ It can probably be assumed that, as the hospital served the London Huguenot community, the majority were protestant. The hospital regulations also prescribed that Anglican divine service should be performed in the hospital twice weekly, suggesting a primarily Anglican gubernatorial leaning, though some could have been

nonconformist.²⁷ Information on the political leanings of the governors was not evident.

A1.5 Discussion

The preceding analysis, albeit limited, suggested that the bulk of the governors came from those successfully engaged in trade, manufacturing and craft-work, rather than the aristocracy and gentry, though these groups, and the professions, were involved to a lesser degree. Not uncommonly governors were also engaged in other forms of civic service, suggesting an upwardly mobile, entrepreneurial group, with pride in their cities, and an interest in their development, as well as more self-interested motives.

Unexpectedly, the clergy rarely appeared as governors, though religious motives may have inspired some lay-governors. During the eighteenth-century the Bridewell and Bethlem governors appear to have been dominated by High Church Anglicans, and a number of early Bethel governors were associated with the Presbyterian church, and its charities. Again, the governors (directors) of the French Hospital came from the Huguenot community and most were probably practising Protestants.

The governors' political affiliations were probably related to local conditions, and many were clearly politically active. In the eighteenth-century the Bridewell and Bethlem court appears to have had Tory leanings, and some of the Bethel governors appear to have been Whiggs, though nothing could be said of political interests of the directors of the French Hospital.

Notes to Appendix 1

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2. Murdoch, T. & Vigne, R. *The French Hospital in England: Its Huguenot History and Collections*. Cambridge: John Adamson, 2009, pp. 95-101.

3. Bateman & Rye. op. cit. pp. 55-72; Murdoch & Vigne. op.cit. pp. 89-94; Andrews, J., Briggs, A., Porter, R., Tucker, P., & Waddington, K. *The History of Bethlem*. London: Routledge, 1997, Chapter 12. pp. 156-177.

4. Op. cit. Andrews et. al. 1997, p. 156.
5. Ibid. p. 162.
6. Ibid. p. 162.
7. Ibid. p. 163.
8. Ibid. p. 163.
9. Ibid. pp163-4.
10. Ibid. p. 166.
11. Ibid. pp. 168-9.
12. Mary Chapman will, dated 4th December 1717: Norfolk Consistory Court Records (Microfilm) MF 432 Records for 1724 Fol 219 Will No 152.
13. Chapman will. op.cit.
14. Bateman & Rye. op. cit. p. 56.
15. Bateman & Rye. op. cit. pp. 56-58; Millican, P. ed. *The Register of the Freemen of Norwich 1548-1713: A Transcript*. Norwich: Jarrold & Sons, Ltd, 1934, p. 190.
16. Bateman & Rye. op. cit. p. 56; Millican. op. cit p. 205; Cozens-Hardy, B. & Kent, E. A. *The Mayors of Norwich 1403-1835 Being Biographical Notes on the Mayors of the old Corporation*. Norwich: Jarrold and Sons, 1938, p. 111.
17. Bateman & Rye. op. cit. p. 58, Millican. op. cit. p. 148.
18. Ibid. p. 58-9.
19. BHTMB 12/1/1724, 22/3/1724.
20. Bateman & Rye. op. cit. pp. 59-60; BHTMB 12/1/1746.
21. Bateman & Rye. op. cit. p. 56, pp. 58-60.
22. Tillett, E. *Norwich Scrapbooks*, Vol 26. Press Cutting dated 10/11/1897: Letter in response to a request by Frederick Bateman for informaton on the trustees, dated 4/11/1897. Norwich Central Libray Local History Section. Ref: L42.615.
23. Bateman & Rye. op. cit. pp. 60-70.
24. Murdoch & Vigne. op. cit. pp. 95-101.
25. Ibid. pp. 89-92.

26. Ibid. pp. 95-101.

27. *Statutes and By-Laws of the Corporation of the Governor and Directors of the Hospital for Poor French Protestants, and their Descendants, Residing in Great Britain*. London: 1761. p. 27. Duty of the Minister: Huguenot Society Library 26.d.

APPENDIX 2

THE CHRONOLOGICAL DEVELOPMENT OF THE INSTITUTIONS AND A CHRONOLOGY OF THE EMERGENCE OF THEIR MAJOR FEATURES.

A2.1 Introduction

This appendix provides, first, a brief account of the foundation, and subsequent chronological development, of each of the sampled institutions and, second, a chronology of the emergence of their key features, which indicates the first reference to these in the sample.

A2.2 Bethlem I, London, 1247-1676.

Bethlem Hospital was founded, in 1247, by the grant of land and property in Bishopsgate by Simon FitzMary, a sheriff of London, to the bishop of Bethlem, as a priory, and a hostel for the reception of the bishop, when in England.¹ The first evidence that the mad were housed there came from a 1402 royal inquiry into mismanagement at the hospital, which reported that it contained, among other inmates, six insane persons.² By 1436, it was, effectively, a hospital for lunatics, as William Mawere, a tailor, was discharged from jury service, and other civic duties, due to his constant attention to its lunatic inmates.³ In 1557, as part of a transfer of hospitals from the crown to the city of London, Bethlem was put under the management of Bridewell, a larger institution for the reformation of the lewd, vagrant and idle.⁴ The only extant image of the hospital is that in the 'Copperplate map' of London, (c. 1559) part of which is reproduced in Figure 1.⁵

A 1598 gubernatorial 'view' of the hospital listed 20 lunatic inmates, referred to as 'prisoners,' by name.⁶ Enlargements took place in 1628 and 1632, after which the hospital could accommodate at least 28 lunatics.⁷ A further building, erected in 1643, increased this to about 48 inmates⁸ and, in August 1669, two further rooms were added, bringing the likely number to about 50, where it remained until the hospital's demise.⁹

In January 1673 the visiting governors, advised that:

....the hospitall house of Bethlem is very old weake & ruinous and to small & streight for keepinge the greate number of lunatikes as are therein at present and more are often needful to be sent thither.¹⁰

Consequently, in March 1673, it was decided that rebuilding was the only option, and this resulted in the construction of the second hospital, in Moorfields, completed in 1676.¹¹

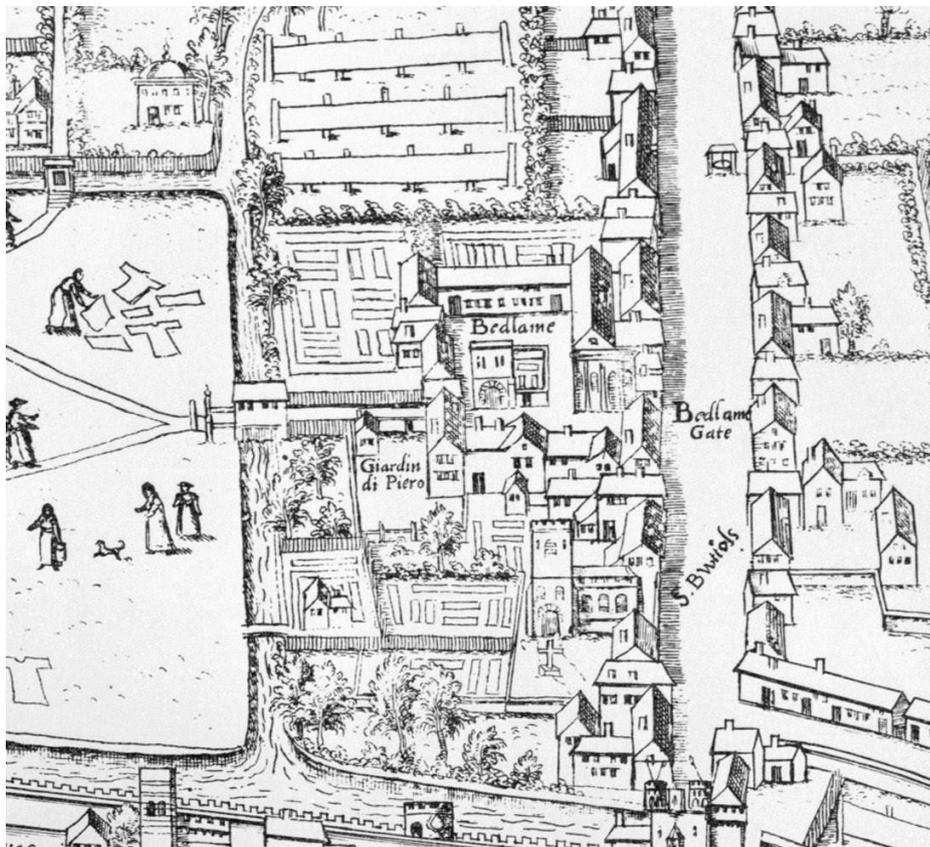


Figure 1. Bethlem Hospital, Bishopsgate, from the 'Copperplate map' of London c.1559. The hospital building was probably that just above the caption 'Bedlame'

The hospital was seldom well-managed, whether by the crown, or the city. The previously mentioned 1402 inquiry found massive malpractice by the hospital porter, as well as neglect of religious observances.¹² Shortly afterwards, in May 1437, when Edward Atherton became master, the city, at his instigation, mounted another inquiry which came to similar conclusions.¹³ In May 1579 John Mell, then keeper, was dismissed for diverting legacies to himself, abusing governors and other

misdemeanours¹⁴ and, in 1619, Thomas Jenner was ejected “*for misgoveninge and misbehavinge himselfe in the governmen^t thereof, beinge altogether unskilfull & unfitt for the same.*” Helkiah Crooke, who was elected master in his stead, lived up to his name¹⁵ and, in 1633, was the subject of an inquiry, which found him guilty of being largely absent from the hospital, lack of care of the inmates, taking illicit admission fees, padding bills, embezzlement, and breaking all his conditions of service. Consequently, in May 1633, he was dismissed.¹⁶

After Crooke stewards replaced masters, and were clearly accountable to the governors. John Jeweller, appointed in October 1635, refused to accept his conditions of service, his major rival, Richard Langley, replacing him.¹⁷ However, Langley was accused of charging for fictitious provisions, cooking the books, ordering illicit building work on his house, and abusing and disrespecting the governors.¹⁸ He, and his wife, appear to have had a rather disorderly lifestyle, even being complained of by Lady Eleanor Davies, the prophetess, confined in their house as a lunatic.¹⁹ A long-running dispute between Langley, and his wife, and the porter, Humfrey Withers, and his wife, absorbed considerable gubernatorial time, and led to the door between their houses being locked, bolted and, eventually, nailed up, to keep them apart.²⁰

Two other managerial changes were notable in the latter days of the hospital. First, the control of disruptive public visiting when, in June 1657 the porter was ordered to keep the doors locked on Sundays and public holidays. Second, at the same meeting, a sub-committee was asked to consider the separation of the male and female lunatics.²¹ However, it was not until January 1662 that a female overseer for the women was agreed, and twenty of the most disturbed of them were moved into the additional building of 1643.²²

The governors continually monitored the state of its hospital buildings and the leased properties in its precinct, and made necessary repairs and improvements. Notable was the subsidisation of the piping of running water into the hospital precinct from the ‘new river,’ in 1663, following a petition by the residents.²³

The last major event, before the move to the new hospital, was the 1666 fire of London. This destroyed much of Bridewell, and forced the court to decamp to Bethlem, where it remained three years.²⁴

A2.3 Bethlem II, London, 1676-1815.

The governors' specifications for the new hospital were "for health and aire", and that it should be "more large and in a more convenient place." By July 1674, land on the south side of Moorfields, had been agreed with the city (Figure 2).²⁵ This site, formerly occupied by the city ditch, was hardly suitable for a large building and caused difficulties during the hospital's construction, and later subsidence.²⁶

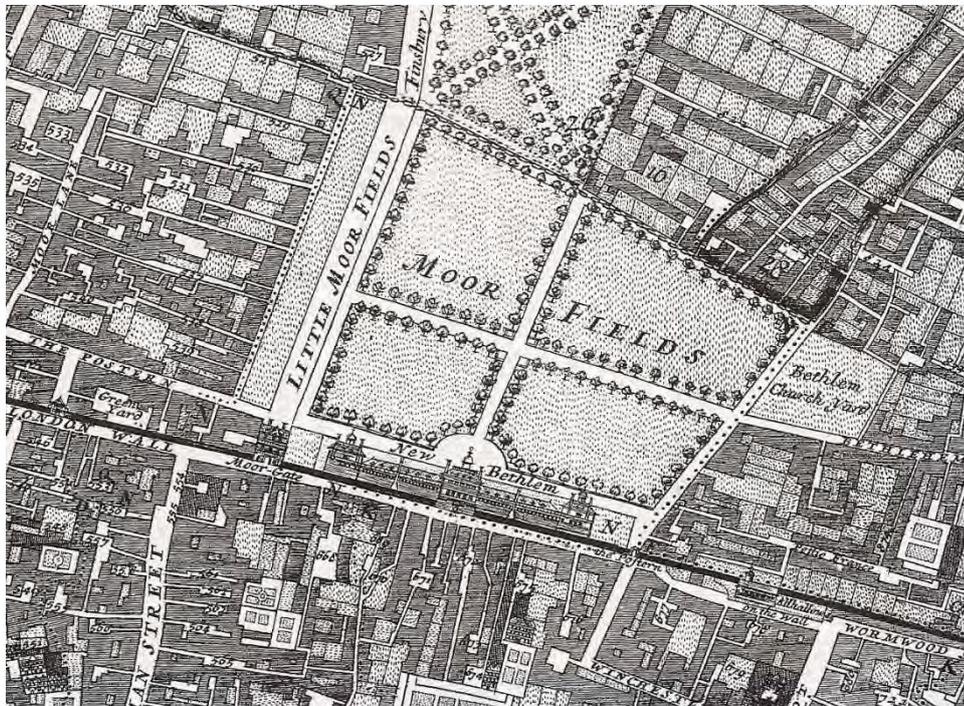


Figure 2. The second Bethlem Hospital: from Morgan's Map of London 1681-2.

The initial design, by Robert Hooke, was probably a double pile building, two rooms deep, with a central corridor.²⁷ However the governors requested a "single building not double," the result being a long, thin, building having wide galleries overlooking Moorfields, on the other side of which were the cells (Figure 3).²⁸ However, there was little rear space, as can be seen in Smith's 1815 etching (Figure 4).²⁹



Figure 3. Bethlem Hospital after the addition of its incurable wings in the late 1720s and 1730s.

From the outset the governors intended to produce a magnificent building, and Moorfields provided a garden in front of it, from which it could be seen to advantage.³⁰ Other factors suggested a conflict between utility and magnificence. The wall facing Moorfields was built only eight feet high “...so that the grace and ornament of the said intended building may better appeare towards Moorefeilds...”, open iron grates were provided through which it could be admired at close quarters, and an imposing gate was aligned with Moorfields’ central walk. Consequently, lunatics were not allowed to walk in this area.³¹ There were three escutcheons on the front of the building, bearing the arms of the king, the city and Henry VIII, the putative donor of the hospital to the city.³² Sculptures depicting raving and melancholy madness were placed on the pillars flanking the gate, and figures of the lion and unicorn on pillars flanking the pedestrian gates resonated with the king’s arms over the entrance.³³ Furthermore, blue was adopted as a corporate colour, as at Bridewell, and used for a uniform for inmates and staff.³⁴ A final touch was the commissioning of a commemorative print of the hospital from Robert White, the engraver.³⁵

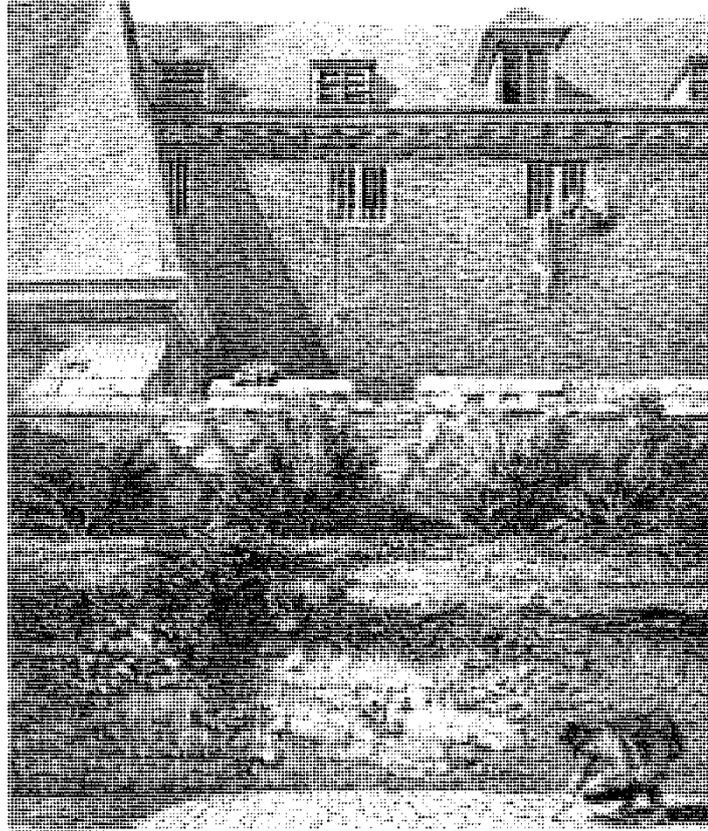


Figure 4. Smith 1815. Parts of London Wall and Bethlem Hospital. Windows of inmates' cells can be seen in the upper storey.

The conflict between functionality and grandeur was particularly apparent in the matter of its impressively long galleries. These were probably intended for inmate recreation and exercise, with women on one side of a central division, and men on the other. However, the governors were unable to resist subverting this purpose and turning them into impressive public spaces, without any central partition, from which the lunatics could be viewed. In consequence the lunatics were denied access, and men and women were placed on different floors. It was not until 1689 that matters reverted to what was probably the original intention, and central partitions separating the sexes were agreed.³⁶

By the turn of the century demand for places was stretching the capacity of the hospital, probably exacerbated by the abolition of the maintenance charge in November 1702, as an embarrassing number of donations and bequests were being received.³⁷ A week later the court ordered that no more than 136 inmates should be

accommodated.³⁸ Nevertheless rising demand continued and, in 1704, new cells were ordered, raising the number of places to 151.³⁹

Under these circumstances a solution emerged, as some inmates began to be labelled “incurable,” allowing their discharge. This label transformed the hospital’s failure to “cure” them into a personal characteristic which rendered them impervious to its curative procedures.⁴⁰ Having extruded “incurables” the court, in March 1723, decided to profitably re-absorb them by building “*Appartments for Incurables*” on adjoining land. The new building was at the east end of the hospital (Figure 3) and accommodated fifty of each sex.⁴¹ By June 1733 this provision was also under pressure and a second, western, building was completed early in 1735.⁴² In 1738 the weekly five shilling charge for incurables was reduced to two shillings and sixpence, due to frequent charitable donations⁴³ and, in October 1739, admission criteria were defined, which required that they should be “*raving madmen*” and “*outrageous and likely to do mischief to themselves or others.*”⁴⁴ Another source of income lay in leasing the hospital’s voluminous cellars as warehousing, initially to the East India Company. The creation of wider access doors to them, and lowering the cellar floors, probably contributed to the hospital’s eventual collapse.⁴⁵

Rising demand continued, and periodic increases in the number of cells were recorded.⁴⁶ By November 1787 300 inmates could be accommodated and a further 54 cells were being planned.⁴⁷

Whether numbers ever rose above 354 is unclear as, by July 1792, the safety of the building was in question.⁴⁸ A report on its condition revealed that it had been built on unstable land, had inadequate foundations, lacked ties to hold it together, and had roofs too heavy for the structure beneath. Modifications to the cellars had also caused structural damage and, in November 1801, the court agreed with a committee recommendation “*to remove the said hospital to another situation.*”⁴⁹ Subsequently, in July 1809, an agreement was reached to exchange the existing hospital site for city land in St. George’s Fields, Southwark. On the 23rd August 1815 those inmates remaining in the old, collapsing, hospital were transferred to the new building.⁵⁰

Other developments were also noteworthy. In November 1692, a legacy was used to establish a wardrobe to supply clothing to needy inmates.⁵¹ Again, in July 1741, an anonymous donation allowed the creation of an infirmary,⁵² which was constructed at the east end of the hospital with male and female apartments holding six beds each.⁵³

Casual visiting, though it could be diverting for the inmates, and generated a small income, also produce problems, and was progressively curtailed. As early as 1707 it was noted that “*severall idle persons resort to Bethlem to the “great and shameful disturbance of the lunaticks there”* and, by 1770, admission had been restricted to those with a ticket signed by one of the governors, effectively bringing casual visiting to an end.⁵⁴

Towards the end of its life the hospital was caught up in moves towards the legislative control of institutions for the mad. In early 1814, a proposed bill for regulating madhouses threatened regular inspections, and the governors resisted this by all means at their disposal. Although the bill never became law, the efforts of reformers resulted in a parliamentary select committee “*to consider of Provision being made for the better Regulation of Madhouses in England.*” Bethlem emerged badly in the reports of evidence to this committee but, nevertheless, the governors managed to evade external inspection until 1853.⁵⁵

A2.4 St. Peter’s Hospital, Bristol, 1698-1860.

St. Peter’s Hospital was housed in buildings dating from the fourteenth-century, situated between St. Peter’s Church and the river Avon (Figure 5).⁵⁶ These had been re-modelled, in Jacobean style, by a sugar refiner, Robert Aldworth in 1612 (Figure 6)⁵⁷ and, subsequently, became one of England’s mints.⁵⁸ Their final transformation, into a workhouse, was on 7th June 1698, when the Bristol Corporation of the Poor purchased them.⁵⁹ This body had come into being, first, because of the problem of balancing an unequal burden of poor-relief between the rural parishes, and the industrial ones and,⁶⁰ second, the campaigning of a local merchant, John Cary. Cary was passionate about fostering English trade and manufacturing to offset the cost of the war with France, and one means of achieving this was the employment of the poor in workhouses.⁶¹

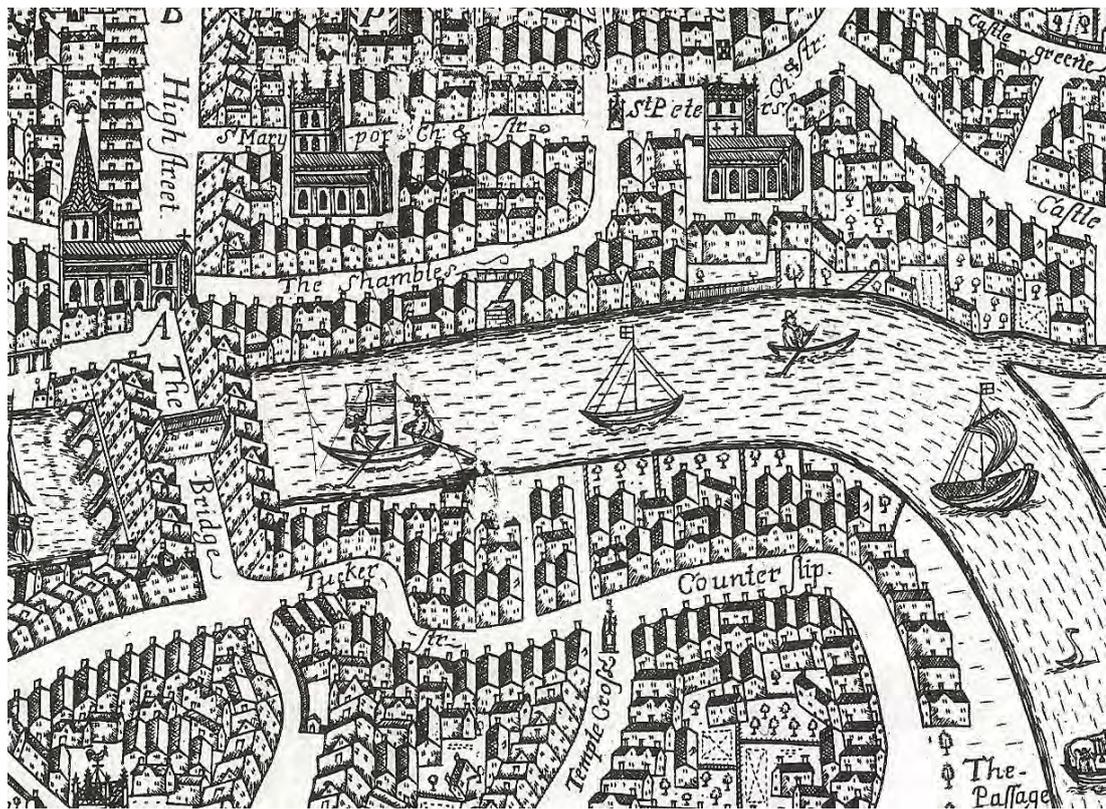


Figure 5. Section of Millerd's 1673 'birds-eye' view of Bristol. St Peter's Church can be seen on the upper right. The gabled building below it became St. Peter's Hospital in 1698.

These two influences resulted in a 1696 Act which incorporated the city's parishes into one corporate body for the purpose of poor relief, and permitted the creation of workhouses, to set the poor to work.⁶² It required the election of four guardians of the poor from each ward which, with the mayor and aldermen, constituted a governing court. From this, officers, comprising a governor, deputy-governor, twelve assistants, a treasurer, a clerk, and a beadle, were elected.

The plan was for two workhouses, and a building lent by the city was used for 100 pauper girls, who were taught to spin. The Sugar House, or mint (subsequently St. Peter's), was the second building, and initially housed 100 pauper boys, who were also set to spinning and weaving.⁶³

In 1709 the girls were transferred to St. Peter's.⁶⁴ Apart from children it also took in the impotent and elderly, and effectively became an overcrowded hospital rather than an effective place of work.⁶⁵

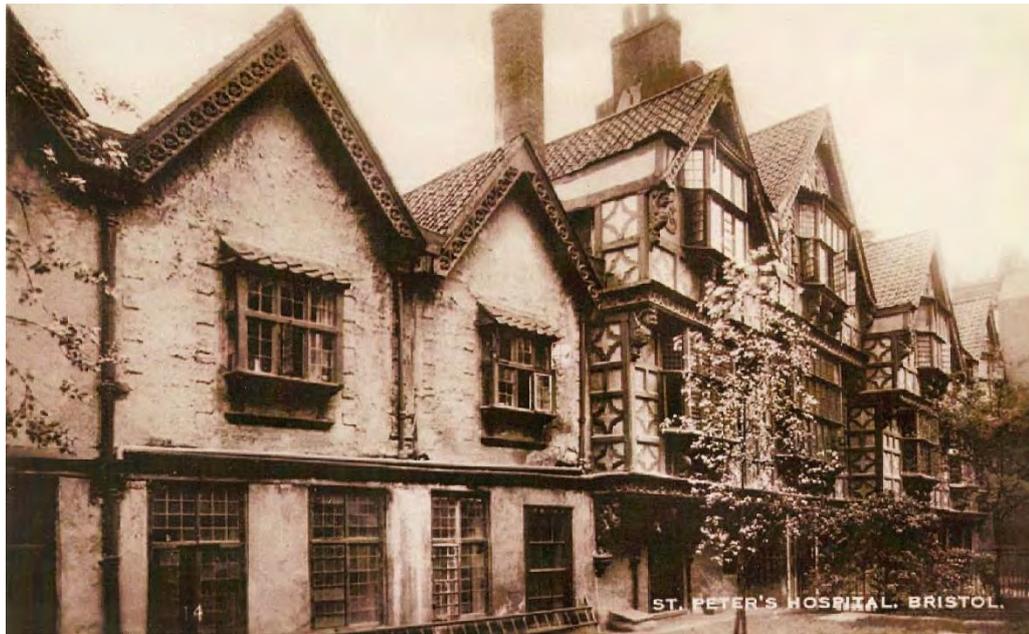


Figure 6. St. Peter's Hospital. The Jacobean style dated from 1612, the plainer, left hand section, functioning as a sugar refinery at this time. Original in colour.

The guardians had almost complete autonomy in the administration of poor relief. They oversaw the administration the Hospital, appointed its master and matron, and met in its elaborate Jacobean courtroom.⁶⁶

The master and matron were responsible for day to day administration, consistent with rules laid down by the corporation of the poor. The matron was in a very subordinate position, being paid an inferior salary, and having duties confined to the domestic area.⁶⁷

Johnson recorded that, in 1800, the hospital had a chaplain, apothecary, clerk, first second and third officers, a brewer and baker, and sundry servants including washer-women, gate-keepers and nurses.⁶⁸ Additionally there would, presumably, have been teachers of literacy and crafts. The first chaplain was appointed in 1767, prayers having previously been conducted by a layman, sometimes an inmate, St. Peter's church being used for formal services.⁶⁹

Medical staff generally comprised visiting physicians and surgeons, often volunteers, and an apothecary. A midwife was appointed 1772, and inmates acted as nurses.⁷⁰ The apothecary also visited until 1811, when a resident and, presumably, full-time,

appointment was made and, in 1738, an infirmary, and an apothecary's shop were built.⁷¹

At first, no specific provision was made for lunatics but, by 1767, it was clear that there were lunatic wards, as the stone floors in them were ordered to be planked.⁷² The number of lunatic inmates, during the period of the present project, was obscure though, by 1826 there were seldom less than thirty.⁷³ Details of individuals were rare, but the first lunatic admission was widow Sweet, in 1698. She seems to have been confined, not for pauperism, but because of concern that she would dissipate her property, and become chargeable to the parish.⁷⁴ Another lunatic, Elizabeth Radborn, confined in February 1743, also had her property taken over by the guardians, and an order for 5 shillings per week maintenance was obtained. She obviously did not go quietly as costs included a payment:

To the Glazier repairing the Windows (besides her own Glass) which she broke in her Lunacy, and appraising the Remainder of the Glass £0 8 5.⁷⁵

Clearly, then, the hospital did not only contain pauper lunatics, and Johnson noted that, in 1826, about half a dozen of the thirty or so mad inmates had a maintenance payment made.⁷⁶

The only other account of a lunatic inmate concerned Abraham Tompson who, in July 1704, was to be sent to Bethlem, presumably as he was excessively disruptive. An undertaking was given to receive him back if he should "*recouer to his senses.*"⁷⁷

In 1822, under a local act of parliament, the lunatic wards were deemed, effectively, to be a county asylum. Consequently the local magistrates became involved with their management and, eventually, along with the commissioners in lunacy, accepted the need for a new county asylum. This, eventually, opened at Fishponds, near Bristol, in 1860.⁷⁸

Details of the treatment of lunatics was sparse. In 1767 the physicians were required to visit the "*frenzy patients*" at least weekly, and they may have been given physick, as there was an apothecary.⁷⁹ In 1769 a cold bath was installed for them but, unfortunately, it collapsed into the river in 1771 and was not replaced.⁸⁰

Johnson, writing in 1826, gave an account of the treatment of the lunatics, which can probably be taken as applying to the earlier part of the century:

.....every degree of tenderness is shewn to the poor unhappy objects, consistent with their safety: no coercive measures being at any time resorted to; no iron chains, manacles, hand bolts, nor any other instruments, being permitted to be used, and when the individuals may be suffering under the highest state of mental excitement, confinement in the pens, application of strong leather straps for the arms, and the strait waistcoat, are the only means applied, and these are sufficient.⁸¹

However, the 1844 Commissioners in Lunacy report could also have reflecting an earlier period. This found the hospital “*totally unfit for an Asylum for the insane*”, noting, among more general deficiencies:

There were small wooden closets, or Pens, for confining the violent and refractory Patients. Those for the men were seven feet long by three feet three inches broad, and about nine feet high, and were warmed by pipes, and had a hole in the door, and also a hole in the ceiling for ventilation. The Pens for the Women were smaller and were not warmed, and were ill-ventilated. The walls of each were of wood, but not padded. Formerly, Patients were occasionally kept in those Pens during both day and night, but the Pens are now very rarely used. The entire body of Lunatics ought to be removed to more spacious premises, and to a more airy and healthy situation. In addition to the jacket and leg-locks, a sort of open mask of leather passing round the face, and also round the forehead, and fastened by leather straps, was at one time placed over the heads of such Patients as were in the habit of biting; but this mask (as the Commissioners understand) has been for some time disused.⁸²

A2.5 Bethel Hospital, Norwich, 1713-1973.

The Bethel Hospital was founded by Mary Chapman, widow of Samuel Chapman, rector of Thorpe. Her reasons, according to her will, were thankfulness for her sanity, as some of her relatives had been afflicted with lunacy, and her husband’s wish to ameliorate the pitiable state of friendless lunatics.⁸³ She established a charity for this purpose and, on 12th December 1712, the city of Norwich leased to its trustees the Committee House, for 1,000 years, at a peppercorn rent.⁸⁴ This became the Bethel Hospital (Figure 7).

She appointed a master, Henry Harlston, to run it for her, and he was succeeded by Robert Waller, the master on her death in 1724.⁸⁵

In her will she named seven trustees to manage her hospital, which was called Bethel, at the wish of her husband. Its name, and a biblical text from Hebrews, was to be set on its front. This read:

To do good and to communicate forget not for with such sacrifices God is well pleased.



Figure 7. The Bethel Hospital, Norwich, 1713. Rear aspect. Photograph by the author November 2003. Original in colour.

Four other biblical inscriptions were to be placed within the house, which was primarily for poor, mad people from Norwich, and not for “*such as are fools or ideots from their Birth*”. Although the poor could be maintained free, a contribution was expected from relatives with the means to pay. Inmates were to be “*kept close and not suffered to wander abroad during their Disorder,*” and were to be discharged when their lunacy had abated. Five pounds a year was to be expended on their clothing.

Her trustees were to manage her charity, and collectively nominate their successors. Following her death five of those appointed met at the hospital and resolved to appoint Sir Benjamin Wrench, a physician, in the place of one who had died. Wrench was also appointed hospital physician, two others became treasurer, and

clerk, and Waller was confirmed as master.⁸⁶ In this capacity he ran the hospital on a day-to-day basis and was reimbursed his expenses.⁸⁷

Waller's relationship with the trustees was poor and, in July 1725, he was recorded as admitting too many visitors, who disturbed the lunatics, abusing them, and expressing contempt for the trustees. In consequence the number of visitors, and visiting hours, were reduced, and Sunday visiting prohibited.⁸⁸ Waller also received money from visitors as, in February 1725, the "*the profitt of the keyes*" was abolished, and these payments were ordered to be applied to the lunatics.⁸⁹ He was expelled for unspecified misbehaviour in 1743, Edward Page being appointed in his place.⁹⁰ Page, and subsequent masters, appear to have been satisfactory.

By 1747 a servant was assisting and, by December 1751, a maidservant was being employed. A second maidservant followed and, in 1809, a boy was also employed. Inmates also helped out. Additionally, by 1753, a bailiff was being employed to manage the estates.⁹¹ By 1727, a visiting apothecary, Thomas Johnson, was in post and, on his resignation in 1748, Abel Meen an apothecary and surgeon replaced him. Meen resigned in January 1773 and was replaced by James Keymer, who also provided surgery.⁹²

In January 1753 the minutes recorded 28 inmates, of which 5 were '*on the foundation,*' that is maintained without charge. By the end of 1815 the number had reached 70, of which 21 were on the foundation.⁹³ Increasing numbers necessitated gradual enlargements. For instance, In May 1749, the bathroom was to be made into a cell, and a cellar was to be fitted up for the "*worst of the lunatics*", suggesting that disturbed inmates were to be separated from quieter ones.⁹⁴

In the early 1750s a good deal of new building occurred. This probably added the southerly wings shown in Figure 7, giving the hospital an H shape. The trustees' committee room was constructed at this time, and its window can be seen on the right of Figure 7.⁹⁵

Separation of men and women inmates began in April 1647 when a brick wall was to be constructed across the back yard. In June, it was further ordered that a partition

should be made in each storey, placing men on one side of the house, and women on the other.⁹⁶

Managerially the trustees obtained a charter of incorporation on 10th December 1764, making them a corporate legal entity. It allowed them to style themselves ‘governors’ and to use a common seal depicting the hospital.⁹⁷ As such they could engage in corporate financial transactions, including investment of donations, and bequests. In one case, Bartholemew Balderston bequeathed a thousand pounds for investment, the income to be used to maintain two lunatics. By October 1763 income from these sources was sufficient for the trustees to support the lunatics from Norwich on the foundation.⁹⁸

Gradual improvement of facilities and practices was also evident. Some inmates were allowed to go out as, in June 1753, the trustees required the master to obtain their written authority before allowing this. They were also allowed to go home on trial before formal discharge.⁹⁹ Separate infirmaries for each sex had been constructed by 1751 and a bath house by 1762, presumably for therapeutic purposes. In 1785 a new bath, in brick, was built.¹⁰⁰ Annual physicians’ reports began in 1810, and provided statistical data on admissions, different categories of discharges and deaths.¹⁰¹

The hospital also had yards, or gardens, for each sex with grass, gravel walks and seats.¹⁰² However, in November 1797 the master appeared to have been using the women’s yard to keep poultry, and was ordered to restore it to its former state.¹⁰³

A2.6 French Huguenot Hospital Lunatic House I, London, 1718-1755.

The first meeting of ‘directors’ (governors) of the French Hospital, built by Peter Legrant (Figure 8), was on 3rd September 1718.¹⁰⁴ A Charter of Incorporation, granted on 24th July 1718, specified a “corporation” comprising a governor, deputy governor and 37 directors, with full management powers, and the use of a common seal depicting Elijah being fed by ravens. At each quarterly general assembly eight, or more, directors were chosen as a sub-committee to deal with the day-to-day management of the hospital, where they met each Saturday.¹⁰⁵



Figure 8. The French Protestant Hospital: Western Quadrangle, c.1740. Original in colour.

Lunatic inmates were accommodated in the ‘petites maisons’ which, according to Legrant’s bill, originally comprised “9 rooms for the Madd Pepell.”¹⁰⁶ However, they were described in a paper by Browning as:

.....a row of 18 cells about 7 feet by 6 feet, awful chambers, apparently as bare as empty packing cases and open on one side to the weather.¹⁰⁷

Browning’s bleak description almost certainly derived from an undated plan of the hospital (Figure 9) showing the “mad house.”¹⁰⁸ This was probably associated with the building of a new wing, between 1732 and 1733 (left of Figure 8), and the original nine rooms may have been increased at that time.¹⁰⁹ Two warming rooms, heated by warm air machines, may have been added, and lunatics’ bedsteads were mentioned, as were stairs, indicating more than one storey.¹¹⁰ As only one stove room (ignored by Browning) was indicated on the plan, there was presumably another, above, with additional cells. A 1752 appeal for donations to rebuild the petites maisons indicated that it contained “*environ 40 Pauvres aliénez d’esprit*” [about 40 mad paupers], a considerable increase on the original cells.¹¹¹

Accommodation was also provided for the madhouse keeper and his wife.¹¹² It appears, then, that Browning's description was probably inaccurate.

The petites maisons' inmates were not only lunatics, cells being occasionally used for general patients, when room in the main hospital was unavailable, and for the punishment of the unruly, or offensive. For instance, on 14th March 1740, Marguerite Augier, a sick widow, was admitted to the petite maisons "*en attendant une meilleure place*" [while waiting for a better place].¹¹³ Again, in February 1742 Jeane Audemar, a general patient was placed there for beating another inmate, supposedly while drunk, for injuring other inmates, and creating unacceptable noise.¹¹⁴

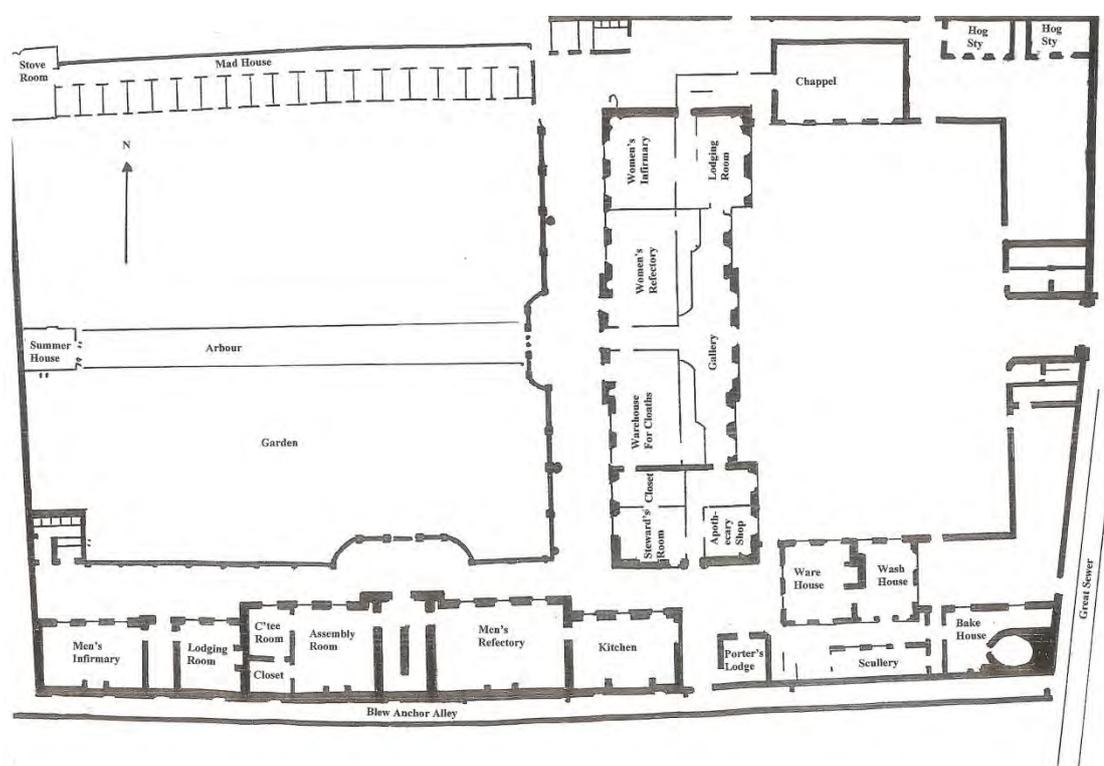


Figure 9. Undated ground plan of the French Hospital (Redrawn).

The lunatics, elsewhere, would have largely been considered incurable, and there was no time limit for their stay, many dying in the hospital, though a proportion showed cycles of admissions and recoveries. Claims of cure were few, and only one direct attempt was recorded. In April 1740 one Mr Fivat chose four lunatics to treat, on condition that, for those cured, he would be paid half his usual fee, and nothing for those uncured. As all four died in the hospital, his efforts were unsuccessful.¹¹⁵

On admission all inmates were required to swear an oath of allegiance to the king and the Protestant faith. Those seeking a lunatic's admission were also required to indemnify the hospital against claims of wrongful detention, and any damage done by the inmate. Earlier bonds also required an undertaking to pay a weekly sum or '*pension*' [allowance] towards the inmate's support.¹¹⁶

A2.7 Guy's Hospital Lunatic House I, London, 1727-1797.

Thomas Guy was a successful London bookseller who, in his mid-thirties, began a series of philanthropic acts. These were initially focused on Tamworth, his birthplace, where he became M.P in 1695. Cameron has suggested that his failure to be re-elected in 1707 led him to transfer his benefactions to London, initially to St. Thomas's Hospital, where he was a governor, and to the Stationer's Company to assist poor members, and their widows.¹¹⁷

Guy's friendship with the physician Richard Mead, and his experience at St. Thomas's, generated an interest in providing for 'incurables' discharged with little hope of cure, or with disorders requiring prolonged stays. In early 1721 he leased land in St. Thomas's Street to build a hospital for them. By his death, in December 1724, the two southern quadrangles were substantially complete (Figure 10). Northern wings were added in 1738 (east) and 1780 (west), providing greater administrative space, and a chapel.¹¹⁸

Guy's will required his executors to complete the hospital for four hundred "*incurable*" persons, including up to twenty lunatics. Its first lunatic house was built, south of the main hospital, in 1727, to a design by Thomas Dance, the surveyor. Its precise location is obscure, but it may have been one of two small buildings at the end of Gravel Walk on Rocque's 1746 map of London (Figure 11).¹¹⁹ The building agreement indicated that it was about 31 by 26 feet, weather-boarded, with "*a hansom outside Doore with a Pademont over.*" Inside were 20 cells, each with a small barred window, on three stories. A separate weather-boarded "*roome*" which was constructed adjoining the madhouse may have been for the keeper.¹²⁰

The building was completed by March 1727 and it was agreed that two men, and one woman, should be appointed as keepers.¹²¹ Colwell Campion, and his wife Dorothy, were appointed to two of the posts and, Joseph Bowler as the other male keeper.¹²²



Figure 10. Guy's Hospital 1725. Engraved by Thomas Bowles.

For each lunatic inmate a bond with a penalty of a hundred pounds was to be entered into by two securities, presumably undertaking to receive the lunatic back on discharge, or pay burial charges. This was waived for those with a parish certificate to the same end.¹²³ It appears that the governors took turns in nominating lunatics for admission as, in January 1737, the system was changed to give the president the first nomination, followed by the treasurer, Guy's executors, the governors named in his will and, finally, the remaining governors in order of election.¹²⁴

The first keepers were not a success. Bowler was discharged, for unspecified reasons, in December 1728, and the Champions in April 1730 for "*Changing the Patients cloths and misusing them & carrying on a Pawn broking Trade in the House.*"¹²⁵ They were replaced by Mary Jones, who was given the title "sister" in the manner of the female overseers of the other wards, and John Smith, who was titled "keeper," a second keeper apparently being dispensed with.¹²⁶

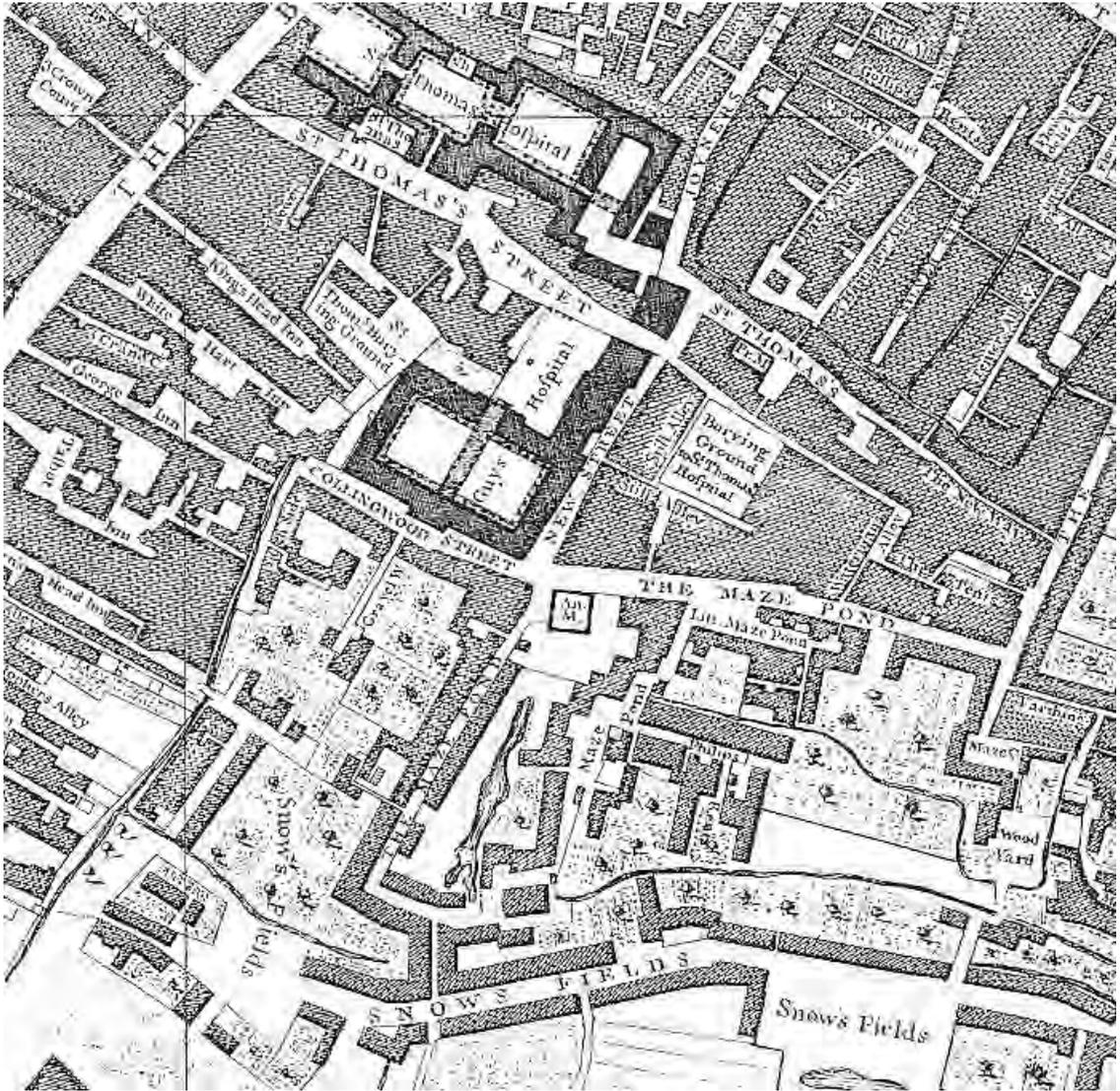


Figure 11. Guy's Hospital. From Rocque's 1646 Map of London.

Admission mistakes were made. For example, in April 1754, Mary Williams was ordered to be discharged as she “*appeared to be an Idiot and not fit to be continued in the House.*”¹²⁷ Such errors may have been common as, in February 1755, the steward was to write to each governor asking him to “*be very careful, that the person he nominates be a real Lunatick.....*”. The physician was also to examine inmates on admission to confirm their lunacy.¹²⁸ Despite their incurable label recoveries occurred, and were clearly acknowledged in April 1783 when the minutes of the court of committees read:

It having been represented to the Court that some of the persons confined in this house as Lunatics have recovered their senses and ought to be discharged

Resolved that the Physicians of this Hospital be desired to attend the Lunatic Patients and to make their Report to the Taking in Committee whether any of them have recovered their senses and ought to be discharged.¹²⁹

The sister and keeper were periodically replaced by competitive election and, by 1756, the lunatic house was being called a “ward” in the same way as the other patient spaces.¹³⁰

In 1784 negotiations for the renewal of the leases of the lunatic house site, and the adjacent burial ground, ran into difficulties, which led to a decision to rebuild the lunatic house elsewhere. The surveyor was asked to prepare a plan, which was finalised in September 1794, the new building being completed in March 1797.¹³¹

A2.8 St. Luke’s Hospital I, London, 1751-1787.

St. Luke’s first General Court Book began with a paper entitled “*Considerations upon the Usefulness and Necessity of establishing an Hospital, by subscription, as a farther Provision for Poor Lunaticks.*” This emphasised the inadequate public provision for lunatics in London, in contrast to that for other maladies. Consequently many “*melancholy objects*” went without care, or their relatives were forced to seek crippling expensive private care. The paper suggested a charitable scheme to remedy this, and finished with the signatures of its six authors.¹³² This group met again on 13th June 1750 to initiate their subscription hospital, subscribers to which would become governors.¹³³ At a further meeting it was reported that six apothecaries had offered their services at no charge. This offer was accepted, and the apothecaries were granted life governorships.¹³⁴

A subscribers’ meeting in September 1750 appointed a committee of fifteen to further the project. Subsequently, on 10th October, it was reported that an old foundry on Windmill Hill, owned by the city, was available and it was agreed to apply for the lease, together with adjoining ground.¹³⁵

On 31st October 1750 William Battie was appointed physician, and on 8th February it was agreed that there would be no charge for inmates, except parish poor. George

Dance, the city surveyor, had produced a plan for the hospital (Figure 12), and a carpenter, and bricklayer, had been set to work.¹³⁶

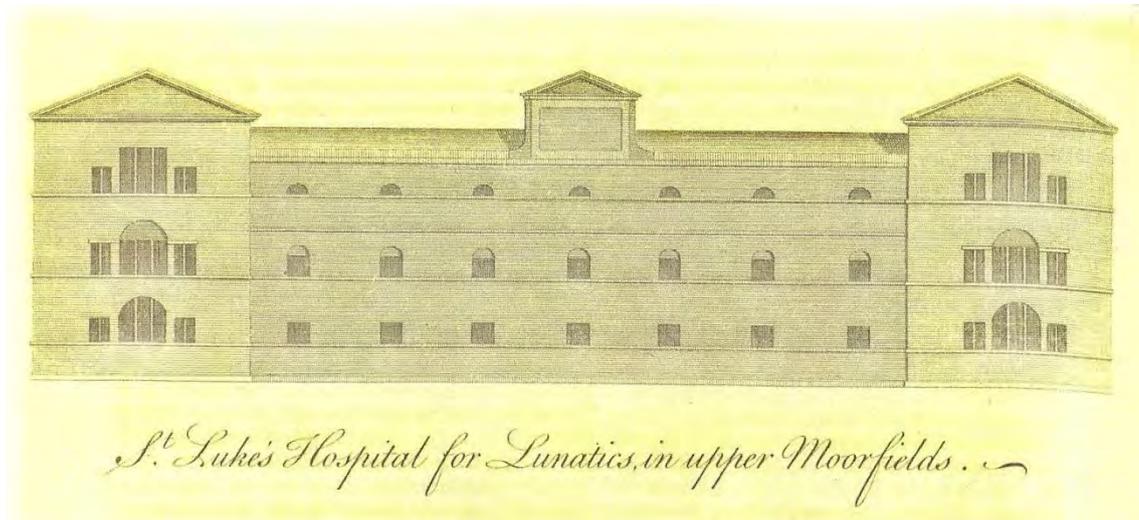


Figure 12. The first St. Luke's Hospital for Lunatics. 1751. Original in colour.

On 22nd March 1750 John Sheron was appointed surgeon and it was reported that a keeper, nurse and maid-servant had been hired.¹³⁷ On 26th June 1751, the subscriber's, now the general court, ratified the appointment of four vice presidents, and a treasurer, and agreed the first rules and orders. The committee was empowered to admit up to twenty-five patients when the building was ready. A governors' dinner was to be arranged, at which no French wine would be drunk, and this became an annual event. By 14th August 1751 the first inmates were being received.¹³⁸

In addition to the bi-annual court, and the monthly general committee, a "house committee" was appointed in August 1751 to undertake the day-to-day management of the hospital.¹³⁹

The general committee of 4th October 1752 recorded the construction of a cold bath and the court of February 1753 resolved that the physician should be permitted to take pupils. On 12th February 1755 Twenty further cells were also be fitted up, raising the hospital's capacity to seventy. . It was also resolved that the governors at the annual dinner should each receive a report of the hospital's finances, and details

of admissions and discharges. As was customary, six new governors were each to be presented with a book of rules and a staff.¹⁴⁰

The system of voluntary apothecaries survived until August 1766, when William Bagster was appointed as the first resident apothecary. He resigned in February 1772 and was replaced by John Harris, who did not last long as he was soon reported to be leaving the hospital before noon, without indicating where he could be found, and returning after midnight “*commonly much Disguised in Liquor.*” He had also been leaving the key to his shop with an inmate, and entertaining his friends at late hours, to the disturbance of the patients. In consequence, he was discharged and replaced by John Meadows.¹⁴¹

In February 1754 the court resolved that:

The Committee be empowered to erect or provide another Room at the Hospital in order that the Men and Women Patients be kept separate.

A further resolution was to begin re-admitting inmates who had been discharged “uncured,” at five shillings a week, emulating Bethlem.¹⁴² By 1755 the term “incurables” was being used and, by the court of February 1760 the hospital held twenty such inmates.¹⁴³

In April 1764 Battie resigned because of age, and Thomas Brooke was elected in his stead. At this time a number of improvements were made, including the provision of stoves in the day rooms, and the creation of a sick ward in a house adjoining the men’s yard.¹⁴⁴

By 1770 the hospital, which had periodically expanded, was again under pressure as “*the number of patients who have been recommended for relief has been greater than the Hospital can Accommodate.*”¹⁴⁵ The existing site would not permit further expansion, and the court of August 1771 empowered the general committee to seek a new one. Eventually land in Old Street, owned by St. Bartholomew’s Hospital, was leased, and the court of 14th August 1776 empowered the general committee to proceed with the new building.¹⁴⁶

In June 1781 Joseph Mansfield and his wife, keepers since the hospital's inception, resigned, due to Mansfield's bad health, and were replaced by John and Martha Pearson. The Pearsons were soon the subject of allegations that they had purloined inmates' money and clothes, replaced regular tradesmen with their acquaintances, kept their children in the hospital, allowed patients to dine out with friends, and illicitly charged for mending. Additionally they had turned the straw chimney into a pig-sty, and foul straw was building up in the yard. They were accordingly discharged and Thomas Dunston and his wife appointed in their place.¹⁴⁷

By August 1782 a number of plans had been produced for the new hospital by George Dance, son of the original architect. One of these was agreed, and the first stone of the new building was laid by the Duke of Montague on 30th July 1782 in the presence of the governors.¹⁴⁸ The building was ready by November 1786, and the inmates were transferred there on 1st January 1787 "*without any Accident or Inconvenience whatsoever.*"¹⁴⁹

In February 1786, the first hospital was reported to have admitted 3479 inmates of whom 45% had been "cured", and 33% "uncured", the remainder being discharged at their friends behest, or under various labels designating them as unfit to be there. At that time the hospital contained 76 curable inmates, and 30 incurables.¹⁵⁰

A2.9 The French Huguenot Hospital Lunatic House II, London, 1755-1799.

By early 1752 the petite maisons were dilapidated and a committee was established to plan their replacement. To fund the project 2,000 copies of a "*memoire*" [appeal] seeking donations were distributed. This made a carefully crafted appeal to Huguenots, who God had blessed by giving them refuge, to contribute to the care of the humblest of their brothers. By April 1756 donations amounted to £2024.17.5, close to the estimated cost.¹⁵¹

The new building was to contain cells ranged along a ground-floor gallery with two further stories above and, in January 1753, the general assembly authorised the committee to proceed.¹⁵² Boulton Mainwaring, the surveyor, was to take overall responsibility and, in February 1753, it was decided to proceed with a plan for 42

cells, close to the existing number, along with a cold bath, and a much needed beer cellar under the building.¹⁵³ It was probably completed by early 1755, as final artisan's bills were paid, and the demolition of the original building ordered.¹⁵⁴

Existing practices continued in the new building. There were regular admissions, along with discharges of those who had recovered, cure rarely being claimed. Occasionally recovered lunatics were retained as they were unable to cope outside, and transfers from the main hospital occurred when non-lunatics began to lose their faculties. For example, in March 1779, Elisabeth Esperbene "*foible dans son Esprit*" [of feeble mind] was bothering her roommates, and was sent to the *petite maisons*.¹⁵⁵ It continued to be used to punish misbehaving patients from the main hospital, and to accommodate non-lunatics for whom space was unavailable there.¹⁵⁶

The building also housed the keeper, though supervision of the lunatics appears to have been relatively lax as one keeper, Mathieu La Ferté, complained that the men were amusing themselves indecently with the poor female lunatics. Escapes also seem to have been easy, as in June 1761, when Louis Castagnet and Catherine Desplanches were discharged for leaving the *petites maisons* without permission.¹⁵⁷ La Ferté died in November 1781 and was replaced by Jean le Dernier, a single man, a Madame Cavaret being paid to assist him. An inmate called Elizabeth Cavaret had been admitted as a lunatic, in May 1770, and may have recovered enough to assist. However, Dernier did not take up the post, and Madame Cavaret was appointed keeper, possibly a unique case of a lunatic taking over the asylum.¹⁵⁸

In January 1783 the general assembly ordered that no more lunatics, idiots or imbeciles should be accepted, as the hospital lacked adequate means of caring for, or curing, them. As existing inmates died, or were discharged, their cells were turned to other uses. Finally, in August 1801 the building was leased to a Mr. Stennett for 21 years at £84 per annum.¹⁵⁹

A2.10 Lunatic Hospital I Newcastle-upon-Tyne, c1763-c1765

The Newcastle Courant for 21st May 1763 solicited subscriptions for a hospital for lunatics which would have medical attendance, provision for incurables, and some

private apartments. Madness was represented as a disease, like others, but the danger of “*Self-murder*,” rendered its alleviation vital. The helplessness of lunatics, and the cost of private accommodation, were stressed, the aim being to provide care “*a moderate Income is able to afford*.” Subsequent editions listed benefactions, and annual subscriptions, including £50 from the city corporation. Further details, published on 25th June, indicated that it would serve Durham, Newcastle and Northumberland, take paupers at three shillings a week, and private patients at a cost determined by the governors. Medical input would ensure that “*all Means may be made use of for the recovery of their Reason*.” In the absence of evidence of construction work, it was probably housed in an existing building.¹⁶⁰ According to a pamphlet by John Hall, its physician, the hospital proved popular and held up to nineteen inmates.¹⁶¹

A2.11 Lunatic Hospital II, Newcastle-upon-Tyne, c1765-1856.

In October 1765 Newcastle common council was approached by a group, mainly composed of governors of the existing lunatic hospital. They sought land on which to build a new hospital as the present one was “*too small and very inconvenient*.” In consequence, a site just outside the city walls was leased to them for this purpose.¹⁶²

The new hospital was designed by a local architect, William Newton. A plan and elevation (Figure 13) indicated twelve cells, six grouped round an open yard, and six at the front of the building, along with the keeper’s rooms, a kitchen and pantry. Central stairs presumably led to a further sixteen cells, as John Hall’s pamphlet, referred to in the preceding section, indicated that it held at least thirty patients.¹⁶³ It was, at least initially, devoted to poor inmates as Hall indicated that he had argued for private patients to be housed, to offset costs, but was overruled.¹⁶⁴

The hospital was certainly in use by December 1768, as the common council gave leave to its governors to create a pathway into Gallowgate.¹⁶⁵ Apart from its rules, which probably dated from early in its life, little is known about it. The rules indicated that those annually subscribing a guinea, or making a single twenty pounds payment, became governors, and met quarterly as a court. The officers comprised a president and three vice-presidents, elected for life, and an annually elected treasurer.

Day to day management was through a committee of five governors, a further six acting as auditors. Taking rewards from tradesmen, patients or others was strictly forbidden to staff, and only those employed in the necessary business of the house, were allowed in the wards.¹⁶⁶

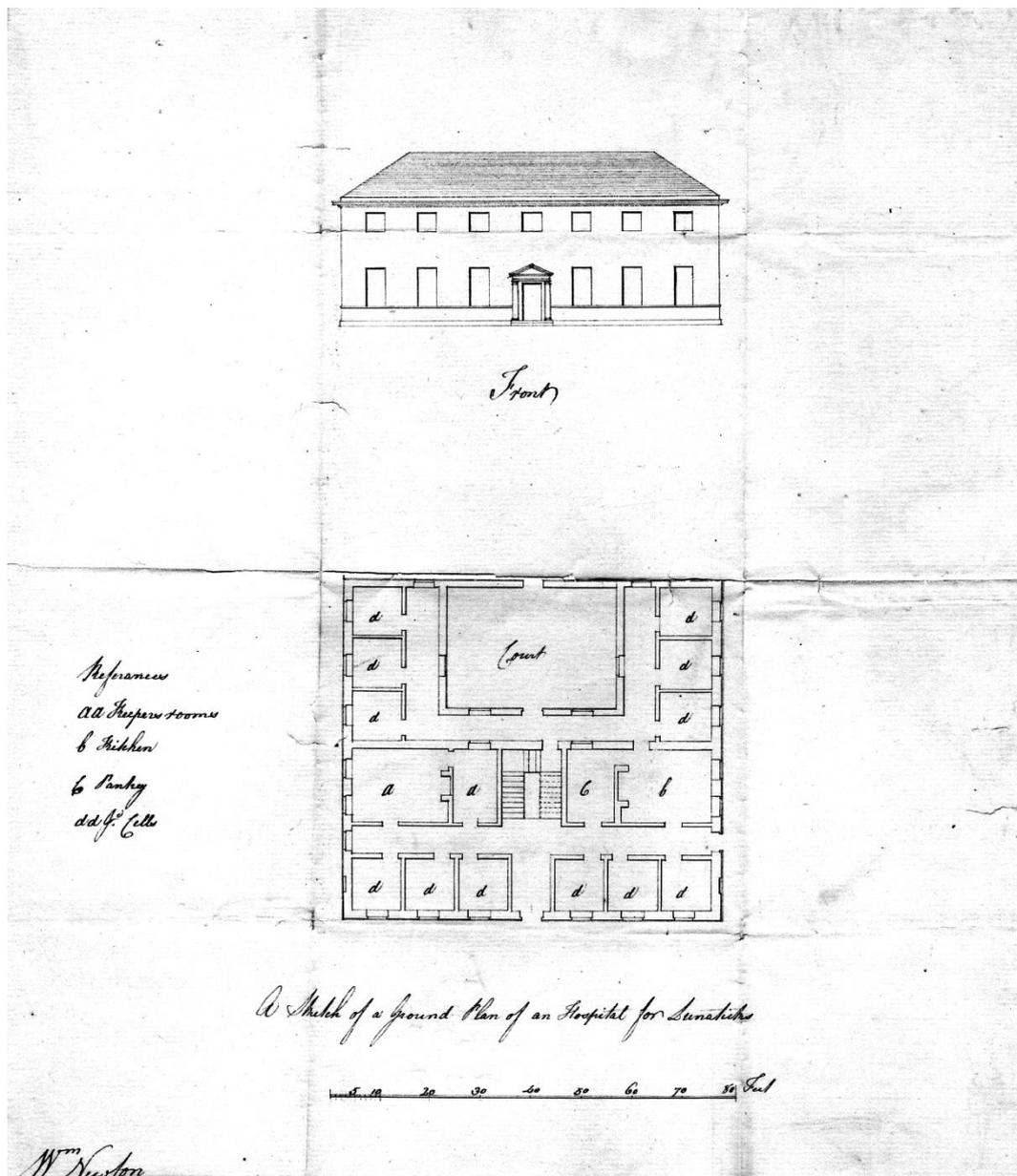


Figure 13. Second Public Lunatic Hospital: Newcastle-upon-Tyne c. 1767. Plan and elevation by William Newton.

The hospital was clearly devoted to cure, as one of the rules read:

VII. EVERY Patient, when cured, shall be called before a Committee of Governors, shall be examined, and being then found fit to be discharged, the Physician shall give a Certificate for that Purpose, and the Matron shall deliver him or her to their Friends.¹⁶⁷

Monitoring of its practices, and staff, was by means of visits by a weekly appointed governor who would “*enquire into the Conduct and Management of the House*”.¹⁶⁸

Medical staff visited, and immediate management was by a resident matron, the male keeper being, at least in some respects, subservient to her, for instance never being absent without informing her.¹⁶⁹ Resident nurses and servants were to be “*free from the Burthen of Children, and the Care of a Family,*” and misconduct was punishable by dismissal, the miscreant being barred from future employment in the hospital.¹⁷⁰

Hall died in 1793 and Stephen Pemberton replaced him, but does not seem to have lasted long as, by 1799, Dr. Wood, in his advertisement for his private asylum, described himself as physician to the lunatic hospital.¹⁷¹ At this time it was still attracting subscribers as an insertion in the Newcastle Chronicle for June 1st 1793 recorded three subscriptions.¹⁷² Wood was succeeded, on his death in 1822, by Dr. Glenton who died, two years later, being replaced by Dr. Smith.¹⁷³

Common council records for April 1824 indicated that, by then, the hospital’s charitable status had been eroded by the deaths of its subscribers. Glenton was said to have “*possessed himself of the said Lunatic Asylum on the death of D^r. Wood*” and, on Glenton’s death, the council was apparently the only remaining subscriber. With the agreement of the magistrates the mayor had appointed Smith to provisionally manage the hospital. This situation resulted in a major remodelling of the hospital, details of which are outside the scope of the present account.¹⁷⁴ However, a report by a council committee of December 1825, detailed its deterioration before these improvements.

...at the Time of the late Improvements being commenced, it then consisted of one airing Court for Females, with a damp and most unwholesome day Room and 21 sleeping Rooms without fire places and in the most wretched state. In another Court were placed, detached from the principal Building, nine sleeping Cells for Males with a Day Room, and nine cells for Females without a Day Room. The whole were without Fire places and the Court Yard was common to both sexes. There was no other access to these miserable apartments than from the open Court. These Cells were damp, unventilated, cold, filthy, and in short unfit habitations for any human being.¹⁷⁵

A2.12 Chronology of the emergence of key Institutional features in the present sample

A2.12.1 Confinement for Public Protection: Bethlem Hospital I 1546.

In July 1546, Richard Cleseman was “sent” to Bethlem for lewd language, and was to be “kept” there, presumably until his behaviour improved, although there were references to his frenzied state.

A lunatic sent to Bedlam

Oone Richard Cleseman, of the Parishe of Lye in Surrey. Sent hither by Sir. Mathew Browne for lewde words, was sent to Bedlam to be kepte there for that he semed to be in a freneseye.¹⁷⁶

A2.12.2 Confinement for Care: Bethlem Hospital I 1577

The second justification for the confinement of lunatics was that of care. The first example of this was in 1577 when Humfrey Whitlock was “sent” to Bethlem, simply because he was a lunatic, and without any evidence that he had created any public disorder. He was to be “received” there and “kept as well as we can.”¹⁷⁷

A2.12.3 Confinement for Cure: Bethlem Hospital I 1618

The third justification for confinement was that the lunatic required admission to a place of cure, and, in September 1618 Henry Shalcross was sent to Bethlem “to be cured.”¹⁷⁸

A2.12.4 Competitive staff appointments: Bethlem Hospital I 1619

On 13th April 1619 Dr. Helkiah Crooke was elected master of Bethlem, in competition with John Perie.¹⁷⁹

A2.12.5 Adequate Beds and Bedding: Bethlem Hospital I 1622, 1666

The first reference to the provision of adequate inmate's beds was at Bethlem Hospital, in June 1622, when it was ordered that “.....*the pores Bedds att Bethlem which are rotten and broken shall be amended.*”¹⁸⁰

The first reference to adequate bedding, however, did not occur until January 1666 in reference to Thomas Dunn, a mariner confined in Bethlem, who was to have “...*twoe blankets and a coverlett*” bought for his comfort.”¹⁸¹

A2.12.6 Surgeons: Bethlem Hospital I: 1629

The earliest reference to a surgeon was at Bethlem where, in January 1642, John Meredith was elected surgeon for Bridewell and Bethlem Hospitals, However, Meredith was apparently the latest of a line which began with John Quince in 1629.¹⁸²

A2.12.7 Expansion in the face of demand: Bethlem Hospital I 1632

A document of 1632, in Bethlem Hospitals's Muniment Book, gave details of the “*old house*” in which work was taking place to house eight more inmates.¹⁸³

A2.12.8 Medical involvement in Cure: Bethlem Hospital I 1633

The justification of the confinement of lunatics in order to cure them required an apparatus of cure, and the provision of medical personnel, and procedures, was the major plank in this. The earliest evidence of this was in 1633, when Helkiah Croke, appointed as master of Bethlem in 1619,¹⁸⁴ was removed by a royal inquisition partly because he had not properly devoted himself to curing the inmates. The inquisition found that he had not:

.....of long time used any yndeavor for the cureing of the distracted persons¹⁸⁵

A2.12.9 Financial audit: Bethlem Hospital I 1635

In November 1635 the Bridewell and Bethlem Court, in connection with the election of a new Steward, laid down a number of requirements for the Steward's post. These included a weekly audit of his accounts by the court of governors.¹⁸⁶

A2.12.10 Administration of Physic: Bethlem Hospital I 1642.

The fact that medicines were regularly administered to inmates as the major mechanism of cure was shown by the appearance of physick as part of the charge levied for an inmate's stay. In September 1642, Robert Leigh was to be admitted to Bethlem at a charge of three shillings a week towards his "*phsicke diett and other releife*."¹⁸⁷

A2.12.11 Competitive Tendering: Bethlem Hospital I 1642

In July 1642 a "view" was taken of the Bethlem buildings to see what repairs were required. The governors concerned were asked to "...give order for the doinge thereof to such workemen as will doe the same best at least charge to this hospitall."¹⁸⁸

A2.12.12 Yards for Exercise and Recreation: Bethlem Hospital I 1643

In June 1643 moves were made to enlarge Bethlem Hospital by demolishing two ruinous tenements at its west end. This would create "*another yard more then now are for lunatiques*."¹⁸⁹

A2.12.13 Adequate Inmate Clothing: Bethlem Hospital I 1644-5

Bethlem hospital provided clothing for inmates who were inadequately clothed by their friends, or parishes. In December 1644 the court ordered such "*Gownes and Coates*" as were necessary for the lunatics to be provided.¹⁹⁰

A2.12.14 Separation of noisy and quite inmates: Bethlem Hospital I 1645

In July 1645, a few years after the first Bethlem Hospital had been enlarged by the provision of a new building, there was evidence that this allowed the first classification of inmates to be introduced. It was ordered that the quiet and orderly should be placed in the new building, the noisy inmates remaining in the old hospital.¹⁹¹

A2.12.15 Prohibition of Abuse of Inmates: Bethlem Hospital I 1646

In July 1646 the first regulation prohibiting physical, and verbal, abuse of inmates was minuted:

Item itt is ordered by this courte that noe officers or servants in Bethlem shall give any blowes or ill language to any of the madd folkes there uppon paine of loosing his place.¹⁹²

A2.12.16 Medical certification, intake selection and the extrusion of the “unfit”: Bethlem Hospital I 1624-1653

Medical involvement in admission and discharge could also be seen as aspects of the representation of the sampled institutions as places of cure. The earliest evidence of this was in January 1648, when Dr. Nurse, the Bethlem physician was recorded as having pronounced six inmates fit to be discharged.¹⁹³

Again, from November 1653, medical procedures also embraced the certification of lunacy at the time of admission:

.... noe lunatike shalbee taken into the hospitall of Bethlem unles the doctor of the same hospitall shall first finde and reporte such person to bee a lunatike to prevent the keeping of idiotts and sottish people there which are noe lunatikes.¹⁹⁴

The aim to “*prevent the keeping of idiotts and sottish people*” in the hospital illustrated the avoidance of admitting inmates who could not be “cured.”

Another process central to the construction of institutions as places of cure was the discharge of those unlikely to remit. This began at Bethlem, in mid-1624, when a group of governors was appointed to examine the inmates and discharge any who were recovered, as well as “*idiots*” whose condition was clearly not going to remit.¹⁹⁵

A2.12.17 Gender Separation: Bethlem Hospital I 1657

In June 1657 the Bridewell and Bethlem court asked a committee:

....to consider and direct the best meanes how the men & woemen may be lodged & kept a sunder in the same hospitall of Bethlem.¹⁹⁶

A2.12.18 Adequate Heating for Inmates: Bethlem Hospital I 1675

In December 1675, towards the end of the life of the first Bethlem Hospital, it was ordered that a barred iron fence should be placed in front of the stoves in the warming rooms, to prevent inmates burning themselves, indicating that attention was being given to keeping them warm.¹⁹⁷

A2.12.19 Galleries: Bethlem Hospital II. 1675.

Long galleries, on two floors, formed part of the second Bethlem Hospital, and were almost certainly intended for inmate exercise and recreation.¹⁹⁸ As noted in Chapter 8 (Section 8.3.3) galleries became a feature of many later institutions for the mad.

A2.12.20 Formal Institutional Rules: Bethlem Hospital II 1676

In March 1676, shortly after the opening of the second hospital, the Bridewell and Bethlem governors accepted the first comprehensive set of rules for Bethlem hospital.¹⁹⁹

A2.12.21 Adequate Inmate Diet: Bethlem Hospital II March 1676

The March 1676 Bethlem rules also contained the first daily diet for the inmates. This ensured adequate nutrition, and listed the food to be given them. Boiled meat

was presented in a variety of forms, alternating with bread, cheese and pottage on successive days, with a ration of fruit on Saturdays. This was held to be better than their previous diet.²⁰⁰

A2.12.22 Development of “Incurable” category: Bethlem Hospital II 1681

By mid-1681 the second Bethlem Hospital was becoming overcrowded, and moves were made to discharge, among others, “incurables,” who had not recovered. This classification, essentially, defined a category of lunatic who was impervious to the institution’s “curative” regime. At a later date, it permitted “incurables” to be re-admitted, and kept, at a reasonable charge, but without any responsibility for “cure.”²⁰¹

A2.12.23 Bath: Bethlem Hospital II 1689

In June 1689 the Bridewell and Bethlem governors, in response to a report from the Bethlem Committee, ordered the provision of “*a bathing place in the said hospital for the poore lunatikes therein.*”²⁰² Like other early baths its precise purpose was obscure and may have been a matter of comfort, hygiene, hydrotherapy, or all of these.

A2.12.24 Development of facilities for “incurables” Bethlem Hospital II 1723

In March 1723 the Bethlem governors sought to extend the second hospital to absorb the “incurables” who were being discharged, by creating a new building for them.²⁰³ This is probably opened during 1728 as, in July of that year the up to 10 incurables were be admitted to the new accommodation “*as soon as convenient.*”²⁰⁴

A2.12.25 Infirmary and Apothecaries Shops: St. Peter’s Hospital 1738.

The first reference to an infirmary for sick inmates, and an apothecary’s shop, was at St. Peter’s Hospital in 1738, when:

“In 1738, the part hitherto occupied as a small garden and summer-house, was converted into an infirmary, and an apothecary's shop built where the old counting-house stood.”²⁰⁵

A2.12.26 Inmate work; French Hospital 1748

The first clear indication that inmates were put to work was at the French Hospital, in 1748, when Madelaine Frenot was admitted to the petites maisons with “*l’esprit foible*” [feeble mind] on condition that she worked with the linen according to the orders of Madame. Roumieu, the Stewardess.²⁰⁶

A2.12.27 Complaints Mechanism: St Luke’s Hospital I 1751

A general court meeting of St. Luke’s, on 26/6/1751, accepted a draft of rules for the hospital.²⁰⁷ Rule 36 read:

That a Book (entitled the Visitors' Book) shall be kept in some convenient publick place of the Hospital, for the Governors to enter complaints of any neglect or misconduct in the Officers or Servants thereof...²⁰⁸

A2.12.28 Discussion of the Chronology

Chronologies are generally inadequate as historical accounts as “*A one-random-thing-after-another*” sequence is simply a list, whereas “*one-thing-because-of-another*” is a proper history.²⁰⁸ The present chronology falls somewhere between the two as its temporally organised segments do relate to each other, as elements of a developing institutional organisation. In this respect it amplifies an important conclusion of the present research project, that early English institutions for the mad formed a platform from which later institutions evolved.

A second observation seems warranted, that the first Bethlem Hospital was a major area of innovation. Of the 27 elements of emergent institutional practice 18 occurred in this institution, the practices of which must be viewed as essential to any knowledge of later developments. Six more showed their first emergence at the second Bethlem Hospital which, similarly, must be seen as an important precursor of later developments. In effect many features of later institutions could be seen as developing in the first two Bethlem Hospitals, and at a much earlier stage than has generally been supposed.

Notes to Appendix 2

1. A copy of the deed of gift can be found in the Bethlem Hospital Muniment Book Fol 175/175v. O'Donoghue has provided an English translation in O' Donoghue, E. G. *The Story of Bethlem Hospital from its Foundation in 1247*. London: T. Fisher Unwin, 1914, pp. 19-22. This translation has been used for the present study.
2. O'Donoghue, E. G. The Full text in English of the Visitation of Bethlem, in A.D. 1402-3. *Under the Dome. New Series*, 1901 **10**(39), pp. 101-107, 1901 **10**(40), pp. 141-147, 1902 **11**(41) pp. 1-8, 1902 **11**(42) pp. 39-50. This translation has been used in the present study.
3. Sharpe, R. R. (ed.). *Calendar of Letter-Books preserved among the Archives of the City of London at the Guildhall. Letter Book. K. Temp Henry VI*. London: John Edward Francis, 1911, p 194, folio 152. b. Original letter (Latin) is in microfilm of Letter-Book K at the Guildhall, London.
4. Andrews, J., Briggs, A., Porter, R., Tucker, P., & Waddington, K. *The History of Bethlem*. London: Routledge, 1997. pp. 55-62.
5. Copperplate Map (c.1559): Museum of London. Also Holmes, H. R. *Moorfields in 1559: An Engraved Copper Plate from the earliest known Map of London*. London: Stationery Office, 1963.
6. BBCM. 4/12/1598.
7. BBCM. 23/4/1628, 31/7/1629; Bridewell and Bethlem Muniment Book Part 2, Fol 208, 1632.
8. BBCM 2/6/1643.
9. BBCM 25/8/1669.
10. BBCM 23/1/1673.
11. BBCM 9/2/1676.
12. O'Donoghue. Visitation of Bethlem 1402-3. op. cit.
13. *Calendar of Patent Rolls Henry VI Vol III 1436-1441*, London: HMSO, 1907 p. 87 Membrane 21d, May 8 1437.
14. BBCM 24/7/1579
15. BBCM 13/4/1619.
16. *State Papers (Domestic Series)*, Public Record Office, **237**(5). The present account used the reproduction in Hunter, R. & Macalpine, I. *Three Hundred Years of Psychiatry 1535-1860*. London: Oxford University Press, 1963. pp. 106-108; BBCM 24/5/1633.

17. BBCM 21/10/1635, 18/11/1635, 20/1/1635, 25/2/1635, 4/3/1635
18. BBCM. 9/2/1637, 20/2/1637, 20/10/1639, 28/7/1641.
19. BBCM. 20/2/1637.
20. BBCM. 21/6/1637.
21. BBCM 12/6/1657.
22. BBCM 21/1/1662.
23. BBCM 28/8/1663.
24. BBCM 14/9/1666, 3/11/1669.
25. BBCM 8/5/1674, 16/5/1674, 30/5/1674, 3/7/1674; Morgan. W. *London &c. Actually Survey'd by Wm. Morgan, His Matie's Cosmogr. 1681/2*. British Library.
26. Kent, W. *An Encyclopaedia of London*, Revised by Godfrey Thompson. London: J. M. Dent & Sons Limited, 1970, pp. 369; BBCM 9/10/1674, 23/10/1674; Cooper, M. 'A More Beautiful City': *Robert Hooke and the Rebuilding of London after the Great Fire*. Stroud: Sutton Publishing, 2003. p.195.
27. BBCM 3/7/1674.
28. BBCM 11/7/1674.
29. Smith, J. T. *Ancient Topography of London Containing Not only Views of Buildings Which may in Many Instances No Longer Exist And For the Most Part were Never Before Published But Some Account of Places and Customs Either Unknown, or Overlooked by the London Historians*. London: Thomas Smith, 1815, p.32.
- 30 Kent. op. cit., 1970, pp. 369; Cecil, E. *London Parks and Gardens*. London: Archibald Constable & Co Ltd. 1907, pp. 10-12; Stevenson, C. Robert Hooke's Bethlem. *Journal of the Society of Architectural Historians*, 1996, **55**(3). pp. 254-275, particularly p. 255.
31. BBCM 23/10/1674.
32. BBCM 8/10/1675.
33. The statues of "raving" and "melancholy" madness are in the museum of the present hospital. The lion and the unicorn can be seen on the numerous engravings of the hospital, for instance in White's 1677 commemorative print of 1677 in the hospital's archives.
34. BBCM 21/7/1676.

35. BBCM 24/8/1677, 5/10/1677; 17/10/1677; 19/12/1677.
36. BBCM 10/9/1675; 3/12/1675, 21/4/1676, 5/5/1676, 21/7/1676, 28/6/1689.
37. BBCM 6/11/1702.
38. BBCM 12/11/1702.
39. BBCM 2/3/1704.
40. BBCM 1/7/1681, 14/5/1708.
41. BBCM 29/3/1723, 18/7/1723, 6/9/1723, 15/11/1723, 17/12/1725.
42. BBCM 28/6/1733, 13/7/1733, 11/2/1735.
43. BBCM 18/7/1738.
44. BBCM 31/10/1739.
45. BBCM 15/5/1678, 31/5/1678, 21/6/1678, 23/6/1737, 27/2/1739.
46. e.g. BBCM 1/11/1750, 11/5/1763.
47. BBCM 29/11/1787.
48. BBCM 22/7/1790, 26/7/1792.
49. BBCM 25/4/1799, 26/11/1801; *Report Respecting The Present State and Condition of Bethlem Hospital*, London: Philanthropic Reform, 1800
50. BBCM 6/7/1809; BethlemHCM 26/8/1815.
51. BBCM 22/4/1692, 11/11/1692.
52. BBCM 30/7/1741, 9/9/1741.
53. BBCM 17/2/1741.
54. BBCM 2/5/1707, 21/11/1770.
55. BBCM 21/4/1814, 6/5/1814, 24/5/1814, 23/6/1814, 28/6/1814, 8/7/1814; *First Report: Minutes of Evidence Taken before The Select Committee appointed to consider of Provision being made for the better Regulation of Madhouses, in England*. London: House of Commons, 1816; Jones, K. *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s*. London: The Athlone Press, 1993, p. 97.

56. The image in Fig. 5 is a facsimile copy probably dating from the early in the 20th century & can be found in Bristol Reference Library. An original print of Millerd's 1673 'birds-eye' view of Bristol can be found in the Bristol Record Office.
57. Deeds: Bristol Record Office 09864(5) a; 09864(6) a; Latimer, J. *The Annals of Bristol in the Seventeenth Century*: Bristol: W. George, 1970. pp. 44-45; Simpson, J. J. St. Peter's Hospital Bristol. *Transactions of the Bristol and Gloucestershire Archaeological Society*, 1926, **48**. pp. 193-226, particularly pp. 210-213; Gomme, A, Jenner, J, & Little, B. *Bristol an Architectural History*. London: Lund Humphries 1979.
58. Simpson op. cit. pp. 218-219 & Plate VI; Bristol Common Council Minutes 8/6/1696: Bristol Record Office M/BCC/CCP/1/8; Latimer op. cit. pp. 477-479; Grinsell, L. V. *The Bristol Mint: An Historical Outline*. Bristol: University of Bristol Branch of the Historical Association. 1972. pp. 18-19.
59. Deed Bristol Record Office 1166 (1).
60. Bristol Record Office: *The Poor Law in Bristol: A hand-list of records held at the Bristol record Office relating to the history of the poor Law*. Undated. p.2.
61. Cary, J. *An Essay on the State of England in Relation to its Trade, its Poor, and its Taxes, For Carrying on the present War against France. By John Cary Merchant in Bristoll*. Bristol: W. Bonny. 1695. pp. 156-157. Bristol Central Library B 1767.
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63. Cary, J. *An Account of the Proceedings of the Corporation of Bristol in Execution of the Act of Parliament for the Better Employing and Maintaining the Poor of that City*. London: F. Collins. 1700; Butcher, E. E. *Bristol Corporation of the Poor 1696-1898*. Bristol: Bristol Branch of the Historical Association. The University of Bristol. 1972. pp.5-6
64. Butcher 1972 op. cit. p. 6.
65. Ibid. pp. 10-12.
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67. Butcher 1972. op. cit. p. 19; Johnson 1926 op. cit. p. 144.
68. Johnson 1826 op. cit. p. 144.

69. Butcher 1932 op. cit. pp. 20-21.
70. Ibid. pp. 10-12; Johnson, 1826 op. cit. pp. 108-111.
71. Butcher 1932 op. cit. pp. 111; Johnson 1826 op. cit. pp. 106, 146.
72. Johnson 1826 op. cit. pp. 96-97; Butcher 1932 op. cit. p. 111.
73. Johnson 1826 op. cit. p. 97.
74. Ibid. p. 96.
75. Butcher 1932 op. cit. pp. 97-99.
76. Johnson 1826 op. cit. p.97.
77. Butcher 1932 op. cit. p. 84.
78. Act of Parliament 3 Geo IV c. xxiv: *An Act for the Employment, Maintenance, and Regulation of the Poor of the City of Bristol; and for altering the Mode of assessing the Rates for the Relief of the Poor* etc. 15th May 1822; Large, D. *The Municipal Government of Bristol 1851-1901*. Bristol: Bristol Record Society Publications, 1999, **50**, pp. 151-158.
79. Johnson 1826 op. cit. p. 109.
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81. Johnson 1826 op. cit. p. 97.
82. *Report of the Metropolitan Commissioners in Lunacy to the Lord Chancellor*. London: Bradbury and Evans. 1844. pp. 52-53.
83. Mary Chapman's Will, dated 4th December 1717: Norfolk Consistory Court Records (Microfilm) MF 432, Records for 1724, Fol 219, Will No152.
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85. Chapman will. op. cit. codicil of 22nd October 1719; BHTMB 22/3/1724.
86. Chapman will. op. cit.; BHTMB 12/1/1724, 22/3/1724.
87. e.g. BHTMB 26/7/1725.
88. BHTMB 28/7/1725.
89. BHTMB 18/2/1725.

90. BHTMB 19/12/1743, 9/1/1743.
91. BHTMB 6/4/1747, 9/12/1751, 3/4/1809, 7/5/1753.
92. BHTMB 30/5/1727, 19/9/1748, 4/1/1773, 7/5/1781.
93. BHTMB 15/1/1753, 4/12/1815.
94. BHTMB 21/4/1727, 26/6/1727, 8/5/1749, 28/5/1750.
95. BHTMB 20/8/1750, 19/11/1753, 11/2/1754, 8/4/8/4/1754, 1/7/1754.
96. BHTMB 27/4/1747, 1/6/1747.
97. BHTMB 10/12/1764, 1/4/1765, 1/7/176; Bethel Hospital Charter of Incorporation 1765: Norfolk Record Office Archive Ref Acc 2003, 176.
98. BHMTB 8/9/1735, 7/2/1763, 3/2/1766; 7/3/1763, 4/4/1763, 3/10/1763.
99. BHTMB 2/7/1753, 7/3/1808, 4/4/1808.
100. BHTMB 9/12/1751, 7/6/1762, 5/9/1785, 7/11/1785.
101. e.g. BHTMB 1/1/18010, 4/2/1811.
102. BHTMB 2/6/1800, 3/8/1801, 7/5/1804, 11/5/1807.
103. BHTMB 6/11/1797.
104. FPHGAM 3/9/1718; Fig. 8 from Marmoy. C. F. A. 'La Providence': The French Hospital during two and a half centuries. *Proceedings of the Huguenot Society of London*, 1965-1970, **21**. pp. 235-247, Fig. 7.
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109. 1731-3 Accounts for Building Work, old and new buildings. Huguenot Society Library Ref: H/F2/2
110. Ibid. Entries dated 1/7/1732, 17/7/1732, 23/10/1732, 29/1/1732, 2/2/1732, 21/3/1732, 26/3/1733.
111. Printed Appeal for Rebuilding Petites Maisons 1752-3. Huguenot Society Library Ref H/F1a/1.
112. Inventory of Hospital Property handed to Roumieu & wife 26 Oct 1742: Huguenot Society Library, Ref: H/C2/2.
113. FPHJCQ 14/3/1740.
114. FPHJCQ 26/2/1742.
115. FPHJCQ 9/4/1740; Marmoy. C, F, A. The French Protestant Hospital: Extracts from "La Providence" relating to inmates and applicants for admission 1718-1957 and to recipients of and applicants for the Coqueau Charity 1745-1901. *Huguenot Society of London. Quarto Series*. 1977 Vols LII & LIII under surnames Herpin, Mire, Mastiniere, Guespin.
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122. GHCCM 29/3/1728, 2/4/1728.
123. GHCCM 23/7/1728.
124. GHCCM 25/1/1737.
125. GHCCM 9/12/1728, 7/4/1730.
126. GHCCM 23/7/1730.
127. GHCCM 2/4/1754.
128. GHCCM 19/2/1755.
129. GHCCM 1/4/1783.
130. e.g. GHCCM 22/6/1756.
131. GHCCM 23/3/1784, 31/10/1786, 27/3/1787, 19/3/1788, 25/3/1789, 30/9/1789, 31/3/1790, 13/10/1790, 22/5/1793, 18/9/1794, 18/3/1795, 10/3/1797.
132. SLGCB 1750-1779 pp. 1-2. *“Considerations upon the Usefulness and Necessity of establishing an Hospital, by subscription, as a farther Provision for Poor Lunaticks”*.
133. SLGCB 13/6/1750.
134. SLGCB 29/6/1750.
135. SLGCB 12/9/1750, 10/10/1750.
136. SLGCB 31/10/1750, 8/2/1750.
137. SLGCB 22/3/1750.
138. SLGCB 26/6/1751, 14/8/1751.
139. SLGCM 7/8/1751, 27/11/1751.
140. SLGCM 4/10/1752; SLGCB 14/2/1753, 12/2/1755.
141. SLGCB 13/2/1754, 12/8/1766, 5/2/1772, 25/2/1772, 19/6/1772, 14/7/1772; SLGCM 16/6/1772.
142. SLGCB 13/2/1754.
143. SLGCM 5/11/1755, SLGCB 12/2/1760.
144. SLGCB 12/4/1764, 19/4/1764; SLGCM 19/10/1764, 7/11/1764; SLHCM 5/10/1764, 28/12/1764, 31/12/1764.

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- 150 SLGCB 8/2/1786.
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154. FPHGAM 3/10/1753; Minutes of the Committee for Rebuilding the “Petites Maisons.” op. cit. 20/4/1754, 4/1/1755, 8/1/1755; FPHJCQ 15/3/1755.
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156. FPHJCQ 15/2/1755, 7/10/1780, 17/9/1768.
157. FPHJCQ 27/9/1760, 22/8/1772, 6/6/1761.
158. FPHJCQ 12/5/1770, 24/11/1781, 26/1/1782, 2/3/1782. 6/4/1782, 11/5/1782.
- 159 FPHJCQ 12/10/1782, 11/1/1783, 25/1/1783, 1/2/1783; FPHGAM 7/1/1783, 8/7/1801, 13/8/1801.
160. Newcastle Courant 21/5/1763, 28/5/1763, 4/6/1763, 25/6/1763, 2/7/1763, 9/7/1763, 30/7/1763; Newcastle-upon-Tyne Common Council Order Book 1743-1766:16/6/1763.
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162. Newcastle-upon-Tyne Common Council Order Book 1743-1766: 7/10/1765.
163. Plan and Elevation of Newcastle Lunatic Hospital by William Newton. C. 1765. Northumberland Archives Service. Ref ZBL 269/69; Hall 1767 op. cit. Footnote to p. 17.

164. Hall 1767. op. cit. pp. 7-8; Newcastle Chronicle 26/8/1769.
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167. Ibid. Rules concerning the admission of patients, VII.
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- 179 BBCM 13/4/1619.
180. BBCM 15/6/1622.
181. BBCM 25/1/1666.
182. BBCM 21/1/1642; Andrews, J., Briggs, A., Porter, R., Tucker, P., & Waddington, K. *The History of Bethlem*. London: Routledge, 1997. Appendix 5.
183. Bridewell and Bethlem Muniment Book 1553-1732, Part 2 Fol 208.
184. BBCM 13/4/1619.
185. Hunter, R. & Macalpine, I. *Three Hundred Years of Psychiatry 1535-1860: A History Presented in Selected English Texts*. London: Oxford University Press, 1963, p. 107.

186. BBCM 4/11/1635.
187. BBCM 30/9/1642.
188. BBCM 1/7/1642.
189. BBBCM 2/6/1643.
190. BBCM 13/12/1644.
191. BBCM 25/7/1645.
- 192 BBCM 18/7/1646.
193. BBCM 13/1/1648.
194. BBCM 16/11/1653.
195. BBCM 28/6/1624.
- 196 BBCM 12/6/1657.
- 197 BBCM 3/12/1675.
- 198 BBCM 4/6/1675, 5/5/1676, 28/6/1689.
199. BBCM 30/3/1677.
200. BBCM 30/3/1677.
201. BBCM 1/7/1681.
202. BBCM 28/6/1689.
- 203 BBCM 29/3/1723.
204. BBCM 26/7/1728.
205. Johnson, J. *Transactions of the Corporation of the Poor in the City of Bristol during a Period of 126 Years, Alphabetically Arranged, with Observations and a Prefatory Address to the Guardians of 1826*. Bristol: P. Rose, 1826, pp. 146-7.
206. FPHJCQ 16/7/1748.
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APPENDIX 3

ANALYTIC EXAMPLES

A.3.1 Introduction

In Chapter 2 the three major phases of the analysis were described. The first phase involved coding discrete segments of the collected material for each institution in a search for recurrent thematic elements. This led to an understanding of the material in terms of the major themes, or discourses, of Care, Confinement, Piety and Commerce. In the second phase, the coded material was sorted, within these categories, leading to the identification, and elaboration, of the specific institutional practices underlying them. In the final phase of the analysis the practices within each institution were combined with related practices in the other institutions, and the understanding of them was progressively refined to produce the integrated model of institutional functioning which has been reported in chapters 4 to 7. The thematic elements (discourses) within this model were further understood as representing the major parts of a broader gubernatorial ethos, and material associated with the generation, maintenance, and change of this ethos was separately identified and reported in Chapter 3.

This appendix aims to present examples of the three major analytic phases, and the different types of material which were encountered in the analysis.

A3.2 Coding

A3.2.1 Introduction

The example of this initial phase of the analysis presented below concerns the establishment of the Guy's Hospital Lunatic House, and was taken from the analysis of the minutes of a meeting of the hospital's court of committees held on 12th February 1727.¹ The "committees" referred to were not, as in modern parlance, groups of people, but individuals appointed by the overall court of governors to manage the hospital.

The verbatim transcription of the minutes will be presented first, followed by the codings assigned to it, with brief analytic memos. This will be followed by a short commentary on the analysis.

A3.2.2 Verbatim transcript

[Fol 128]

At a Court of Committees held at the Clerk's house in Sherborn Lane on Monday the twelfth day of February 1727

Lunatick House will be ready by Lady Day

Mr Treasurer acquainted this Court that the house for reception of Lunaticks will be ready by Lady Day next. This Court proceeded to consider what number of Servants will be necessary to take care of the Lunatick patients

2 men and woman to be keepers of Lunaticks

Resolved It is the opinion of this Court that two men and one woman be appointed to be keepers of the said Lunatick patients And that they be chose at first for one year only.

50 l. security

Resolved That the said Keepers do give security of fifty pounds each for their Honesty and good behaviour

[Fol 129]

Court of Committees for Choice of Keepers

Ordered That a Court of Committees be Summoned for Monday the Eleventh day of March to be held at Mr Guy's Hospital for the Choice of three Keepers for the Lunatick patients.

A3.2.3 Codings

Codings and memos for this material were as follows:

CARE/CONFINEMENT

Material Modality Fixed Element: New Lunatic House will be ready by Lady Day

Relational Modality: Number of servants considered to "take care of" [continuous rhetoric of care and no mention of cure] 2 men and 1 woman to be chose as "keepers" [air of confinement here]

COMMERCE

Material Modality Fixed Element: New Lunatic House

Relational Modality: Keepers appointed for a year and to give £50 security each “for their Honesty and good behaviour”

CONTROL (Of staff)

Material Modality Fixed Element: New Lunatic House

Relational Modality: Keepers appointed for a year and to give £50 security each “for their Honesty and good behaviour” Court of Committees Summoned to choose three Keepers for the Lunatic patients. [Called patients] [Yearly appointments a form of control as contracts need not be renewed and, at least, an annual review takes place]

A3.2.4 Commentary

Four early codings were used to reflect broad themes in this material which were consistent with those found in the collected material as a whole. These were Care, Confinement, Commerce, and Control of Staff.

The theme of care was seen as reflected in the terms “reception” and “take care,” and the relevant memo notes that the use of such terms were part of a transformation of coercive confinement into care. These terms were also seen as falling within the relational modality. It was further noted that the term “cure” was absent, implying that this was not seen as a function of the hospital in relation to lunatics.

The theme of confinement was reflected, in the material modality, by the construction of a building in which lunatics would be confined, and the building fell within the “fixed element” category of this domain. Confinement was also indicated, within the relational domain, by the appointment of “keepers,” as the relevant memo suggested.

The theme of commerce was reflected, in the material modality (fixed element), by an expansion of the hospital’s activities into the management of lunacy, through the construction of a lunatic house, though this was required by Thomas Guy’s will and, in the relational modality, by the competitive appointment of staff to manage the inmates. The staff were to contract to be of honest and of good behaviour, and were

to mark this by laying themselves open to a financial penalty if they were not. Their employment was also to be reviewed on an annual basis. These were processes seen as analogous to those of businesses.

Allied to the theme of commerce, and eventually combined with it, this was that of control of staff. Within the material modality (fixed element) the keepers were to be appointed to work in a particular segment of the hospital (the lunatic house) and, within the relational modality, were to be controlled by competitive election and the previously noted processes of being financially penalized for bad behaviour, and of risking the non-renewal of their contracts on annual review. An additional memo in this section also noted that the inmates of the lunatic house were described as “patients”, an example of “leakage” the application of a term used for other inmates of the hospital to coercively confined lunatics, and one which gradually infiltrated other lunatic institutions as part of a “rhetoric” of cure.

A3.3 Sorting and Identification of institutional processes

A3.3.1 Introduction

The example of this phase of the analysis comprises a transcribed sample of the entries in the record of the disbursements made by the master of the Bethel Hospital from 1764 to 1795.² Again, the verbatim transcript will be presented first, followed by its analysis.

A3.3.2 Verbatim transcript

The use of memos is notable in the following transcript. These mainly raised questions about the meaning of particular entries but were also, occasionally, reflections on institutional processes.

Bethel Hospital Master’s Disbursements 1764-1795 (BH 6)

This volume is undamaged by water and the handwriting is neater and less faded, so it is easier to read. This volume is in chronological order.

The Columns are:

Beer & Milk
 Beef & Mutton
 Fish, Fowl, Butter & Eggs
 Meal, Flour, Oatmeal, Salt
 Groceries
 Miscellanies (tends to relate to food, washing etc)
 Incidents & Salaries (the most interesting category from my viewpoint)
 Cloathing
 Charges of keeping ** lunatics from --- to ---

Each double page has three horizontal bands of accounts, one for each month, though the months don't run from 1st to last day.

May/June 1764 Whey for the lunatics 2/6½
 June/July 1764 Strong Beer for the sick -/6, Spirits of wine 1 pt 1/6
 Dec 1764/Jan 1765 Spanish White -/1½ [A common purchase what was it? Poss whitening for walls]
 Jan/Feb 1765 Brand ½ p for sick -/8
 April/May 1765 Wine ½ p for ye sick -/4½
 Nov/Dec 1765 ½ load wheat straw 10/6, muck man 1/-
 March/April 1766 2 whiting brushes 1/6
 June/July 1766 Mending Susan Osborne's shoes -/10 [common references to buying/mending shoes, presumably for patients]

Records at this time refer to charge of keeping X "lunaticks"

Sept/Oct 1766 ¼ pint of rum for the sick -/4
 Oct/Nov 1766 Catching 3 ratts -/9
 June/July 1767 Susan Osborn 1 pair of stockings, Eliz Larwood 1 lace
 Sept/Oct 1767 17 yards of camblett at 1s for gowns for E. Larwood & Mary Newham 17/-, E Larwood 1 pr shoes 2/9 [E. Larwood and Susan Osborn are perpetually having their shoes mended]
 Jan/Feb 1768 Susan Osborn 2 mobbs 1/5
 Sept/Oct 1769 Eliz Larwood 6 yards & ½ of cloth at 16d for 2 shifts 8/8, Mary Newham ditto 8/8, Eliz Larwood 1 pr shoes 3/-
 May/June 1770 E. Larwood's Funeral Charges £1-0-0
 Sep 1770 1 years insurance 10/-
 Aug 1772 10 lb feathers at 18d for maidservant's bed & pillows £0-15-0
 Oct/Nov 1772 1 doz dwiles 1/3 [what were they? They were always buying them]
 Dec 1772 to Jan 1773 Leather thongs -/6 [common purchase what for ?] Nb still called "lunaticks" in list of charges
 Dec/Jan 1775 A Flecting dish-/4
 Jan/Feb 1775 Camblet 8 yds for a gown for Susan Osborn 8/-, Lining 1/-, making 2/-
 June/Jul 1776 Balm for tea 1/-
 July/Aug 1776 Sage for tea -/6, Iron box & heater 9/6
 Aug/Sept 1776 physic cupps -/6, Nitre 1lb 1s/2d [Common purchase] Still called lunaticks
 Oct/Nov 1776 Susan Osbourne Funeral Expenses £1-0-0 [NB followed by "sieve bottom" 1/- [either callous or death an everyday occurrence]
 Nov/Dec 1776 Apples for sick-/3
 Oct/Non 1777 Delph Ware ¾, sugar for sick -/6
 Jul/Aug 1778 Ratts catching 3/6
 Sept/Oct 1778 Mary Stinson Camblet gown 7 yds at 1s 7/-, lining 1/-, making 2/-, a petticoat 4/- do 2/6, Martha Barnard shoes mending -/4½

July/Aug 1780 Two waistcoats 11/- [no pts mentioned ? strait waistcoats], Three legg
 locks 3/9, three chains 3/-Oct/Nov 1780 Teas, suger & strong beer for the watchers 4/9
 March 1782 Cakes & wine for ye sick 1/3 [still called lunatics]
 March/April 1782 A box iron & heater 5/3
 May/ June 1782 2 shifts Deb Neave 6/5
 July/Aug 1782 4 new chains 2/7½, 3 leg locks 4/6
 Jan/Feb 1783 Three waistcoats 12/8 [No pts names so probably strait waistcoats]
 March/April 1783 Seeds for the garden -/6½
 May/June 1783 A jacket 5/6 [no pts name]
 March/April 1784 Wash engine 15/-
 Dec 1785 to Jan 1786 2 padlocks 1/6
 Jan/Feb 1786 2 padlocks 1/6
 Dec 1786 Honey for sick -/2½ , cakes & oranges for the sick 1/9
 Jan/Feb 1787 Whiting sick room 1/2 [had they had an outbreak of infection?]
 March/April 1787 6 leg locks 7/6
 July/Aug 1787 Beer & Washers 3/2 [they were always buying washers for some
 reason]
 Dec 1787/Jan 1788 Iron back for stove 2/8
 March/April 1788 1 doz locks 15/-
 Nov 1788 Brandy wine & tea for the sick 5/8
 March/April 1789 1 doz trenchers 3/- [common purchase]
 April/may 1789 Portring the straw -/3
 May/June 1789 7 chamber pots 1s/2d
 June/July 1790 4 leather straps etc etc 5/4
 Oct 1790 204 bunches Lyng 6/6 [Ling or Lyng a common purchase. What for ?] Still
 called lunatics
 Oct/Nov 1790 Flecting dish -/6
 Jan/Feb 1791 Portring in straw -/3
 Feb/March 1791 Strong Beer for sick 3/-, tea for do 4/8
 July/Aug 1791 1 doz leg locks 19/6
 Oct 1791 4 locks for patients 4/8 [NB first reference to patients here], 2 pillow cases
 3/8,Half load of straw 8/3
 Oct/Nov 1791 Insurance for fire 17/6
 Nove/Dec 1791 Mary Stimson 1 pr of stockings 1/6
 Jan/Feb 1792 12 chamber pots 7/6
 Feb/March 1792 2 doz leg & waist locks £1-10-0
 March/April 1792 12 chamber pots 7/6 [what are they doing with them all?]
 Aug/Sept 1792 6 pr blankets 3/6 [they have been buying a lot of blankets & sheeting
 why?]
 Dec 1792 to Jan 1793 Load of straw £1-11-6 [Suggests some pts still sleeping on
 straw]
 Sept 1793 ½ load of straw £1-1-0
 Feb/March 1794 6 straight jackets £3-16-3
 Nov/Dec 1794 ½ doz chairs £1-5-6
 Dec 1794 to Jan 1795 14 pr blanketts £9-10-0, 2 ruggs £1-18-0
 Jan/Feb 1795 34 yds rug @ 2/6£4-5-0
 Feb/Mar 1795 Tarmaric 2/-
 March/April 1795 Wrist & leg shackles £4-19-6
 April/May 1795 Tamarick 2/- [What for ?], Wine Mrs Neave 2/6 [Mrs Neave ? Pt
 seems to be chronically ill and additional food & alcohol constantly being bought for
 her.]

A3.3.3 Analysis

DISCOURSE OF CONTROL AND COMMERCE

Master's List of Disbursements

Books with separate headings as a form of financial control and as constructive of the reality of care

The Columns are:

Beer & Milk

Beef & Mutton

Fish, Fowl, Butter & Eggs

Meal, Flour, Oatmeal, Salt

Groceries

Miscellanies (tends to relate to food, washing etc)

Incidents & Salaries (the most interesting category from my viewpoint)

Cloathing

Charges of keeping ** lunatics from --- to ---

Each double page has three horizontal bands of accounts, one for each month, though the months don't run from 1st to last day.

Supplies

Various Supplies, salaries and other payments

Food

Note much of this "for the sick"

Things "for the sick" [better diet] Apples, cake, honey, oranges etc

May/June 1764 Whey for the lunatics 2/6½

June/Jul 1776 Balm for tea 1/-

July/Aug 1776 Sage for tea -/6

Nov/Dec 1776 Apples for sick -/3

Oct/Non 1777 sugar for sick -/6

March 1782 Cakes & wine for ye sick 1/3 [still called lunatics]

Dec 1786 Honey for sick -/2½, cakes & oranges for the sick 1/9.

Alcohol and other Beverages

Note things "for the sick" Alcohol Tonics, sugar, tea? [better diet] [See Mrs Neave at end]

Alcohol of various kinds "for ye sick" etc [Seems to have been used as a tonic, but possibility of use as sedation]

Tea of various kinds [Why tea now, this may have been used as a reward]

Teas, suger & strong beer for the watchers

Note night “watchers” have beer which, paradoxically, seems likely to make them sleepy

June/July 1764 Strong Beer for the sick -/6, Spirits of wine 1 pt 1/6
Jan/Feb 1765 Brand ½ p for sick -/8
April/May 1765 Wine ½ p for ye sick -/4½
Sept/Oct 1766 ¼ pint of rum for the sick -/4
Oct/Nov 1780 Teas, suger & strong beer for the watchers 4/9
July/Aug 1787 Beer & Washers 3/2 [they were always buying washers for some reason]
Nov 1788 Brandy wine & tea for the sick 5/8
Feb/March 1791 Strong Beer for sick 3/-, tea for do 4/8
April/May 1795 Wine Mrs Neave 2/6 [Mrs Neave ? Pt seems to be chronically ill and additional food & alcohol constantly being bought for her.]

Clothes and Shoes

Note Mending shoes

Note much for E Larwood, whose funeral is also recorded.

Clothing for patients, including shoes, also material for making up clothes. A good picture of what the patients wore is provided, at least for women, for whom clothes appear to have often been specially made.

June/July 1766 Mending Susan Osborne’s shoes -/10 [common references to buying/mending shoes, presumably for patients]
June/July 1767 Susan Osborn 1 pair of stockings, Eliz Larwood 1 lace
Sept/Oct 1767 17 yards of camblett at 1s for gowns for E. Larwood & Mary Newham 17/, E Larwood 1 pr shoes 2/9 [E. Larwood and Susan Osborn are perpetually having their shoes mended]
Jan/Feb 1768 Susan Osborn 2 mobbs 1/5
Sept/Oct 1769 Eliz Larwood 6 yards & ½ of cloth at 16d for 2 shifts 8/8, Mary Newham ditto 8/8, Eliz Larwood 1 pr shoes 3/-
Jan/Feb 1775 Camblet 8 yds for a gown for Susan Osborn 8/-, Lining 1/-, making 2/-
Sept/Oct 1778 Mary Stinson Camblet gown 7 yds at 1s 7/-, lining 1/-, making 2/-, a petticoat 4/- do 2/6, Martha Barnard shoes mending -/4½
May/ June 1782 2 shifts Deb Neave 6/5
May/June 1783 A jacket 5/6 [no pts name]
Nove/Dec 1791 Mary Stimson 1 pr of stockings 1/6 .

Bedding & Rugs

Straw for bedding

Maidservants bedding

Nov/Dec 1765 ½ load wheat straw
Aug 1772 10 lb feathers at 18d for maidservant’s bed & pillows £0-15-0
April/may 1789 Portring the straw -/3
Jan/Feb 1791 Portring in straw -/3
Oct 1791 2 pillow cases 3/8, Half load of straw 8/3
Aug/Sept 1792 6 pr blankets 3/6 [they have been buying a lot of blankets & sheeting why?]

Dec 1792 to Jan 1793 Load of straw £1-11-6 [Suggests some pts still sleeping on straw]
Sept 1793 ½ load of straw £1-1-0
Dec 1794 to Jan 1795 14 pr blanketts £9-10-0, 2 ruggs £1-18-0
Jan/Feb 1795 34 yds rug @ 2/6 £4-5-0.

Restraint Equipment, Leather Thongs, Padlocks, Chains, Straps

These may not all be for restraint, but most certainly are

Inmates still called lunaticks [Decontextualised state permitting confinement] 1791 “4 locks for patients” [First reference to patients?]

Two waistcoats [? strait waistcoats, almost certainly as no patient names attached],
Three leg locks, three chains, padlocks and various other restraining devices such as waist locks. Feb/March 1794 “6 straight jackets £3-16-3” [Clearly strait jackets bought and previous references to “waistcoats” probably refer to these] Wrist & leg shackles £4-19-6

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July/Aug 1782 4 new chains 2/7½, 3 leg locks 4/6
Jan/Feb 1783 Three waistcoats 12/8 [No pts names so probably strait waistcoats]
Dec 1785 to Jan 1786 2 padlocks 1/6
Jan/Feb 1786 2 padlocks 1/6
March/April 1787 6 leg locks 7/6
March/April 1788 1 doz locks 15/-
June/July 1790 4 leather straps etc etc 5/4
July/Aug 1791 1 doz leg locks 19/6
Oct 1791 4 locks for patients 4/8 [NB first reference to patients here],
Feb/March 1792 2 doz leg & waist locks £1-10-0
Feb/March 1794 6 straight jackets £3-16-3
March/April 1795 Wrist & leg shackles £4-19-6.

Whiting and Brushes

Whiting, Whiting sick room [Miasma?]

Dec 1764/Jan 1765 Spanish White -/1½ [A common purchase what was it? Poss whitening for walls]
March/April 1766 2 whiting brushes 1/6
Jan/Feb 1787 Whiting sick room 1/2 [had they had an outbreak of infection?]

Muck Man

Night Soil Collection?

Nov/Dec 1765 10/6, muck man 1/-

Rat Catching

Oct/Nov 1766 Catching 3 ratts -/9
Jul/Aug 1778 Ratts catching 3/6

Funerals

May/June 1770 E. Larwood's Funeral Charges £1-0-0
Oct/Nov 1776 Susan Osbourne Funeral Expenses £1-0-0 [NB followed by "sieve bottom" 1/- [either callous or death an everyday occurrence]

Insurance

Sep 1770 1 years insurance 10/-
Oct/Nov 1791 Insurance for fire 17/6

Chamber Pots

May/June 1789 7 chamber pots 1s/2d
Jan/Feb 1792 12 chamber pots 7/6
March/April 1792 12 chamber pots 7/6 [what are they doing with them all?]

Heating

July/Aug 1776 Iron box & heater 9/6
March/April 1782 A box iron & heater 5/3
Dec 1787/Jan 1788 Iron back for stove 2/8

Seeds and Ling [Heather]

Not sure whether ling was used medicinally or for ornament

March/April 1783 Seeds for the garden -/6½
Oct 1790 204 bunches Lyng 6/6 [Ling or Lyng a common purchase. What for ?]

Apothecary/Surgery supplies

Physic cupps, Nitre, "Tamarick" [Turmeric?], Flecting Dish [Not sure what this is]

Dec/Jan 1775 A Flecting dish-/4
Aug/Sept 1776 physic cupps -/6, Nitre 1lb 1s/2d [Common purchase]
Oct/Nov 1790 Flecting dish -/6
Feb/Mar 1795 Tarmaric 2/-
April/May 1795 Tamarick 2/- [What for ?]

Crockery etc.

Oct/Non 1777 Delph Ware ¾
March/April 1789 1 doz trenchers 3/- [common purchase]

Dwiles

Oct/Nov 1772 1 doz dwiles 1/3 [what were they? They were always buying them]

Furniture

Nov/Dec 1794 ½ doz chairs £1-5-6

Wash engine

March/April 1784 Wash engine 15/-

DISCOURSE OF CARE

Care of Inmates

Food [Particularly for Sick]

Note much of this “for the sick”

May/June 1764 Whey for the lunatics 2/6½

June/Jul 1776 Balm for tea 1/-

July/Aug 1776 Sage for tea -/6

Nov/Dec 1776 Apples for sick-/3

Oct/Non 1777 Delph Ware ¾, sugar for sick -/6

March 1782 Cakes & wine for ye sick 1/3 [still called lunatics]

Dec 1786 Honey for sick -/2½, cakes & oranges for the sick 1/9

Alcohol and other Beverages

Note things “for the sick” AlcoholTonics, sugar, tea? [better diet] [See Mrs Neave at end]

Alcohol of various kinds “for ye sick” etc [Seems to have been used as a tonic, but possibility of use as sedation]

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Jan/Feb 1765 Brand ½ p for sick -/8

April/May 1765 Wine ½ p for ye sick -/4½

Sept/Oct 1766 ¼ pint of rum for the sick -/4

Oct/Nov 1780 Teas, suger & strong beer for the watchers 4/9

July/Aug 1787 Beer & Washers 3/2 [they were always buying washers for some reason]

Nov 1788 Brandy wine & tea for the sick 5/8

Feb/March 1791 Strong Beer for sick 3/-, tea for do 4/8

April/May 1795 Wine Mrs Neave 2/6 [Mrs Neave ? Pt seems to be chronically ill and additional food & alcohol constantly being bought for her.]

Clothes and Shoes

[Note much for E Larwood, whose funeral is also recorded.]

[Clothing for patients, including shoes, also material for making up clothes. A good picture of what the patients wore is provided, at least for women, for whom clothes appear to have often been specially made.]

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May/June 1783 A jacket 5/6 [no pts name]
Nove/Dec 1791 Mary Stimson 1 pr of stockings 1/6

Bedding & Rugs

Straw for bedding

Nov/Dec 1765 ½ load wheat straw
April/may 1789 Portring the straw -/3
Jan/Feb 1791 Portring in straw -/3
Oct 1791 2 pillow cases 3/8, Half load of straw 8/3
Aug/Sept 1792 6 pr blankets 3/6 [they have been buying a lot of blankets & sheeting why?]
Dec 1792 to Jan 1793 Load of straw £1-11-6 [Suggests some pts still sleeping on straw]
Sept 1793 ½ load of straw £1-1-0
Dec 1794 to Jan 1795 14 pr blanketts £9-10-0, 2 ruggs £1-18-0
Jan/Feb 1795 34 yds rug @ 2/6 £4-5-0

Sick Room

Jan/Feb 1787 Whiting sick room 1/2 [had they had an outbreak of infection?]

Funerals

May/June 1770 E. Larwood's Funeral Charges £1-0-0
Oct/Nov 1776 Susan Osbourne Funeral Expenses £1-0-0 [NB followed by "sieve bottom" 1/- [either callous or death an everyday occurrence]

Care of Staff

Maidservants bedding

Aug 1772 10 lb feathers at 18d for maidservant's bed & pillows £0-15-0

Care of Staff and Inmates

Garden

March/April 1783 Seeds for the garden -/6½

DISCOURSE OF CONFINEMENT

Coercive Confinement

Lunatics

May/June 1764 Whey for the lunatics 2/6½

Restraint Equipment, Leather Thongs, Padlocks, Chains, Straps

These may not all be for restraint, but most certainly are

Inmates still called lunaticks [Decontextualised state permitting confinement] 1791 “4 locks for patients” [First reference to patients?]

Two waistcoats [? strait waistcoats, almost certainly as no patient names attached], Three legg locks, three chains, padlocks and various other restraining devices such as waist locks. Feb/March 1794 “6 straight jackets £3-16-3” [Clearly strait jackets bought and previous references to “waistcoats” probably refer to these] Wrist & leg shackles £4-19-6

Dec 1772 to Jan 1773 Leather thongs -/6 [common purchase what for ?] Nb still called “lunaticks” in list of charges

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July/Aug 1782 4 new chains 2/7½, 3 leg locks 4/6

Jan/Feb 1783 Three waistcoats 12/8 [No pts names so probably strait waistcoats]

Dec 1785 to Jan 1786 2 padlocks 1/6

Jan/Feb 1786 2 padlocks 1/6

March/April 1787 6 leg locks 7/6

March/April 1788 1 doz locks 15/-

June/July 1790 4 leather straps etc etc 5/4

July/Aug 1791 1 doz leg locks 19/6

Oct 1791 4 locks for patients 4/8 [NB first reference to patients here],

Feb/March 1792 2 doz leg & waist locks £1-10-0

Feb/March 1794 6 straight jackets £3-16-3

March/April 1795 Wrist & leg shackles £4-19-6

Rhetoric of Cure

“Patients”

Oct 1791 4 locks for patients 4/8 [NB first reference to patients here]

Garden

March/April 1783 Seeds for the garden -/6½

Apothecary/Surgery supplies

Physic cupps, Nitre, “Tamarick” [Turmeric?], Flecting Dish [Not sure what this is]

Dec/Jan 1775 A Flecting dish-/4

Aug/Sept 1776 physic cupps -/6, Nitre 1lb 1s/2d [Common purchase]

Oct/Nov 1790 Flecting dish -/6

Feb/Mar 1795 Tarmaric 2/-
April/May 1795 Tamarick 2/- [What for ?]

A3.3.4 Commentary

The analysis of this material shows the broad grouping of the recorded disbursements under thematic headings (at this point termed “discourses”) of Control and Commerce, Care, and Confinement. No “challenges” to these discourses were recorded as a simple list of purchases did not lend itself to this categorisation. Although the purchase of a good deal of restraining equipment would suggest that inmate protest was likely to be occurring, it was impossible to discriminate this from routine confinement. Within each discourse the material has been categorised under headings which begin to elaborate institutional processes, for example concerning the material care of inmates and staff, or medical supplies concerned with the cure of madness. A change in the descriptive term used for inmates from ”lunatics” to “patients” has also been noted.

Within the Discourse of Control and Commerce the fact that the master kept books of his disbursements was noted as an aspect of financial control within the hospital and the content of the book was separated out under different expenditure headings.

Under the Discourse of Care expenditure concerning care was separated into that concerning the care of inmates, that concerning the care of staff, and that (the purchase of seeds for the garden) concerning care of both groups. Memos elaborated on various aspects of care, for instance the considerable amount of food and beverages “for the sick,” the fact that clothes were made for individual inmates, and the provision and painting of a “sick room.” The fact that some inmates still slept on straw, whereas others had blankets and rugs, was also noted.

Under the Discourse of Confinement it was noted that the use of the term “lunatic” changed to “patient” in October 1791, and may have been part of the development of a rhetoric of cure. The provision of a garden, and medical supplies, was also seen as part of the rhetoric of cure. A range of restraining devices was listed and, materially, attested to the confining nature of the institution and, albeit indirectly, to the

possibility of inmate protest. A move to the use of straitjackets was also noted, though iron restraining equipment continued to be bought.

A3.4 Amalgamation of institutional material and the construction of explanatory narrative

A3.4.1 Introduction

The example of this analytic phase will be presented, without further comment, as this is contained within the example. It concerns one aspect of what has been termed the ‘rhetoric of cure’ which, it has been argued, was one way in which coercive confinement was translated into something more benign. The particular argument was that a proportion of inmates spontaneously recovered, and that such recoveries could be claimed as cures by representing the institution, its staff and practices, as dedicated to cure. This could be done verbally, by adopting a curative nomenclature and, materially, by the provision of staff, such as physicians, whose practices and equipment could be seen in this way. It was, further, argued that, over time, institutions developed practices of filtering their intake of inmates so that only those with the best chance of spontaneously remitting were admitted, and those found not to have remitted after a reasonable time could be discharged, making room for more promising individuals. Such discharges, it was suggested, were labelled as various kinds of ‘unfit object’, these labels serving to mitigate any responsibility the institution could be seen as having for their lack of recovery and, statistically, allowing a more favourable rate of cure to be claimed than would otherwise have been the case. It is with this filtering process, specifically at the admission stage, that the present example is concerned.

A reduced version of this analysis can be found in Chapter 4, section 4.5.2.

A3.4.2 Analysis of Admission Process

This section concerns those institutions in the sample which clearly pursued a policy of cure, other than viewing confinement as, in itself, curative. Therefore it excludes the Guy’s Hospital lunatic house, which was clearly intended for “incurables” and St Peter’s Hospital which confined lunatics but, in the period considered, did not appear to have a clear policy of curing them. The French Hospital lunatic house has also

been excluded for the same reason. While it claimed occasional “cures” there was no evidence that any consistent effort at cure was made. The remaining institutions, Bethlem, the Bethel, St. Luke’s and the Newcastle Lunatic Hospital appeared to have had clear policies of cure, though evidence from the latter institution was very limited.

The argument which will be pursued here is that, except in rare cases, the “cures” claimed by these institutions were spontaneous remissions and that, by a mixture of logic, and a process of trial and error, the governors, and medical staff, became increasingly able to discriminate between those who were likely to spontaneously remit, and those who were not. Those unlikely to remit, it will be suggested, were increasingly prevented from being admitted by an initial screening process which labelled them as “unfit objects” for admission. However, some inmates who had been admitted were later found to be unlikely to spontaneously remit, and were discharged under a variety of “unfit” labels which avoided attributing their lack of “cure” to any defect in the institution’s curative apparatus. This left a reasonably consistent level of spontaneous recovery which enabled the governors to claim that their institutions were curing lunatics, and that any lack of cure was due to defects in the lunatics which rendered them impervious to attempts at cure. Furthermore, the curative ability of the institutions could be boosted by the creation of a category of partial cure which served to minimise the unfortunate necessity of having to admit that a good proportion of the inmates were unaffected by the institutions curative ministrations. Finally it will be suggested that such categorisation of intake and discharge processes allowed numbers of inmates in different categories to be counted, their numbers aggregated and statistics such as rates of cure calculated, which could be used to compare institutions. This, it is argued, marked the beginning of a statistical “rhetoric of cure” (as well as death and other institutional characteristics) through which governors could statistically represent their institutions in the best light, and compete with other institutions.

The process of admission typically went through a series of stages. First, a petition giving details of the inmate’s lunacy, and making a case for admission, was presented to the governors. This was sometimes required to be accompanied by independent certification of lunacy by a physician who, in the case of St. Luke’s, also had to swear an affidavit before a Justice of the Peace. The petition was considered by the governors, and could be accepted by them, or rejected on the grounds that the potential inmate was in some way an “unfit object” for the institution. At this stage, or a little later, and certainly before admission, a parish certificate confirming that the lunatic was resident in the parish and, in the case of paupers, that the parish would pay any necessary charges, was required to be presented. Certification of parish residence might also be required if “friends” (a term which was applied to all manner of persons caring for a lunatic) were paying the charges, as the inmate might, at some time, become chargeable to the parish, or might need to be discharged into parish care. Those seeking admission were required to provide the names of two or more “securities,” normally householders, or parish officers, who would be held responsible for the payment of the charges, and undertake to receive the inmate on discharge, or pay any burial charges in case of death.

Those for whom the petition was successful would then be placed on a waiting list, if such existed, and, on a vacancy occurring, would be ordered to be brought by their “friends” to be examined by a committee of governors, at which the physicians and, possibly, other medical staff would be in attendance. This group would assess the potential inmate’s status as a fit object for admission, a critical aspect being a medical judgement as to lunacy and curability. Prospective inmates could, again, be rejected as “unfit” at this point and, occasionally, could not be produced at all as they had died or absconded. However, successful passage through the “view” or “examination”

resulted in a date for admission being set, on which the lunatic would be brought to the hospital by their “friends”, and a written order being issued requiring the master, or steward, to admit the inmate on its presentation.

Although practice differed slightly in the institutions considered here, the rules for the Newcastle Lunatic Hospital exemplified the admission process reasonably well, and briefly described the discharge process for “cured” inmates:

In Order to procure Admission into this Hospital for any Patient, it is necessary that a Petition be presented to the Committee, which shall meet at the Hospital every Wednesday in the Forenoon, at Eleven o’Clock, setting forth the following particulars, viz.

I. THE Patient’s Name, Age, and Abode, whether married or no, how many Children, and what he or she did for a Livelihood, when sensible.

II. HOW long distracted, and whether ever so before.

III. WHETHER melancholy, or raving, and had attempted to do any Mischief.

IV. PLACE of the Patient’s legal Settlement, and the Names of the Church-Wardens and Overseers of the Poor of the Parish where such legal Settlement is.

V. THAT the Parish Officers shall give a Certificate of his or her Poverty, to entitle them to be admitted as Poor. And that Security shall be given by the Parish Officers, for the Payment of FOUR SHILLINGS per Week, during their Stay in the Hospital; also for the Expence of their Cloaths and their Burial, in case they die in the Hospital.

VI. THE above Petition being examined, and the Patient approved of as a proper Object, the Name and Place of Abode of the Patient shall be entered by a Secretary in the Book; and so soon as a Vacancy shall happen, the Friends of the Patient in their Turn, as they are entered in the Book shall be acquainted by a Letter from the Secretary, and desired to attend at the the next Committee with the Patient, that the Committee appointed may determine whether he is a proper Object for the Charity; and such Patient shall be admitted or not, according to their Determination.

VII. EVERY Patient, when cured, shall be called before a Committee of Governors, shall be examined, and being then found fit to be discharged, the Physician shall give a Certificate for that Purpose, and the Matron shall deliver him or her to their Friends.³

Petitions, being written by the inmate’s friends, or sometimes written for them by paid scribes, were very different from the terse, decontextualised, descriptions of inmates typically made by governors and medical staff. As exercises designed to achieve admission they were rhetorical constructions redolent with the misery and danger lunatics could cause. Few have survived, perhaps suggesting that governors attached little value to them, and that they considered that friends would say anything to be rid of their lunatic. However, occasionally, details of the petition were given in the institutional records of admission, as in the plaintive plea of Joseph Read who sought admission to Bethlem Hospital for his young son in December 1776. Surprisingly the governors assented to his admission, though a more hopeless case can scarcely be imagined:

Upon reading the humble petition of Joseph Read of the Parish of Saint Stephen Coleman Street on behalf of his son Joseph nine years of age in the words and figures following viz.

‘That at the age of Four Years and a half he was afflicted with the small Pox the consequences of which, it settled in his Brain ever since but more so within these twelve

months. He is very mischievous will not wear any cloaths, and fearful will be more Outragious as he gathers strength , these circumstances render me very unhappy as I see no prospect of his reason returning, and (what increases my affliction) am totally Incapable of providing for him without the kind assistance of this worthy Charity, else must remain a Burthen to me all the days of my Life, having at this time a wife and three children And your Petitioner will ever pray Etc.”

This Court having duly weighed and considered the said petition doth order that the said Joseph Read “Jun” be admitted a Patient at Bethlem Hospital for 12 months upon producing a certificate of his settlement and giving the usual security⁴

The major concern here is to demonstrate the creation of filters which screened out “unfit objects,” who were unlikely to spontaneously remit, at the petition and examination stages of the admission process. St. Luke’s Hospital, for example, issued instructions to petitioners listing the major categories of “unfit objects” which would be excluded when the petition was considered:

INSTRUCTIONS to such Persons who apply for the Admission of Patients into St. LUKE’S Hospital for Lunaticks:

I. THAT no Person shall knowingly be received as a Patient into this Hospital, who is not in Point of Circumstances, a proper Object of this Charity, that is, Poor and Mad.

II. Or who hath been a Lunatick more than twelve Kalendar Months.

III. Or who hath been discharged uncured from any other Hospital for the Reception of Lunaticks.

IV. Or who is troubled with Epileptick or Convulsive Fits.

V. Or who is deemed an Ideot.

VI. Or who is infected with the Venereal Disease

VII. Nor any Woman with Child.

And every such Person who through Mistake or Misinformation shall be received into this Hospital, shall be discharged immediately on a Discovery of any of the above Disqualifications.⁵

The requirement that the potential inmate should not have been mad more than 12 months reflected the common belief that early treatment was likely to be most effective, and that the prospect of “cure” fell dramatically with time. However, it seems likely that this requirement would tend to select those who had acute, short-lived, episodes of derangement, sometimes of a recurrent nature, which would quickly spontaneously remit, as opposed to those with chronic disorders which would not. For example Bethlem Hospital specifically excluded “mopes,” those with long-term, low-level, states of melancholy, who almost never remitted. On the other hand some potential inmates who, with better timing, might have yielded a respectable “cure” had remitted before they ever got to the hospital, as in the case of the prospective St. Luke’s inmate Thomas Hawkings, in 1758:

The Friends on behalf of Thomas Hawkings attending and acquainting this Committee the Patient is recovered.

Ordered That his name be taken off the List.⁶

Returning to the St. Luke's list, those who had already had a spell in another hospital without remitting were relatively unlikely to do so in St. Luke's. Again, those with fits probably had chronic cerebral disorders, which would not remit, and "ideots" were known to permanently remain in the same state. The exclusion of those with venereal disease was very common and, presumably, indicated an awareness of the incurable neurological consequences of syphilis. The common exclusion of pregnant women is interesting as puerperal mental disorders might be seen as having a reasonable chance of remitting. Exclusion could be to ensure the safety of the mother and baby, to avoid any possibility of infant or maternal death which could be laid at the governors' door, or because the institution lacked facilities for a birth. However, women in the institutions who were discovered to be pregnant were rapidly discharged, as were individuals judged to weak to take physick, and a more likely reason for excluding pregnant women may have been because they could not be given physick without danger of damage to the foetus. Those who recovered without being given physick, that is without "treatment," could, perhaps, not be legitimately claimed as "cures" and were excluded for this reason.

At the examination stage inmates could also be excluded as "unfit" for similar reasons to those that would have led to the rejection of the petition, had they been known at that time. For instance, on 10th November 1722, Jane Steavens was rejected for admission to Bethlem at a view as she was "*paraletick & mopish*":

Jane Steavens of St Butt wth out Aldgate London was this day brought to be viewed but being paraletick & mopish was rejected.⁷

Again, those recovered at the time of the view would be rejected, though there is also the possibility that some had never actually been mad, simply being represented as such in the petition. For instance, in January 1722 Robert Hounsell was rejected at a Bethlem view for being "in his senses":

Robert Hounsell of of Poorstock Coun Dorsett was this day viewed & appearing to be in his senses was rejected.⁸

Inability to take physick due to physical weakness was another reason for rejection at the examination stage, again suggesting that medical treatment was a prerequisite for a legitimate "cure" to be claimed, though there was also, perhaps, the danger of fatalities from vigorous physicking. In November 1723, for instance, Samuel Morley was rejected at a Bethlem view as not strong enough to take physick:

Samuel Morley was this day brought to be view'd pursuant to an order of committee the 16th instant but not being strong enough to take physick was rejected.⁹

An interesting illustration of the process of honing disqualification categories to enhance the rate of cure occurred at St. Luke's Hospital in January 1771, when the physician, Dr. Brooks, proposed that palsied patients should be excluded from admission, as they did not recover. He was asked to confer about this with William Battie, the former physician, who wrote the original exclusion clauses.

Dr. Brooks having acquainted this Committee that he had observed for a considerable time past few or none of those Patients afflicted with Palsies have been cured of their Lunacy and Submitted it to the Judgement of this Committee whether it would not be conducive to the good of the Hospital to add an Exclusive Article of Disqualification for such Cases This Committee took the same into Consideration and are of Opinion that Dr. Brooke be desired to confer with Dr. Battie thereon who was originally consulted about the Disqualifying Clauses.¹⁰

However, Brooke declined to humble himself by discussing disqualification articles with Battie, and the Committee decided there was no need to change the disqualification clauses as, on medical recommendation, they could discharge any inmates considered to be unfit objects.

This Committee having received a Letter from DR. Brooke wherein he declines having any Conference with Dr. Battie in pursuance of the Minute of the last Committee and having taken the same into Consideration. This Committee are of Opinion it will not be prudent to make any further Article of Disqualification And this Committee are the more induced to be of that Opinion because they have the Power of Discharging any Patient upon the Physician of the Hospital reporting to them any Patients Case to be such as to render him or her unfit to be continued in the House.¹¹

Notes to Appendix 3

1. GHCCM 12^{1/2}/1727.
2. Bethel Hospital Master's Disbursements 1764-1795.
3. NUTRHL.
4. BBCM 12/12/1776.
5. St. Luke's Hospital: Instructions for admission of patients into St. Luke's Hospital for Lunatics, undated. Reproduced in French, C. N. *The Story of St. Luke's Hospital 1750-1948*. London: William Heinemann, 1951, Appendix III, and handwritten in the hospital archives.
6. SLHCM 1/12/1758.
7. BethlemHSCM 10/11/1722.
8. BethlemHSCM 12/1/1722.
9. BethlemHSCM 30/11/1723.
10. SLGCM 2/1/1771.
11. SLGCM 7/2/1771.